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An Evaluation of an In Reach Model of Care in LA Care Homes

REPORT 1

The In-Reach Model of Care in Residential Homes Described from the Perspectives of Stakeholders, Home Managers, Care Staff, and the In Reach Team

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REFERENCES FOR ABBREVIATIONS AND TERMS

B&NES	**Bath and North East Somerset**
COREC	**Central Office for Research Ethics Committee**
CHM	**Care Home Manager**
CSCI	**Commission for Social Care Inspectorate**
DN	**District Nurse**
GP	**General Practitioner**
IRT	**In Reach Team**
LA	**Local Authority**
NHS	**National Health Service**
NToW	**New Type of Worker (also given in the text as New Role Carer)**
NVQ	**National Vocational Qualification**
ODPM	**Office of the Deputy Prime Minister**
PCT	**Primary Care Trust**
S2	**Stage 2 of the Evaluation Study**
S3	**Stage 3 of the Evaluation Study**
SWOT	**Strengths, Weaknesses, Opportunities, and Threats**

Executive Summary

The following descriptive and qualitative findings from this Evaluation Study compliment those given in the Audit Report (September 2007).

Key Message 1.
Residents appreciated the In-reach Team's service over time, and its presence and the up-skilling of new role care staff through NVQ3 had a positive effect upon quality of care in LA care homes.

Key Message 2.
A strategy for introducing change needs to take account of structures and processes, but also needs to address the likely perspectives of, and the anticipated effects on, those involved. If too many changes are happening concurrently, receptiveness may be damaged. If this cannot be avoided by more considered timing, it needs to be recognised and mitigation planned.

Key Message 3.
Care home managers, care staff, and In-reach Team members need to learn to understand and appreciate the differences between each other's roles and responsibilities. In-reach Team members could spend more time on the 'shop floor' to improve and personalise relationships, but care workers need to understand where the nurses have come from and what their roles and accountabilities are as trained nurses. A review of In-reach Team activities in relation to community services' input to homes will be required as a part of Model development.

Key Message 4.
Communication difficulties in both information systems and relationships need a team approach and one that encompasses all parties meeting informally and formally.

Key Message 5.
As care staff are beginning to move forward in acknowledging personal and resident benefits from training, there is a window of opportunity for the In-reach Team to create a practice-driven learning environment involving all Team members with new role carers and other care staff in all homes.

Key Message 6.
Mutual recognition of contributions made by individual groups to the improvement of resident quality of care is needed. The care home manager as the mainstay of the home's environment is ideally placed to act a leader in communicating both successes and challenges within the model.

Key Message 7.
The development of the new role carer could have LA resource implications ahead in terms of workforce demand for: i] increased pay for those in this role, and ii] increased staffing levels for those not in this role, who feel that it has put additional pressure on their workload. However, any increase in LA manpower resource could be offset by savings to the PCT created by IRT and improved resident care, i.e. reduced need for hospitalisation of residents, facilitation of early discharges, and early detection and treatment of residents' illnesses in the home.

1. Introduction

1.1. Background to the Evaluation Study

In 2004, The University of the West of England, Bristol (UWE) was invited by Bath and North East Somerset Local Authority (B&NES LA) in partnership with B&NES Primary Care Trust (PCT) to submit a proposal for an evaluation study of the efficacy of an in reach team's (IRT) provision of nursing and physiotherapy to support up to 15 'virtual' beds in a group of LA residential care homes. Over time, these beds provided IRT care for a total of 131 residents. The IRT project was funded from a successful bid to the Office of the Deputy Prime Minister (ODPM). In addition, the evaluation study's remit included a monitoring of the IRT members' support for designated IRT support 'new role' care staff undertaking health training to the National Vocational Qualification (NVQ) level 3, funded by Skills for Care. A shortfall in funding for the evaluation study was ultimately met by the Joseph Rowntree Foundation enabling the study to commence in December 2005 for a period of two years. Ethical approval was sought and gained during stage 1 (set up) of the study from the Centre of Research Ethics Committee (COREC) and the local PCT Committee. A summary of the study's key aims and objectives is given at Appendix 1. Although this Report is presented as a 'stand-alone' document, it is complimentary to the later *Audit of In-Reach Nursing Team for Residential Care Homes: Activity, Costs, Benefits & Impact on Long-Term Care* (Szczepura, Nelson & Wild, September 2007) presenting predominantly quantitative findings.

1.2. The Research Team

The research team comprised**:** Mrs Deidre Wild (Project Lead), 0.8 FTE research associate (Dr Sara Nelson) from the University of the West of England, Bristol, and Professor Ala Szczepura from the University of Warwick. Professor Robin Means and Mr Simon Evans (UWE) have provided additional research expertise.

2. Overview of the Research Methodology

2.1. Design

The study's design was two-fold. One part of the study was exploratory and descriptive with multiple sources of evidence obtained from key stakeholders, IRT members, care home managers and care staff, and a resident groups in B&aNES through qualitative and quantitative methods. The use of mixed methods is valuable in addressing the complex issues faced by workers at service interfaces (cultural as well as organisational) and can provide richness of data to make implicit findings more explicit [Giorgi, 1995].[1] In the other part of the study, an economic evaluation included the costs of the introduction of the IRT model and the cost savings realised through its activities. Following a *set up stage 1* of three months, evaluation activities have included repeated methods (audit, interviews, focus groups) for *stage 2* (**S2**) - baseline data collections and *stage 3* **(S3)** – follow up data collections.

[1] Giorgi, A. (1995). Phenomenological Psychology. In J. A. Smith, R. Harre & K. Van Langenhive (Eds.) *Rethinking Psychology*. London: Sage Publications.

2.2. Study Sites and the Impact of Organisational Change

The study commenced in December 2005 when IRT had been undergoing it's own set up period from June 2005. The original study plan identified a group of 5 LA homes and during the course of the study four of these homes (and their staff and residents) were each designated as an IRT home for some period during the study's **S2 - S3** timeframe, although only three were under study at any one time due to home closures. Only one home remained a non IRT home throughout, although NVQ3 training was extended to some care staff in this home with input from the IRT members but without full IRT care activities for the home's residents. By June 2007, 3 homes had undergone a staged closure, and only two of the original IRT homes remained open. This staged process of closures necessitated a winding down of staff and residents and their gradual transfer mainly into the first of a programme of new build homes. The move to this new home, designated as an IRT home, was completed by June 2007.

The above complex organisational changes inevitably required the research team to make some adaptations to the original research plan. These were discussed at the three Advisory Boards held since the study commenced and are outlined as follows:

- Between March 2006 and February 2007, the study's evaluation sites comprised 3 IRT homes and 1 non IRT home , The inclusion of the non IRT home permitted the collection of some comparative qualitative data from care staff and their manager to represent the more traditional social care environment.

- To gain two 'stable' rounds of data collections on IRT activities, albeit from homes subject to restructure, **S2** and **S3** data collections were run concurrently to permit a full analyses of both time-phases' data by April 2007.

- It was recognised that the upheaval of care home managers and staff due to organisation change was in addition to the changes to 'ways of working' brought about by the presence of the IRT. Thus, account should be taken of this, as it could have some impact upon the acceptability of IRT across time.

2.3. Methods and Materials

2.3.1. Primary Sources

Data analysed for this report were gained predominantly through interview, the content of which is detailed below related to each sample group:

Key Stakeholders: the level and nature of role involvement in the IRT model; perceived expectations of the IRT model in terms of strengths, weaknesses, opportunities and threats (SWOT) linked to IRT project objectives and local protocols; communication pathways; measure of confidence in model; and exploration of cross-boundary issues arising.

Care Home Managers: the level and nature of role involvement in the IRT model; perceived expectations of the IRT model in terms of strengths, weaknesses, opportunities and threats (SWOT) linked to project objectives and local protocols; communication pathways; measures of confidence in model, job pressure, job satisfaction, intention to leave, and relationships;

expectations of project benefits and challenges; and exploration of cross-boundary issues arising.

Care Home Staff: the level and nature of role involvement in IRT model; perceived expectations of IRT model in terms of strengths, weaknesses, opportunities and threats (SWOT) linked to project objectives and local protocols; communication pathways; measures of confidence in model; job satisfaction, intention to leave, and relationships; expectations of project benefits and challenges, and exploration of cross-boundary issues.

IRT Members: the level and nature of role involvement in the IRT model; perceived expectations of IRT model in terms of strengths, weaknesses, opportunities and threats (SWOT) linked to project objectives and local protocols; communication pathways, measures of confidence in model; job satisfaction, intention to leave, internal and cross sector relationships; expectations of project benefits and challenges, and exploration of cross-boundary issues.

2.4. Participant Sample Groups

Table 1 provides details of the numbers of participants and sample groups providing information via interview in stage 2 (**S2**). The percentages given at the bottom of the table indicate the percentage response of the total of those approached in each group. As can be seen, all of the stakeholders, the care home managers and members of IRT at the time of **S2** data collections agreed to be interviewed, but only 30 (33%) of a potential sample of 90 care staff in four homes (3 IRT and 1 non IRT) agreed to this, despite several and diverse efforts by the researcher to interest them in the study. Of the 30 care staff, 13 were IRT 'new role' care staff, representing 65% of the potential sample of 20 with NVQ3 (or in training) designated for IRT support within the IRT homes.

Table 1. Samples' Descriptions

Key Stakeholders	Managers*	In reach Team	Care Staff
2 Senior Care Home Managers	3 IRT home managers	11 Nurses	13 designated IRT staff
1 IRT Consultant Project Lead	2 non IRT home managers	1 Physiotherapist	10 care staff in IRT homes
1 IRT Nurse Manager			7 non IRT care staff
1 PCT Director of Nursing			
1 LA Director of Housing			
1 LA manager with IRT development responsibility *			
1 General Practitioner			
1 Finance Director LA			
1 CSCI Inspector			
1 NVQ Assessor			
1 Community Nurse			
Totals: 12 (100%)	***5 (100%)***	***12 (100%)***	***30 (28%)***

Includes the managers of the 5 original homes (4 designated as IRT homes and 1 non IRT home). All of the managers were included in IRT development consultation even if not in a designated IRT home.

By the stage 3 **(S3)** data collection, the stakeholder group was reduced to **11** (1 LA manager was unavailable); managers were reduced to **4** (one failed to return the questionnaire); two nurses left the IRT reducing this sample group to **10**. Of the care staff sample, there was an overall reduction of 8 to **22** (7 from IRT homes and 1 from the non IRT home: 5 resigned or retired, 3 failed to respond). Of the **22** remaining care staff, 10 were designated IRT "new role' (sometimes referred to as New Type of Worker [NToW]) support carers; 6 were care staff in IRT homes, and 6 were from the non IRT home. Unless otherwise stated the above total figures (in bold) form the sample sizes for data presented in the tables and figures below.

2.5. Analysis and Presentation of Findings

Descriptive analysis was undertaken using SPSS 13 for quantitative data. However, as numbers in some sample groups (care home managers, IRT, and stakeholders) were small, this prohibited the reliable use of inferential statistics. Content analysis for qualitative data employed two researchers in an independent review of written comments from the questionnaires and audio-taped interviews' transcribed comments where available (permission for audiotape by care staff was generally refused). From this process an identification of key themes and sub themes was made. Illustrative comments reported in the report's text were drawn from the comments presented in their entirety as Appendices 2-4.

2.6. Report Outputs

Outputs from this report comprise:

- A description of the IRT model's early development and a 12 months evaluation of its challenges and activities from March 2006 - February 2007.
- The exploration of workforce enhancement and 'ways of working' within and between participant groups, to permit understanding of helpful mechanisms (and those that hinder), which can be promoted in future joint and cross agency working.
- The samples' perceptions of resource issues and sustainability of the IRT model.

2.7. Ethical Considerations

The principles of full written and verbal study explanation, consent, right to withdraw, doing no harm, confidentiality and anonymity have been adhered to throughout the study (Merril & Williams 1995[2]). Ethical approval was sought from COREC and the University Ethics Committee for the study.

To render respondents (IRT members, care home managers and care staff) anonymous and to protect information provided in questionnaires, audiotapes, and on databases, all respondents were allocated code numbers. The researcher linked the respondents' names with the code number identifiers solely for the purpose of re-contacting them for repeat data collections. The participant homes were also given a unique identifying code to protect their identity. The responsibilities of the researchers within the project's ethical framework formed a part of the initial project orientation. All data was safely stored under the provisions of the Data

[2] Merril J, Williams A (1995). Benefice, respect for autonomy and justice: principles in practice. *Nurse Researcher,* 3, 24-3

Protection Act (1998). The data collected during the course of the project will be destroyed following its completion.

3. Findings Related to the Early Development of IRT: Stage 2

3.1. Recruitment of Staff Members and Diversity of Professional Backgrounds

The IRT project commenced in June 2005 with 4 IRT members recruited around or soon after this time including the IRT manager, a senior community nurse appointed prior to its launch. The remaining 8 members of the team were appointed between 2 to 10 months after the IRT project started, indicating a slow recruitment to achieve full capacity.

The IRT members comprised 10 nurses and 1 physiotherapist to meet 8 WTE posts providing 24 hours cover, 7 days a week to the 3 IRT homes. The nursing backgrounds of IRT members included hospital-based and community experience in areas such as wound care, respiratory care, stroke, rehabilitation and palliative care. Four nurses said that they had worked in independent sector nursing homes in their past but none had worked in residential care homes. Two of the nurses worked on night shifts.

3.2. Identification of Local and National Policy Drivers for IRT

Table 2 provides an identification of the National and local policy '*drivers*' perceived by stakeholders, care home managers, and members of the IRT as influential in promoting the IRT project.

Named Government policy documents were only mentioned by IRT members. However, reducing NHS costs Nationally and locally, through prevention of avoidable hospital admissions by the enablement of residents to stay put in a home when ill, was identified within comments from all sample groups. Only within the stakeholder and IRT groups was there recognition of the need for LAs and PCTs to work together either as a National or local 'driver'. Only stakeholders raised the need for flexibility within the regulations by the Commission for Social Care Inspectorate (CSCI), to permit nursing to take place in homes registered for social care. Within the stakeholder and manager groups, improved service provision for older residents was mentioned. The responses made by care staff including preventing admission to hospital, earlier discharge, and saving money, indicated their clear grasp of general policy trends. Additionally, some care staff's comments related to their need for increased training, knowledge and professionalism; taking the pressure off community staff, and improving the standard of care homes, suggested that they saw themselves as having some responsibility in meeting policy demands.

Table 2. Stakeholder, Managers and IRT Identification of National and Local Policy 'Drivers' for IRT Development

Sample	National Policy Drivers	Local Policy Drivers
Stakeholders	• Need for PCT/LA joint working • Increased numbers of elders and morbidity • Effect change to facilitate better use of NHS resources; reduce hospital admissions; dependency on private sector homes • Flexibility in regulation	• Reducing PCT/ LA care costs • Commitment to drive up local standards of care through care staff training and development. • Commitment to delivery of high quality care to residents • Bid opportunism ODPM • Re provision of homes and development of Resource Centre
IRT	• National Service Framework • White Paper re: care in the community • Save NHS costs • Meet government guidelines re: older people	• Reduce costs • Prevent hospital admissions and access early discharge. • Reduce local costs • Staying put in home • Social Services and BaNES PCT working together.
Managers	• To cut costs • To improve service to users • To reduce hospital bed costs for inappropriate admissions • Free up hospital beds and give people more choice where they are cared for.	• To prevent hospital bed blocking • To enable residents to stay put in own home • To prevent hospital admissions
Care Staff	• People living longer - hospitals can't take them all • Trying to encourage people to remain in own homes so when (do get into) care they have increased needs – hence need IRT. • Good for residents and staff • Palliative care	• Prevent hospital admission • To save people being moved on • Save money • To give better standard of care • Needs of residents are increasing, residential care is becoming more like nursing care • To increase staff understanding • Save having to call in community staff and lots of other people. Better for residents. • Finance - to save money for when new homes are up and running • If residents not well, (can) do basic checks. If need nurse or Dr. (can give them) more info. • Provide palliative care – reduces distress for residents. Provide more nursing care • Take on more responsibilities – takes pressure off DN. Not having to call GP in for things that can wait. • To help community teams • To stop residents moving into nursing care • So residents don't get stuck in hospital for long periods especially with dementia. – Reduces trauma • Increased training for staff To increase skills for care staff and to increase professionalism

3.3. Origin of IRT Model and Consideration of Alternative Models

Early dialogues for the IRT Model commenced in 2003 at a senior management level in the LA and PCT. Thus only a few respondents in any sample group were aware of IRT Model's origin. This was not surprising as most respondents would not have been involved, or in post, at that time. Of those that were aware (mainly stakeholders), the following comments capture some early thinking around the rationale for the development of IRT.

'It was around the time of the thinking for putting into the Investasave bid – we were in the middle of this other group which was about closing homes and building new ones –there was a lot of stuff about where LA were going to be impinged upon by Government for not getting people out of hospital beds quickly enough. **[Independent Project lead]**

'It met the needs of the original bid – testing out alternative ways of meeting nursing needs in a residential situation and reducing dependency upon hospital nursing.' **[LA Senior Manager]**

It was good timing because of the planned opening of the new Community Resource Centre developments. Hence opportunities for staff to complete NToW **[new type of worker/new role carer]** ***training to develop their skills.'*** **[Care Home Line manager]**

'To enable a testing of the model prior to the opening of the new Community Resource Centre –identify saving and re-investment opportunities and develop and test cross partner working.' **[IRT]**

Similar to knowledge of the origin of IRT as a model, few respondents knew if any alternative models to IRT were under consideration at that time. Of those that did, the shaping of the nurse-led IRT model rather than that of an alternative model was described suggesting that the shape of the IRT model was a direct response to provision needs.

'Developing the bid- we didn't have a model rather we had the concept - talking to other people – kind of adapted the model a bit – it has changed along the way as you engage different people.' **[LA Senior Manager]**

'*I suppose the only alternative thinking was whether the IRT could be 9-5, or did it have to be 24/7 – we came up with 24/7 in order to make it work'.* **[Project Lead]**

3.4. Early Obstacles to IRT Development

The stakeholders, care home managers and IRT members were asked to identify obstacles arising early in the IRT project's development. Respondents' comments are given in their entirety at Appendix 2 and from these, key '*obstacle*' themes have been summarised in Table 3. Care home staff were not asked this question, as early discussion with managers suggested that the former were unlikely to have been involved with the IRT Project's set up.

Table 3. Identification of Obstacles in Early IRT Development

Sample Group	Key 'Obstacles' Themes
Stakeholders	Cross sector partnership communications CSCI Registration IRT/staff communications Staffing (New role carers and IRT) recruitment issues Joint working/ Cross cultural issues Progressing NVQ3 new role training
Managers	IRT/staff communication Progressing NVQ3 new role training Joint working/ Cross cultural issues
IRT	IRT/staff communication Progressing NVQ new role training Team building Joint working/ Cross cultural issues Raising Awareness of IRT Project

Senior level stakeholder managers largely focussed upon obstacles related to achieving joint working communications between the LA and PCT and the need to attain a flexible approval from the Regulatory body (CSCI).

'***Initially the PCT didn't know if they wanted to play this one and went along because of joint working – that's moved along quite a lot and so has the whole thing of integration – Interpretation of the regulation that has been a fairly significant barrier –we've overcome it by involving CSCI from the beginning discussions - it does tend to be dependent upon local people – very helpful- an advocate for it but a stickler for interpretation of the regulations.'*** **[LA]**

All sample groups showed a general awareness of difficulty during set-up in communicating the benefit of the IRT service to the homes' staff with some comments indicating a recognition of cross-cultural (social care with health care and nursing) differences. The potential resource implication for 'professionalising' a 'new role' care worker was raised.

'A major challenge, and still is, was getting staff on board - that it had some value to them as professionals.' **[CSCI]**

'(IRT) lack of knowledge about social care side – need to work with staff more. Poor team work-involve staff, more 'them and us', need joint-working.' **[Home Manager]**

'Working or integration between health and care home staff – very different cultures - care home staff are being enhanced along the nursing model and the implications that has in terms of grading/pay.' **[PCT]**

Meeting regulatory requirements and progressing NVQ training was identified by those in the IRT as a delaying 'obstacle' during the set up of the IRT service. All sample groups perceived difficulty in recruitment to and retention of care staff undertaking NVQ3 training as inhibiting the development of IRT.

'Not having enough NToW staff trained to meet CSCI regulations for 24 hr cover-more training groups funded by skills for care but needs to be main streamed by LA.' **[IRT]**

'Losing NToW staff from one pilot home - partly lack of local leadership as well as co-incidental negotiations with staff over terms and conditions in progress at same time as development of IRT.' **[LA]**

'Loosing 'signed up' NToW staff because of delays in getting things off the ground' **[Home Line Manager]**

IRT and some stakeholder respondents raised the concurrent early challenges of recruitment to IRT (see above at 3.1) while trying to act as a support for NVQ3 training, and team-build within IRT.

'***Recruitment of nursing team – huge resources spent on advertising – took 12 months to fully recruit staff.'*** **[IRT]**

'Extra nurses needed to train as NVQ assessors – much unresolved.' **[IRT]**

'Personality clashes.' 'Working together as a team.' **[IRT]**

4. Comparative Findings from Stages 2 and 3

4.1. Consideration of Alternative Models to IRT At Stage 3

From the stakeholder interviews, transcribed qualitative comments suggested that the future for IRT was already under review by the LA and PCT partnership during the **S3** data collections in 2007, even though the project was scheduled to run until March 2008. Comments included the following perspectives:

'We are looking to see the sustainability of them (IRT) when funding has come to an end and whether it is something we will be able to afford - integration with community nursing service and the team providing support to extra care housing' **[PCT]**

'We've been looking at the Evercare Model **[comprising specialist nurses for older people]** ***for district nursing – integrate IRT and have specialist nurses who relate purely to residential homes, not just within the LA but across the whole sector.*** **[Senior Care Home Manager]**

'If it was a successful project we would gain a more sustainable model of care whilst being affordable. We're looking at it very much as what is the place of IRT work in the whole gambit of community health and social care services for older people – the interface between the team with district nursing is quite interesting' **[LA]**

Care home managers, and members of IRT were asked only at **S3**: '*At present, is an alternative model to IRT being considered?*' As shown in Table 4, 4 IRT members stated that an alternative model was under consideration but none of the care home managers seemed aware of this alternative. This could suggest that a formal dissemination by the LA and PCT

partnership of higher level deliberations had not as yet taken place with all respondents, and in particular with care home managers.

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Table 4. Stakeholder, Managers, and IRT Consideration of Alternative Models

Sample Group	Yes	No	Unsure	Unanswered	Totals
Managers (N= 5)	**0**	**2**	**0**	**3**	**5**
IRT (N=10)	**4**	**2**	**2**	**2**	**10**

Of the IRT respondents, the following comments were received and although these appear less informed than those given above by stakeholders, they do suggest that within the team there was recognition that the IRT model might not be sustained as a discrete team working with, but ostensibly separate from, other community services.

'*Some talk about* [IRT] *taking over DN role*.'

'*PCT are looking at a more integrated model with other PCT services with the essence of locality working.'*

'Trying to see where our future lies when the funding runs out!'

4.2. Inter-group Liaisons and Committee Structures.

All sample groups were asked in **S2** and **S3** how they liaised over matters concerning IRT, and what related committees they were members of. From these questions, the following description has been compiled from individual sample groups' responses. IRT key stakeholders (IRT manager and the Independent Project Lead) had a direct report line of communication to senior LA and PCT managers, who similarly liaised together through other joint LA/PCT development meetings but not specific only to the IRT project. IRT stakeholders liaised informally with each other on a weekly or more bases and included the senior care home line manager responsible for all homes. A monthly formal project development meeting took place between the IRT key stakeholders with the Senior Care Home Line Manager and other IRT care home managers, but care staff representation was not apparent at these meetings at either **S2** or **S3**. However in **S2,** a series of informal dissemination meetings were set up between IRT key stakeholders and the Senior Care Home Line Manager with invited care staff. The IRT key stakeholders met regularly and informally with individual care home managers, who were responsible for disseminating IRT information to their care staff at monthly staff meetings held within each home. Within the IRT, monthly meetings included senior IRT members but not junior staff members, who by **S3** had begun holding their own informal meetings.

Information concerning IRT was disseminated to residents via the resident/relative committee held monthly in each home and run informally by the care home manager or a designate member of staff.

The above liaisons and structures suggest that, whereas at a senior level, regular informal and formal *'top down and up'* liaison mechanisms to manage and disseminate IRT activity were in

place, those at the bottom of the management chain (care staff and junior IRT members) were more reliant upon informal '*top down'* dissemination from their respective managers. In the case of care staff, no change to this system was reported at **S3**.

4.3. Inclusion in IRT Consultation

Figure 1 shows the levels of inclusion in consultation for the IRT project for **S2** and **S3**, expressed as mean values for care staff and managers in IRT homes, and for IRT members. The means were calculated from a scale with *1 = very high level of inclusion* to *5 = not included*. The non IRT home's care staff have been excluded as they were not involved with IRT. In **S2**, at face value, care home staff's mean value indicated the lowest level of inclusion in the consultation process for IRT, followed by that for care home managers. In contrast, IRT members demonstrated a greater level of inclusion than either of the other groups. At **S3**, a similar pattern to the **S2** findings was observed with the IRT members showing the highest level of inclusion in the consultation for IRT and care staff the least inclusion.

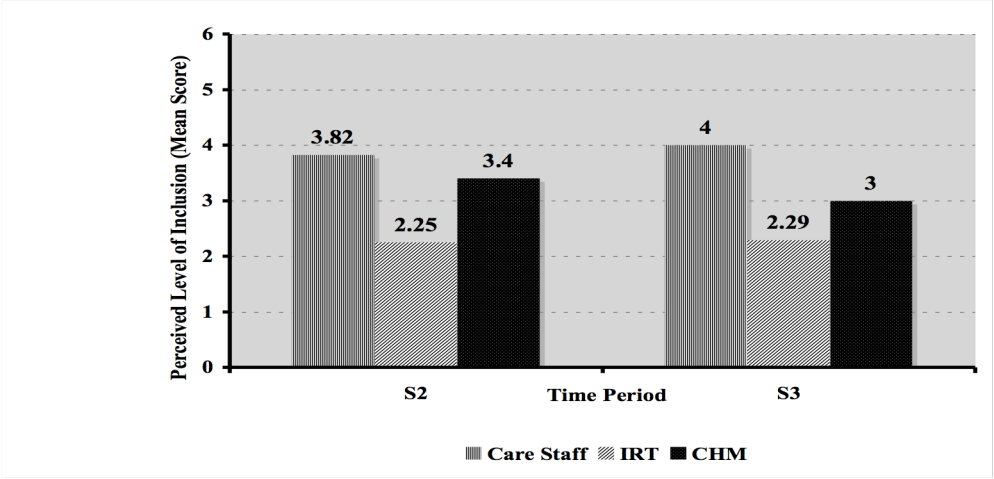

Figure 1 – Levels of inclusion in consultation for the IRT Project

Some caution is recommended in the interpretation of these findings, as they may have been skewed by responses from the 10 non IRT support care staff working in IRT designated homes but who may not have been included in the consultation loop. However, when these findings are considered in relation to the description of liaisons and committee structures given above at 4.2, it seems likely that care staff in general, could have felt a sense of exclusion from IRT development across time. Furthermore, it could provide some rationale for the low level of participation of care staff in this evaluation study.

4.4. Confidence in IRT Model

Figure 2 displays the mean scores obtained in **S2** and **S3** for IRT homes care staff's and managers', and IRT members' level of confidence that the IRT model would succeed. Mean scores were calculated from a four point scale with 1 = *very confident* to 4 = *no confidence*. At face value, of the three samples at **S2**, care staff respondents were the least confident in the

success of the project and IRT members the most confident. In contrast in **S3**, whereas the scores for care staff remained constant from **S2** to **S3**, those for IRT members and to a lesser extent the care home managers rose indicating a loss of confidence over the same time period. These findings could reflect some consistent doubt in care staff's understanding of IRT across time, and possibly linked to their lower level of inclusion in consultation for IRT. In contrast the decreased confidence in care home managers (CHMs) and IRT by **S3** could reflect their growing uncertainty around the future sustainability of the IRT Model already under discussion (see also above at 4.1)

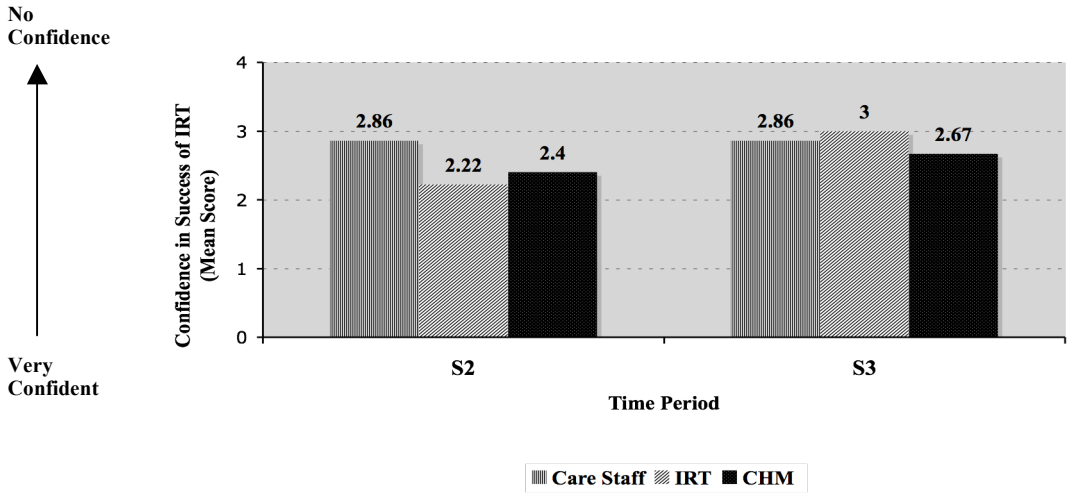

Figure 2. Levels of confidence in the IRT Project

4.5. Strengths, Weaknesses, Opportunities and Threats (SWOT)

4.5.1. Sample Groups

In **S2** and **S3,** IRT members, home managers and care staff from IRT designated homes (13 NVQ3 in 'new roles' and 10 lower grade staff) were asked in an identical part of their individual questionnaires to identify and record up to 5 aspects related to each of the following: the ***strengths, weaknesses, opportunities*** and ***threats*** (**SWOT**) [Humphries 1960-1970] of the IRT model. For each recorded aspect, respondents were requested to provide a rationale. In the case of care home staff with no direct involvement with IRT working in the non IRT home (7), they were asked to describe the strengths, weaknesses, opportunities and threats related to their traditional social care model.

4.5.2. Mode of Analysis

Content analysis of both SWOT aspects and their rationales was conducted by 2 researchers to maximise reliability and enabled the identification of key themes and issues within these. Full transcription of written comments is provided at Appendix 3 for **S2** data, and Appendix 4 for **S3** data for each sample group (IRT members, care home managers, and care staff).

The identified key SWOT themes are provided in tables below and are described in the text with illustrative comments drawn from the respective appendices. Numbers of comments (from original data in Appendices) for each key theme has been provided but only as a crude means of quantifying subscriptions to key themes by individual sample groups, i.e. they are not indicative of the strength of feeling underlying each theme. The reader is advised to cross reference the content of the text with the data given in Appendices 3 and 4.

4.5.3. Strengths

S2

As shown in Table 5, at **S2**, care home managers identified ***IRT Model and ways of working*** as the key 'strength' theme. Rationales were given mainly in terms of improved care for residents through IRT intervention and influence upon care staff. ***Progressing NVQ training*** was the main secondary theme, referring to IRT as a support for care staff's competency acquisition. One of the five managers described IRT as *'a long term vision'*.

Similar to care home managers at **S2**, IRT members identified the ***IRT Model and ways of working*** as their key 'strength' theme with associated sub themes of improving residents' care through meeting IRT aims, and improved communication between (social and health care sectors) and within sectors (the LA care homes). The second most frequently identified strength was ***Progressing NVQ training*** through supporting and developing the new role carer. Although, this contained some altruist rationales, given as '*support', 'inspire', 'trust'*, most rationales were focussed upon IRT staff members transferring practical skills/procedures to care staff rather than giving them new knowledge. The support of their manager was seen as a 'strength'.

Table 5. Participant Samples' Key Themes for Strengths in IRT in Stages 2 and 3

Participant Sample	Key Themes for Strengths in IRT – S2	Key Themes for Strengths in IRT – S3
Managers ***N=5 (S2)*** ***N=4 (S3)***	• IRT model/ ways of working (6) • Progressing NVQ training (1) • Long term vision (1)	• IRT model/ ways of working (2) • Progressing NVQ training (1) • Long term vision (1)
IRT ***N=12 (S2)*** ***N=10 (S3)***	• IRT model/ ways of working (11) • Progressing NVQ training (8) • Supportive management (2)	• IRT model/ ways of working (24) • Progressing NVQ and other training (6) • Diversity of skills and experience (within IRT) (4) • Supportive management (2)
Care Staff ***N=28 (S2)*** ***N=22 (S3)***	• Models of care /ways of working (23) • IRT model and ways of working (16) • Progressing NVQ training (3)	• Models of care /ways of working (23) • Traditional care home model and ways of working (15) • Progressing NVQ training/ increased awareness of 'medical' matters (8)

For reasons given above at *4.5.1,* SWOT information at **S2** and **S3** was obtained for both the ***Traditional Model*** and the ***IRT Model*** and their respective ***ways of working***. At **S2**, care staff not involved with IRT tended to place greater emphasis upon the traditional care model than that for IRT, describing the former as something that worked well in the interests of residents' social care *('secure', 'safe', 'routine'*), with sound cross sector communication, and

relationships meeting residents' health care needs. However, within this picture of stability were comments suggesting that within this sense of comfort was a resistance to change: *'What people are used to - don't like change'*. In contrast, care staff involved with IRT described benefits from the IRT Model's intervention in terms of improved residents' health options, *'Providing health skills for early diagnosis', 'Residents can stay put, even when needing extra care'*. However, there was evidence that whereas some care staff perceived the strength of IRT as a health resource within their social care system, others saw it as an external intervention that could reduce their workload pressure: *'People with knowledge – take some of the load*', *'IRT takes some of the pressure off support workers'*. In some comments, reducing workload was described in terms of the IRT members' performance of tasks in which care staff do not seem to have been involved, e.g. *'Good that IRT can do dressings but dressing, washing, care left to care workers – so IRT come in and do tasks and then go even if heavy workload'*. These findings could suggest that despite reported benefits from IRT, its function was narrowly perceived by care staff as separate, task-driven and lacking care staff's involvement. Unlike IRT members and care home managers, ***Progressing NVQ training*** was poorly subscribed to as a theme by care staff and was focussed upon skills acquisition rather than the learning needed to underpin it: '*Learning physio/nursing skills', 'Supports care staff skills development'*.

S3

By **S3**, care home managers continued to find ***the IRT model and its ways of working*** supportive to both staff and residents and specifically mentioned the good relationships built with staff by the IRT trained NVQ3 nurse assessors. The long-term vision for IRT was linked to the move of one former care home manager to the new build home which would have the IRT service: *'When relocated to new home – then can be part of IRT'*.

IRT members subscribe more heavily to the theme of the ***IRT model and ways of working*** in **S3** than in **S2**. Comments suggested a greater sense of team cohesion with improved relationships between team members, and with care staff and community staff, than at **S2**. Comments around the theme of ***Progressing NVQ training*** expressed a view that care staff had made progress in both learning and practice; *'More staff have achieved NVQs as NToW* [new role carer] *– more staff able to understand reasons for care requested/given.'* IRT members also created a new theme, '*Diversity of skills and experience',* as many of the IRT members mentioned the importance and benefits of their own diversity of skill mix within their small group. Resident benefits were evident in many comments in particular the prevention of hospital admissions, continuity of care and early assessments, and bringing health and social care services together.

Care staff contributed more 'strengths' comments to the theme ***IRT Model and ways of working*** at **S3** than those given **S2** and **c**onversely there were fewer 'strengths' for the ***Traditional Model*** than at **S2.** This could suggest a growth in awareness of IRT and the 'new carer role' development across all care staff leading to a diminishing resistance to change over time. Certainly some comments (see Appendix 3) related to IRT reflected this more positive awareness: *'Increased standards of care'; ' GP listening more'; 'Earlier identification of illness'; ' Team work- best interests of client'*. However, some care staff still adhering to the ***Traditional Model*** reflected their continuing contentment and belief in their ways of working and reliance upon community services to meet residents health needs: *'It just works – we're here to give basic care, washing etc.'; 'Staff doing their best for residents not linked with IRT'; ' Don't have the responsibility of doing medical care—support workers feel safe when DN is in.'*. At **S3,** the theme ***Progressing NVQ Training*** also depicted a range

of skills and understanding of IRT acquired by IRT new role care staff which was less apparent at **S2**: *'We know what we are doing now, i.e. increased understanding that IRT training has brought'*

4.5.4. Weaknesses

S2

At **S2**, care home managers described most weaknesses in the theme of the ***IRT model and ways of working*** as due to communication difficulties between IRT members with care staff, e.g. '*There was not a very clear message and information to staff - kept changing.'* Issues of confidentiality and exclusion were also raised. The second theme identified by care home managers was that of ***Resources*** (raised in terms of sustainability), short term funding for IRT, and adequacy of care staff. One manager observed staff trying to cope not only with IRT but also with other concurrent organisational changes.

Table 6. Key Themes for 'Weaknesses' in IRT in Stages 2 and 3

Participant Sample	Key Themes for Weaknesses in IRT – Stage 1	Key Themes for Weaknesses in IRT – Stage 2
Managers ***N=5 (S2)*** ***N=4 (S3)***	• IRT model/ ways of working (4) • Resources (3) • Pace of change (1)	• IRT model/ways of working (7)
IRT ***N=12 (S2)*** ***N=10 (S3)***	• IRT model/ ways of working (9) • Progressing NVQ training (2) • Resources (1)	• IRT Model/ ways of working (18) • Resources (7) • Progressing NVQ training (4)
Care Staff ***N=28 (S2)*** ***N=22 (S3)***	• Models of care/ ways of working ((15) • Resources (10) • Traditional Model/ways of working (8) • Progressing NVQ (7) • Pace of change (1)	• Models of care / ways of working (20) • Resources (11) • Traditional models/ ways of working (10)

Similarly at **S2,** the theme ***IRT model and ways of working,*** was identified by IRT members as a dominant theme. Rationales emphasised resistance to change and a lack of understanding of the nurse's role by care staff, e.g. '*No trust –not understanding nursing role – unwilling to change*.' In addition, cross sector challenges with other services emerged, '*We still have to let other services carry out duties which causes overlap.'* One IRT staff member indicated a need for greater team support. ***Progressing NVQ Training*** was identified as the second weakness theme highlighting a lack of new role carers and the need to progress training with staff as a means of raising standards of care, e.g. '*Not all staff are involved – quicker training completed the better care will become*'.

Care staff with an awareness of IRT, identified issues related to the ***IRT model and ways of working*** as the key theme, and those who were not involved described issues related to their ***Traditional Model*** of care. In the case of the former, some issues around poor communication by IRT staff appeared to influence the negative attitude of care staff, e.g. '*Lack of communication - lack of respect give the impression they [staff] are stupid*.' Whereas, in other comments, there was confusion about the way IRT members functioned, e.g. '*Confusion over*

who gets called and when - GP? IRT? One person says one thing and another suggests something else.' A further issue evident from staff comments was related to differences in culture between nursing and social care, e.g. '*Nurses v care staff - IRT forget care staff not nurses – they're in residential social care situation not a clinical one – friction.'* In contrast, non IRT aware staff focused on weaknesses in their model linked to deficits in community services, and predominantly those provided by GPs, e.g. *'GP not good - doesn't listen to care workers – no care, puts everything down to old age - sent home too soon.'*

Similar to care home managers, but less so from IRT members, ***Resources*** formed the second most frequently mentioned weakness. However, unlike care home managers, care staff identified a lack of care staff (with some new role staff reportedly leaving), increased resident numbers, and increased workload as key features. A third theme was also apparent for both groups of care staff in terms of ***Progressing NVQ training,*** and in this there was recognition by some care staff of problems in re-educating long serving staff, the institutionalisation of residents, and the exclusion of some staff from 'new role' training. Interestingly, these issues were similar to those expressed by IRT members in their 'weaknesses' contributions to this theme.

S3

Care home managers at **S3** raised weaknesses solely related to ***Models of care and ways of working***. The non IRT home's staff and residents were described as "*loosing out on the benefits of having IRT*", and although training staff to new role skills they '*can't put these into practice*'. In contrast, weaknesses from the perspective of IRT homes' managers were generally centred around ***communication*** problems between IRT with their care staff rather than with themselves: '*not informing staff of what they are doing', 'IRT can have expectations that people understand when they don't'.*

By **S3**, within ***IRT Model and ways of working***, IRT members raised the sub theme ***Communication and relationship building***. This sub theme reflected concern from some IRT members about the ongoing conflict within the team and its ways of working; *'Some members of the team trying to turn residential homes into nursing homes – or not doing full investigations to identify needs'*. This possibly stemmed from the hospital or community diversity of experience held by the team members. In addition, there was an acknowledgement by the team of conflict between IRT members with some care staff and with some care home managers: *'Inability to change attitudes'; 'Attitudes of some care managers- inconsistency of attitudes towards In reach nursing staff.'* Some IRT members recognised that such challenges may have been a result of a lack of inclusion of care staff or their failure as a team to show a '*united front when in the presence of non-group members'*. A further area of concern by **S3** was the continuation of an overlapping of services input into the homes causing confusion amongst care staff who were often left with the dilemma of who to call (GP, IRT, DN) should a particular incident arise. The dual tasks of undertaking clinical commitments with ***progressing NVQ training*** were seen as members *'trying to fulfil too many roles'*. In the theme of Resources, the uncertainty around continuing IRT project funding was raised as well as the need to address employment issues (pay reflecting skills) arising from the development of the new role carer.

For care staff, the **S2** themes of ***Progressing NVQ training*** and ***Pace of change*** were not apparent in **S3**. However, similar to IRT, within ***Models of care and ways of working*** the sub theme ***Communication*** emerged by **S3** as a topic of increased importance to many of the

interviewees suggesting an increased awareness of their support role needs in relation to IRT, *'No togetherness-still work as separate units'*, '*Communication barrier – IRT forget that it's a care home – come out with fantastic ideas – we know they won't work 'cos we know our residents'*. In contrast, care staff in the non IRT home generally perceive their challenges around ways of working with community professionals, *'Sometimes DN comes and goes and home staff not aware of her visit', 'Waiting for appropriate people, e.g. nurses, GPs.*

As a general comment, and despite evidence of continuing challenges, care staff comments across the above theme appeared more articulate at **S3** than at **S2**, and this could be viewed as a positive change reflecting increased awareness of new roles and new ways of working.

4.5.5. Opportunities

S2

At **S2**, care home managers (Table 7) subscribed mostly to the theme of ***IRT Model and ways of working*** in terms of opportunities**,** but in their case a greater emphasis was placed upon shared ways of working, e.g. *'shared knowledge', 'joint working', 'openness', 'trust',* and *'inclusion'*.

Opportunities identified by IRT members in **S2** were also mainly within the theme of ***IRT Model and ways of working***. However, unlike managers three different sub-themes were evident. In the first, opportunities were perceived around promoting IRT to outside agencies, e.g.. '*Raising Awareness of IRT*,' and achieving recognition for good practice, e.g. '*Towards a centre of excellence.'* In the second sub-theme, meeting IRT aims in terms of improved resident opportunities was evidenced, e.g. '*Cut down hospitalisation in times of acute need'; 'Health promotion/illness prevention'*. Finally, and to a lesser extent, opportunities for learning from other sources were identified, e.g. *'Learn from other models'; 'Resident/ relative feed-back*'. A second key theme was ***Progressing NVQ training***, in which opportunities to improve carers' skills, knowledge, and teambuilding were featured. Although these sub-themes suggest a growing confidence in the project and what it could achieve, beyond forming working relationships with care staff, there was little evidence that IRT members had something new to learn from social care or were moving towards the joint working emphasised above by managers.

Care staff aware of IRT at **S2** subscribed to the theme of ***Resources*** and had a resource list including more remuneration as a means of staff retention and more money for both the IRT project and homes. This theme also attracted comments from care staff not involved with IRT, and in general, these were presented as a wish list to improve current resources, i.e. more staff, equipment, facilities and less paperwork, and concerns about the use of agency and overseas staff where English is not their first language. Care staff involved with IRT, also contributed to the theme ***Models and ways of working.*** Their comments generally centred around opportunity to improve communication between IRT staff and themselves as carers, both in terms of relationships and ways of working, e.g. '*Improve communication – listen to care staff about residents - communication and respect - need teamwork as carers provide holistic care - nurses very task oriented.* A final theme related to opportunities in ***Progressing NVQ training*** attracted comment from IRT and non IRT care staff with positive desire for more training and a recognition that IRT was a means of achieving this, e.g. '*Bring IRT into all homes - staff training and prevention of hospital admissions.'*

Table 7. Participants' Key Themes for Opportunities for IRT in Stages 2 and 3

Participant Sample	Key Themes for Opportunities for IRT – S2	Key Themes for Opportunities for IRT – S3
Managers ***N=5 (S2)*** ***N=4 (S3)***	• IRT Model/ ways of working (5) • Resources (1) • Progressing NVQ training (1)	• Progressing NVQ training (10) • IRT Model/ ways of working (3)
IRT ***N=12 (S2)*** ***N=10 (S3)***	• IRT Model/ ways of working (13) • Progressing NVQ training (4) • Resources (1)	• IRT model/ways of working (11) • Resources (6) • Progressing NVQ training (2)
Care Staff ***N=28 (S2)*** ***N=22 (S3)***	• Resources (13) • Models of care/ ways of working (11) • Progressing NVQ training (9)	• Models of care /ways of working (25) • Resources (9) • Progressing NVQ training (5)

S3

By **S3,** care home managers in their consideration of opportunities for ***IRT and ways of working*** recognised that closer relationships between care staff with IRT was crucial to the confidence of the former. Encouraging care staff to develop practice was also seen as a way of '*empowering them to make decisions*.' The move to a new home was seen as a particular opportunity to *'explore new models*'.

Similarly at **S3**, IRT members continued to perceive the main opportunities for IRT within the theme of ***IRT Models and Ways of Working,*** but with a sub-theme of opportunity for the establishment of clear boundaries for ways of working with DN services to remove care staff's '*confusion*' over who does what. This echoes the above weaknesses raised by IRT, where overlapping of services was raised. The theme of ***Resources*** was focussed upon IRT needs for increased job security, more dedicated time for training of nurses and care staff, but also included a recognition of the need for increased pay for new role care staff. Importantly overall, the IRT members' perceptions of opportunities suggested that over time they had gained a better understanding that the success of IRT included taking account of and meeting care staff's needs as a part of developing and achieving their own clinical and operational objectives.

By S3, for ***Models of care and ways of working***, care staff provided considerably more constructive comment related to opportunities to improve the IRT service than was evident in **S2**. In this, the need for the creation of opportunity through closer working relationships with IRT members was very apparent. This further evidenced the care staff's increased critical awareness of IRT over time and in particular, their need to be included: '*Staff should be involved in meetings as opposed to just IRT and manager*'; '*New role care staff need more input as regards running of project*.' The theme of ***Resources*** represented a list of more IRT time, funding, space, equipment and most of all '*more staff*'. Similarly, in the theme ***Progressing NVQ training,*** more training from IRT was recognised as needed: *'More in house training from IRT'*. Interestingly, this desire for training was subscribed to by care staff working in the non-IRT home as well as those in the IRT homes.

4.5.6. Threats

S2

At **S2**, under the theme of ***Resources*** care home managers raised (see Table 8) the short-term funding for the project that could result in the loss of IRT support for care staff with a loss of skills.. A further concern was, '*Limited funding- not enough to train staff*', which could suggest that without the IRT input progressing the care staff's 'new role' could be threatened from a funding perspective, and whether Regulation of the homes would permit trained care staff to undertake nursing procedures. In their second theme, ***Progressing NVQ training,*** the sustainability of care staff's new learning from the IRT project, was raised in the question**,** ***'Will staff continue to use knowledge if nurses withdraw?'*** Another manager questioned the continuation of IRT *'if not enough residents are ill',* and in doing so, perhaps had not considered the crucial importance of the IRT's illness prevention role comprising health monitoring and the early detection of signs and symptoms.

The IRT members perceived their main threats at **S2** within the theme of the theme ***IRT Model and ways of working*** (Table 8) and most threats given were perceived as stemming from poor relationships, information, and communication with care staff. One member described relationships with managers as a '*barrier.*' Another gave problems with care staff as being due to IRT being seen as a change to be resisted, or something that would increase workload. In the second theme ***Resources***, most members perceived these as external threats to the team and those capable of terminal damage, *'Without IRT being picked up in someone's budget, IRT cannot continue'*. However, a few comments echoed those of care staff in terms of the difficulty of progressing IRT as a Model when care staff had heavy workloads coupled with insufficient pairs of hands. Other changes affecting the homes were perceived as inhibitors: '*pay changes, moving homes, insecurity about jobs'*.

Table 8. Participants' Key Themes for Threats to IRT in Stages 2 and 3

Participant Sample	Key Themes for threats to IRT – S2	Key Themes for threats to IRT – S3
Managers ***N=5 (S2)*** ***N=4 (S3)***	• Resources (4) • Progressing NVQ training (3) • IRT Model and ways of working (1)	• Resources (5) • IRT Model/ ways of working (1)
IRT ***N=12 (S2)*** ***N=10 (S3)***	• IRT Model/ ways of working (8) • Resources and sustainability (7) • Progression of NVQ training (2) • Concurrent changes (1)	• IRT Model/ ways of working (7) • Resources (12)) • Training issues (2)
Care Staff ***N=28 (S2)*** ***N=22 (S3)***	• Models of care/ ways of working (16) • Resources and sustainability (14) • Progression of NVQ training (5)	• Resources (15) • Models of care/ways of working (14) • Employment issues (5)

Models of care and ways of working formed the theme most subscribed to by care staff in **S2**. In both the IRT Model and the Traditional Model of care, reluctance to engage in change was viewed as a threat. For those aware of IRT, there seems to be the threat of a 'them'

(IRT) and 'us' divide, perhaps compounded by the visual differences of nurses' uniforms and badges, e.g. ' *Issues around uniform and elitism.'* In the second theme ***Resources and sustainability***, the threat of the short-term funding of the IRT project appeared to justify care staff's openly expressed reluctance to buy into change, e.g. '*If funding removed - the project stops'.* This, coupled with the comfort of a long established, well understood, and shared traditional model of care, although subject to internal change through closures, appeared to make IRT (as yet another change), a target for disaffection, e.g. '*Traditional and IRT are opposing models*'; *'Staff who have worked in care for a long time don't like change – may sabotage any changes - knock on effect to other staff.'*

S3

By **S3,** care home managers associate most 'threats' with issues associated with ***resources*** and most comments were directed towards questioning the viability of the IRT project, *'Inflexible – because it is a funded project.'* A few comments reflect misguided beliefs (internal reports from IRT would have countered these) that IRT was '*not cost effective'*, and that there was *'not enough referrals – because IRT have not prevented any admissions to hospital or been able to facilitate early discharge*.' The lack of incentives for care staff undertaking new roles was also raised as an inhibitor to recruitment and participation in the project.

IRT members also raised the threat of lack of sustainability of the project under the main theme of ***Resources***. In this, they raised concerns around job security, contracts, and staff losses: *'staff insecurity and funding'; ' Temp contracts- staff feel insecure'.* Such comments came at a time when the future of IRT was under review by the PCT and LA partnership, sand the insecurity this created resulted in a few IRT resignations. A further concern was the possibility of the disbandment of the team; ' *No funding - we can't carry on*.' Within the theme of ***IRT model and ways of working'***, team members commented about negative attitudes or a lack of insight from care home managers in term of a lack of support to carers and IRT, *'Poor management support – some carers feel that the managers do not support them enough in their new roles.* Some GPs also were described as lacking interest in IRT and in preventative care for residents. They also expressed fear that district nurses may feel that their job had been eroded by the presence of IRT.

Consistent with their care home managers, at **S3** care staff subscribed negatively to issues around ***Resources*** (and to a far greater extent than at **S2)** with the key focus upon the uncertainty of IRT funding and its sustainability, '*Lack of resources – how long will it go on for*? A re-occurring issue was that of value for money from the IRT project with many suggesting that there was not enough work to justify the presence of an '*expensive*' group of nurses, perhaps echoing the above management perspective. In the themes of ***Models of care and ways of working*** and ***Employment issues***, the difficult of retention of new young support workers and maintaining the interest of existing support workers was seen as a problematic ahead if new incentives were not addressed, suggesting an increased awareness in some care staff of their 'new role' and of a growing need for professionalisation of it. By **S3** only a few comments were given as threats to the traditional model of care but of those that did, feeling undervalued in a non-IRT home, the increased dependency of residents, lack of staff and facilities, and lack of management intervention for resident challenges, were issues raised.

4.6. IRT Members' and Care Staff's Opinions of the Impact of the New Role Carer

IRT members (**S2:** N=12**, S3:** N=10**)** and care staff (**S2**: N=15, **S3**: N=12) were asked to gauge the impact of the new role carer upon the key areas of ***workload***, ***resident care***, and ***relationships and ways of working*** at **S2** (N=12) and **S3** (N=10). At both points in time, they were requested to confine their responses to the preceding six months. Both groups responded to a 5 point likert scale, with values of *1=greatly increased* (or in some aspects *improved*) to *5=greatly decreased* (or in some aspects *damaged*), and with a mid point of 3=*neither/nor.* Numbers in the figures are presented as mean values calculated from their overall scores. Where appropriate, findings in this section will be cross-referenced to earlier qualitative data.

4.6.1. Workload

As shown in figure 3, IRT members' mean values indicate that the development of the new role carer had consistently increased care staff's workload across time. At **S2**, IRT members' mean value shows that GPs' workload was neither *increased nor decreased*. However, by **S3**, their mean value suggested a move towards this being '*fairly decreased'*. IRT members' mean values also show that new role carers had '*slightly decreased'* community nurses' workload across time.

In figure 4, care staff's man values indicated that their workload was '*fairly increased'* by the new role carer development at both **S2** and **S3**. Whereas, their responses for GPs' and community nurses' workloads centred around '*neither increased nor decreased'* at **S2** but indicated a move toward '*fairly decreased'* by **S3.**

These findings suggest that from perspectives of IRT members and care staff, this new role raised the challenge of increasing care staff's workload (**see SWOT Weaknesses S2, page 22, para 2: page 23, paras 2 and 4**). However, of benefit is the positive impact of the new role carer upon external community workloads by **S3,** where **(**albeit small) decreases in such workloads could reflect the new role carer's better articulation of residents' basic signs and symptoms for illnesses, as mentioned in related comments (**see SWOT Strengths page 2 paras 3 and 4).**

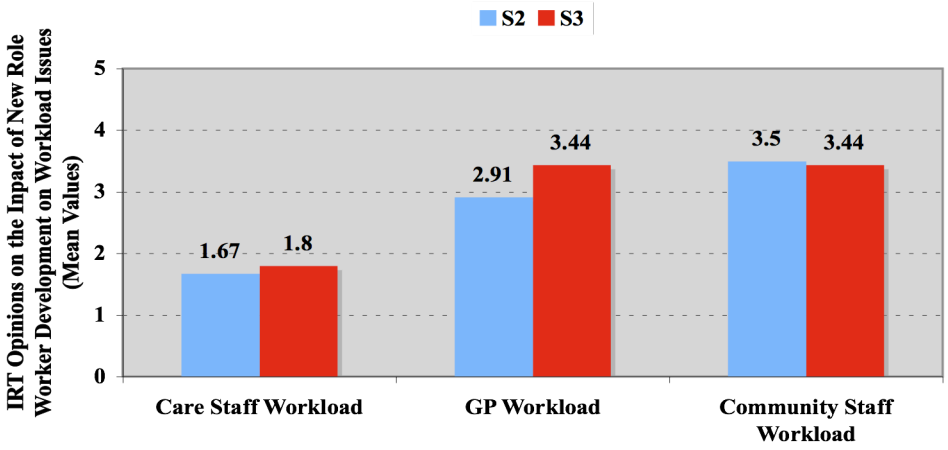

Figure 3. IRT opinions of the impact of new role carers upon workload

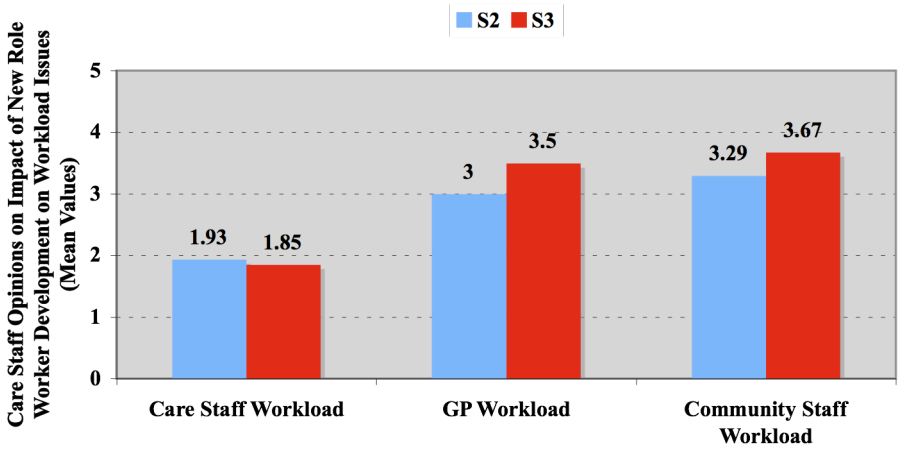

Figure 4. Care staff's opinions of the impact of the new role carer upon workload

4.6.2. Resident Care

Figure 5 shows the IRT members' opinion of the impact of the new role carer upon resident care. At both **S2** and **S3,** the new role's impact was perceived as '*fairly increased'* for prevention of avoidable hospital admissions, the early identification of hitherto undetected illness, and residents' person-centred care (**see SWOT Strengths, page 21, para 1)**. At **S2** the facilitation of early discharge was similarly given at a level of '*fairly increased*', but by **S3** their mean value for the impact of new role carer upon this aspect of care was perceived as being towards '*neither increasing nor decreasing'*. In contrast, care staff's mean value tended show a positive impact for the new role carer development on prevention of avoidable admissions and facilitation of early discharge (both at the level of '*fairly increased'*), but identification of undetected illness and person centred care were both centred around '*neither increased nor decreased'*. Furthermore, unlike the mean values of IRT members, there was little variation from **S2** to **S3** in each of those from care staff's for these key areas.

Explanation for some of these differences could lie in the fact that IRT members contributed to a continuing process of audit documentation and thus would have been better placed to provide reliable information, particularly for the new role carer's contribution to preventing avoidable hospital admissions and the facilitation of early discharges. That IRT members were more optimistic about the development of the new role's impact upon the identification of hitherto undetected illness and person centred care than were care staff could be open to several explanations. It could be indicative of care staff's ongoing resistance to change and reluctance to put new learning into practice (**see SWOT Weaknesses, page 22, paras 2, 3 page 23, para 2; Threats S2, page 26, para 2, page 27, para 1**). Alternatively, it could be argued that the rather task orientated approach adopted by some IRT nurses (**see SWOT Strengths, page 20, para 2, page 21, para 1; Opportunities page 24, final para**) could have excluded new role carers from contributing their new skills for the identification of illness in residents. Finally, with regard to person centred care, many care staff would say that this concept and associated way of working was adhered to in social care before the introduction of IRT, hence it would neither be increased nor decreased by the development of the new role carer **(see SWOT Strengths, page 20 final para).**

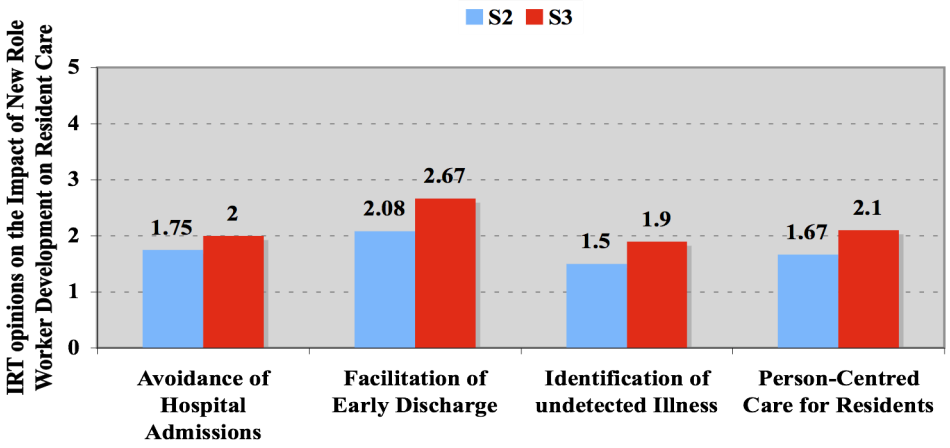

Figure 5. IRT opinions of the impact of new role carers upon resident care

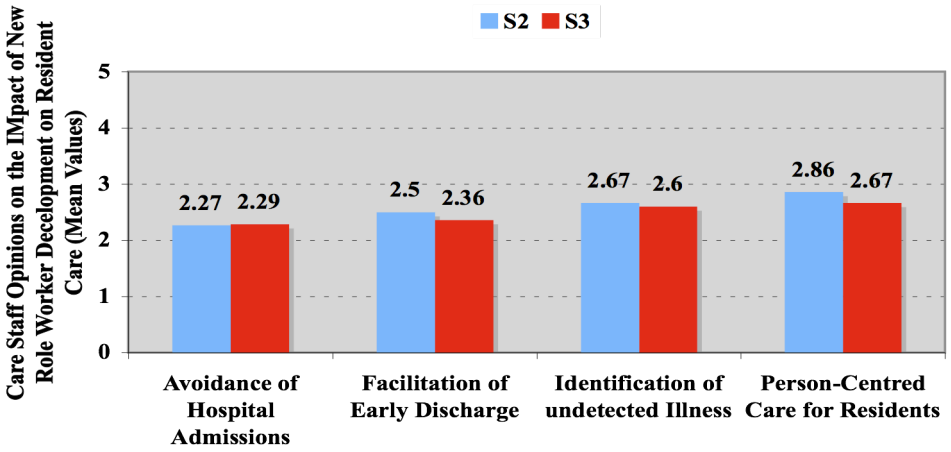

Figure 6. Care staff's opinions of the impact of the new role carer upon resident care

4.6.3. Relationships and Ways of Working

In figure 7, although at **S2** IRT members' mean value suggested that new role development *'neither improved nor damaged'* relationships with other care staff, this moved towards *'fairly improved*' at **S3,** perhaps because with increased time, all care staff had adapted to the presence of new roles and changes to their ways of working. The new role carer was seen clearly as improving cross sector relationships over both time phases, e.g. the GP was listening more (**see SWOT Strengths, page 20, para 4**). Across the **S2** and **S3** time phases**,** the impact of the new role carer upon cross sector relationships was estimated by IRT members as being '*fairly improved*'. In contrast, the '*fairly improved'* level describing the new role carer's cross sector ways of working at **S2**, moved towards '*neither improved nor damaged*' by **S3** and could suggest either a slight deterioration in ways of working by care staff, or that little had changed between the time phases**.**

The care staff's mean values for the impact of the new role carers' relationships upon their home's care staff, cross sector professionals, and the development of cross sector ways of working are shown below in figure 8. All of the care staff's mean values were slightly higher than those given by IRT members for the impact of new role development i.e. around *'neither increased/improved nor decreased/damaged,* with some slight improvement at **S3** from **S2** in all but cross sector working.

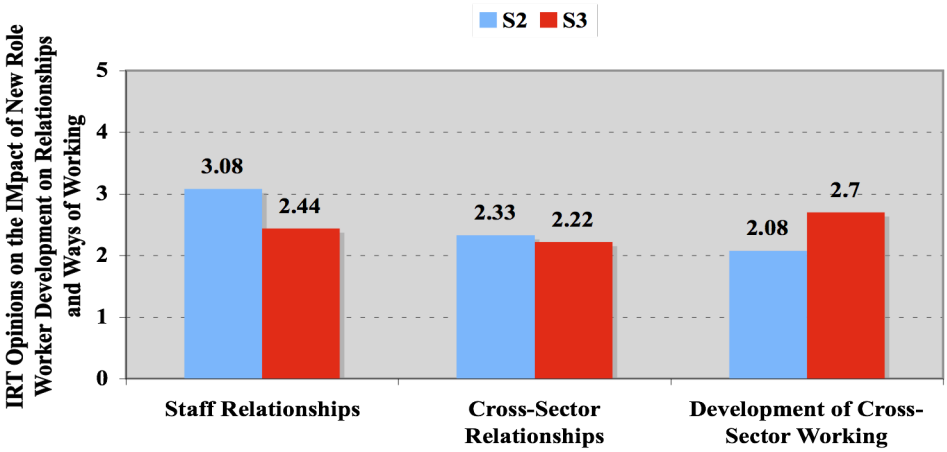

Figure 7. IRT opinions of the impact of the new role carer upon relationships and ways of working

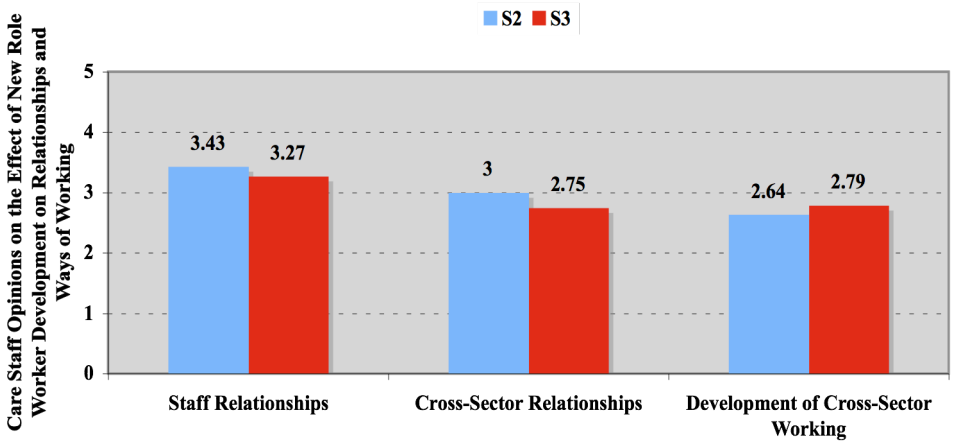

Figure 8. Care staff's opinions of the impact of the new role carer upon relationships and ways of working

4.7. IRT and Care Staff's Opinions of the Impact of IRT

In the same way as for the impact of the new role carer, IRT members were asked to gauge the impact of the IRT service upon the key areas of ***workload***, ***resident care***, and ***relationships and ways of working*** at **S2** (N=12) and **S3** (N=9) and at both points in time, they were requested to confine their responses to the preceding six months. IRT members responded to a 5 point likert scale, with values of *1=greatly increased* (or in some aspects *improved*) to *5=greatly decreased* (or in some aspects *damaged*), and with a mid point of 3=*neither/nor.* Numbers in the figures are presented as mean values calculated from their scores.

4.7.1. Workload

As with their opinion of the impact of the new role carer upon care staff workload, IRT members perceived the IRT service as '*fairly increasing'* care staff's workload in **S2** and **S3,** as shown in Figure 6. Of the community staff's workloads, mean values for GPs were consistently around '*neither increased nor decreased*' at **S2** and **S3**, but in contrast those for community nurses were towards '*fairly decreased*' over the same time period.

In figure 10, care staff's mean values for the impact of IRT upon their own workload followed a similar pattern across time to those given by IRT members, i.e. it was '*fairly increased'*. However, although they also provided a similar set of means indicative of '*neither increased nor decreased'* for IRT impact upon GPs workload to that given by IRT members, unlike IRT members, only at **S3** did they begin to move slightly towards the view that the IRT service '*fairly decreased'* community nurses' workloads. This minor variation between IRT and care staff could again be a reflection of the greater awareness of IRT members than that of care staff of the impact of IRT upon community nurses workload arising not only from IRT audit, but also from their closer professional interactions.

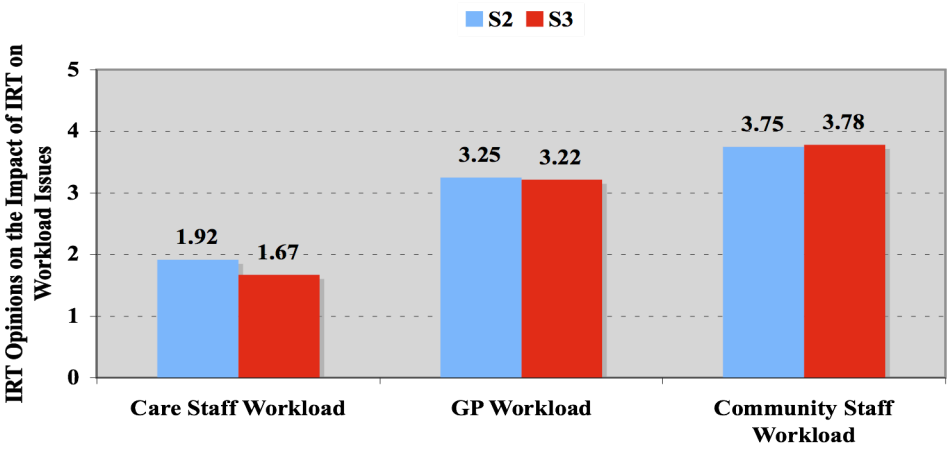

Figure 9. IRT opinions of the impact of IRT service upon workload

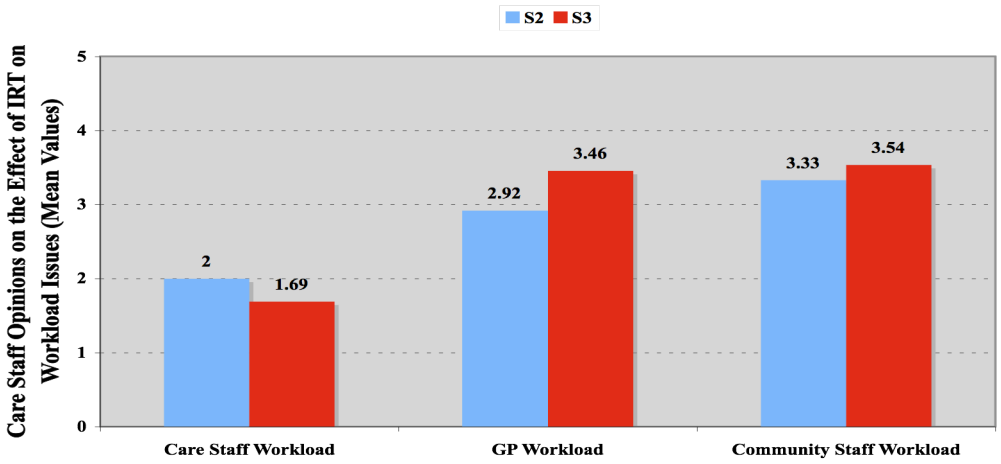

Figure 10. Care Staff's opinions of the impact of IRT service upon workload

4.7.2. Resident Care

Of the aspects of resident care, given in figure 11, IRT members' mean values indicated the highest level of increase over time for their identification of residents' hitherto undetected illness. In the remaining aspects, at both **S2** and **S3**, avoidance of inappropriate hospital admissions and person centred care were also represented around '*fairly increased*' levels. Only in the area of facilitation of early hospital discharge did the members' opinion of impact decease towards '*neither increased nor decreased*' by **S3**. These findings largely support the direction of the findings of the study's audit given in the Report *Audit of In-Reach Nursing Team for Residential Care Homes: Activity, Costs, Benefits & Impact on Long-Term Care* (Szczepura, Nelson & Wild, September 2007).

All of the care staff's mean values for the impact of IRT service upon resident care presented in figure 12 below, were higher (less positive) than those gives in figure 11 by IRT members. Similar to their values for the impact of the new role carer upon resident care (see figure 6, page 30) above), in **S2** and **S3,** care staff tended to view the prevention of avoidable admissions and facilitation of early discharge at the levels of '*fairly increased',* and person centred care continued to be around '*neither increased nor decreased'*. However, unlike their mean values for the impact of new role carer, care staff showed some slight change towards the more positive view of '*fairly increased'* for IRT's detection of hitherto undetected illness, perhaps an early indicator of their increased awareness of resident benefits from IRT **(see SWOT, Strengths, page 21, para 4)**.

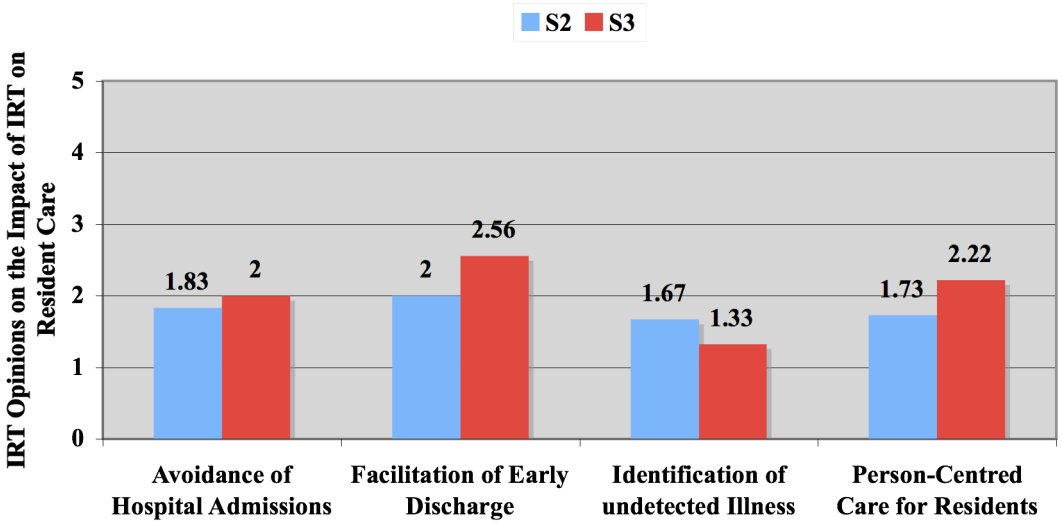

Figure 11. IRT opinions of the impact of IRT upon resident care

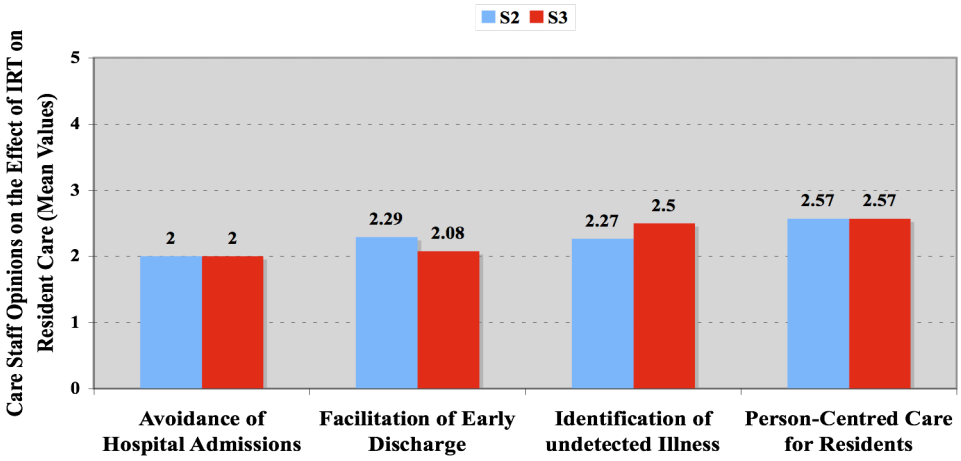

Figure 12. Care Staff's opinions of the impact of IRT upon resident care

4.7.3. Relationships and Ways of Working

As shown in figure 13, IRT members' opinions of the impact of the IRT service upon relationships with care staff showed some improvement between **S2** and **S3,** i.e. from around *neither improved nor damaged* towards a '*fairly improved'* level. Cross sector relationships and cross sector ways of working were consistently described as '*fairly improved'* over time. However when these mean values are compared with those given for the impact of the new

role carer development upon these aspects (see above figure 7), in the main, the former are slightly lower (more positive) with the exception of the development of cross sector ways of working whereas in figure 13 at **S3** it was slightly higher.

The care staff's responses to the impact of the IRT service's impact upon relationships with their home's care staff and cross sector professionals, and the development of cross sector ways of sector working are shown below in figure 14. In contrast with the mean values for **S2** and **S3** given by IRT members in figure 13, those given by care staff across time were markedly higher (less positive) suggesting that in general, their opinions of IRT's impact upon these aspects were less positive than that of the IRT members. In particular at **S2**, care staff perceived care staff relationships as *'fairly damaged'* by the IRT service, and although this seemed to lessen over time this was only to the **S3** level of *neither improving nor damaging'*. Furthermore, in the remaining aspects, care staff's mean values for relationships between IRT with cross sector professionals and the development of cross sector ways of working as being '*neither improving nor damaging'* across the two time phases, the converse of that perceive for these aspects by IRT. Although care staff seemed more negative than members of IRT for these aspects, some alternative explanations can be suggested. In terms of relationships with their own group, care staff and IRT members were in effect presenting self-evaluations and perhaps of human nature, each group tended to be less positive about the other group than their own. The clinical decision-making needed for residents would bring IRT members in much closer contact with cross sector professionals and their ways of working and possibly to some degree to the exclusion of new role carers whose underpinning knowledge was not comparable. However, in the *Weaknesses* and *Threats* in SWOT in both S2 and S3, evidence suggests that despite ongoing awareness by IRT members of relationship difficulties with care staff (**SWOT weaknesses, page 22, para 2;Threats, page 26, para 2)**, and to some extent their managers (**see SWOT Weaknesses, page 23, para 4, Threats, page 26, para 2; page 27, para 4**) and they efforts to address them, from the care staff perspective little had changed over time.

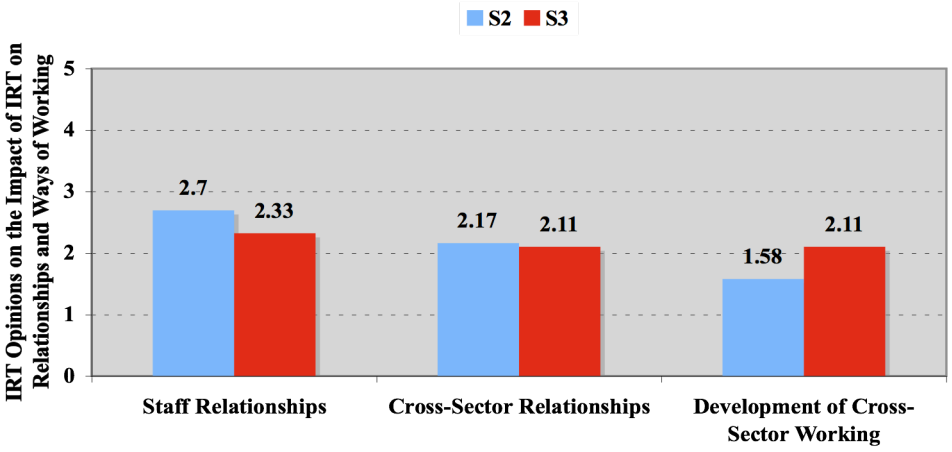

Figure 13. IRT opinions of the impact of IRT on relationships and ways of working

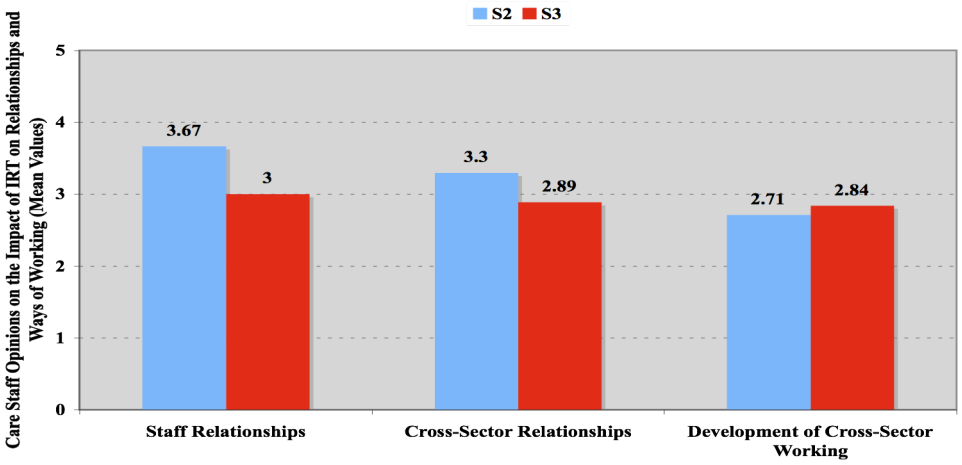

Figure 14. Care staff's opinions of the impact of IRT on relationships and ways of working

4.8. Boundaries between Social Care and Nursing

The three sample groups (including the perspectives of care staff in the non IRT home) were each asked whether or not they believed there to be a boundary between health and social care. The results are displayed in Table 9.

Table 9. Boundaries between Social Care and Nursing Care

Sample Group	S2			S3		
	Yes	No	Unsure	Yes	No	Unsure
Care Staff	18	6	6	8	10	0
IRT	10	2	0	9	1	0
Care Managers	5	0	0	2	2	0
Totals all respondents	*33*	*8*	*5*	*19*	*13*	*0*

4 non respondent care staff at S3

At **S2,** a clear majority of all sample groups believed a 'boundary' exists between health and social care, and in particular this was most marked in IRT members' responses. However at **S3**, although care home managers and care staff showed a marked narrowing of their of opinion towards a 50/50 split, IRT members demonstrated little change. These findings suggest that following a period of working with IRT, both managers and care staff had begun to see a 'blurring' of care cultures, possibly because they were the recipients of added value to social care. In contrast, IRT members, as the 'givers' of such added value, seemed to continue to perceive their role as being set apart from that of social care.

4.9. Pressure at Work

The work pressure scale is made up of 26 items (see Appendix 5). Each item has a likert scale of *1= no pressure* to *5 =high pressure*. Values for each participant for each of the items were summed and then divided by 26 (the number of items) to give a single mean score to enable face value differences to be observed. Care staff from the non IRT home were excluded. This resulted in the following numbers of participants in each role group: **S2:** 23 care staff; 12 IRT team: 5 care home managers (given as CHMs in figure 18 below), and at **S3:** 16 care staff; 11 IRT, and 4 care home managers. Figure 18 depicts the change in the level of pressure both within and between each group from **S2** to **S3.**

Overall, all of the sample groups appeared to have low levels of job pressure over time, although care home managers consistently had the highest levels of work pressure scores and those in IRT the lowest pressure scores.

Figure 15. Mean Job Pressure Scores for S2 and S3

To identify areas of work that were causing the most work pressure, mean scores for each item for the three sample groups were calculated for **S2** and **S3.** However, a difference was found only between the groups on the item: '*Insufficient time to do justice to the job*' in **S3**, as shown in Table 10 below, where care home managers and care staff in particular had higher mean score levels of pressure than those in IRT. This finding echoes some of the qualitative comments provided by care staff expressing concern over manpower shortages (**see SWOT Threats, page 27, para 4).**

Table 10. Mean Scores for Sample Groups on '*Insufficient time to do justice to the job*' at S3

Sample Group	Mean Score
Care Staff	3.75
Care Home Managers	3.50
IRT	2.36

4.10. Satisfaction at Work

An overall measure of job satisfaction (see Appendix 5) was calculated in the same way as in that described in the previous section for job pressure. Although in this case, the sum of the scores of all items was divided by 10, reflecting the number of items. The likert scale ranged between *1 = extreme dissatisfaction* to *7 =extreme satisfaction*. Figure 19 depicts the mean scores for each group's job role at each of the time periods.

At **S2** no major differences at face value can be seen between the three sample groups with all groups showing *fairly good* levels of job satisfaction. However, at **S3** it appears that the IRT respondents and care home managers (CHM) had lower levels of job satisfaction than that of care staff.

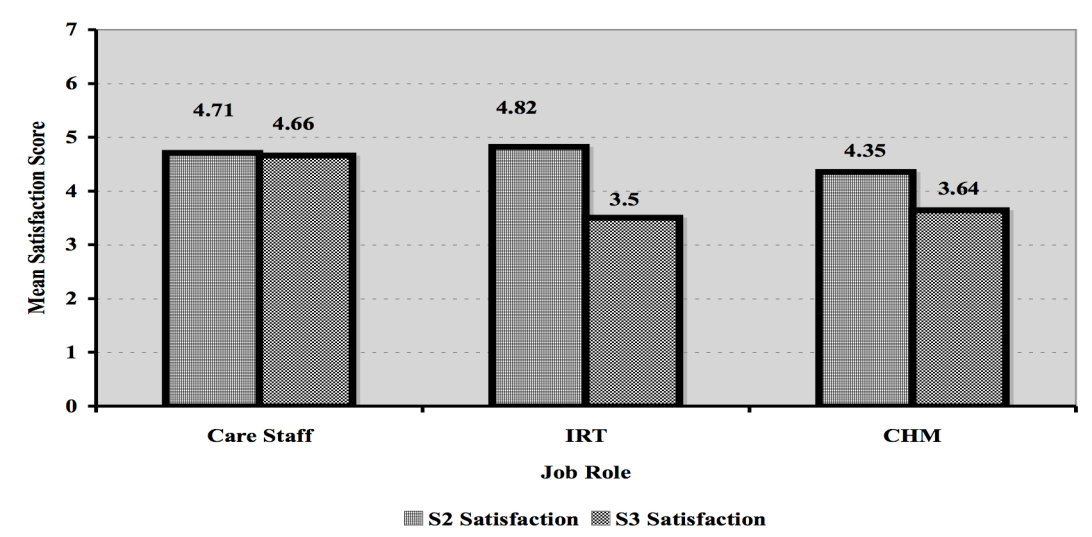

Figure 16. Job Satisfaction Mean Scores

The mean scores for work items causing each sample group the greatest and lowest levels of job satisfaction were calculated to demonstrate whether or not further differences were evident between the sample groups. As shown in Table 11, one item at S2 and another at S3 showed face value differenced between the 3 groups. '*Satisfaction with pay'* gave the lowest satisfaction scores across the three sample groups at **S2** with care home managers and care staff's mean scores, both showing much lower satisfaction with pay than that for IRT respondents. Conversely, *'Hours of work*' at **S3** produced the highest level of job satisfaction; with care staff the most satisfied of the three sample groups.

Table 11 – Mean Scores for Sample Groups on Items of Satisfaction

Sample Group	Satisfaction with pay (S2)	Hours of Work (S3)
Care Staff	3.13	5.50
IRT	4.75	4.27
Care Home Managers	2.20	4.75

4.11. Intention to Leave Work

The three sample groups were asked to indicate the likelihood of any possible future changes to their work life. They responded to each of 6 questions using a scale of 1 – 5 where 1 indicated *a zero likelihood of change* and 5 *a high likelihood of change*. The results are shown in figure 20 and include only care staff in the IRT homes (S2 N=16, 7 missing values; S3 N=10, 4 missing values)

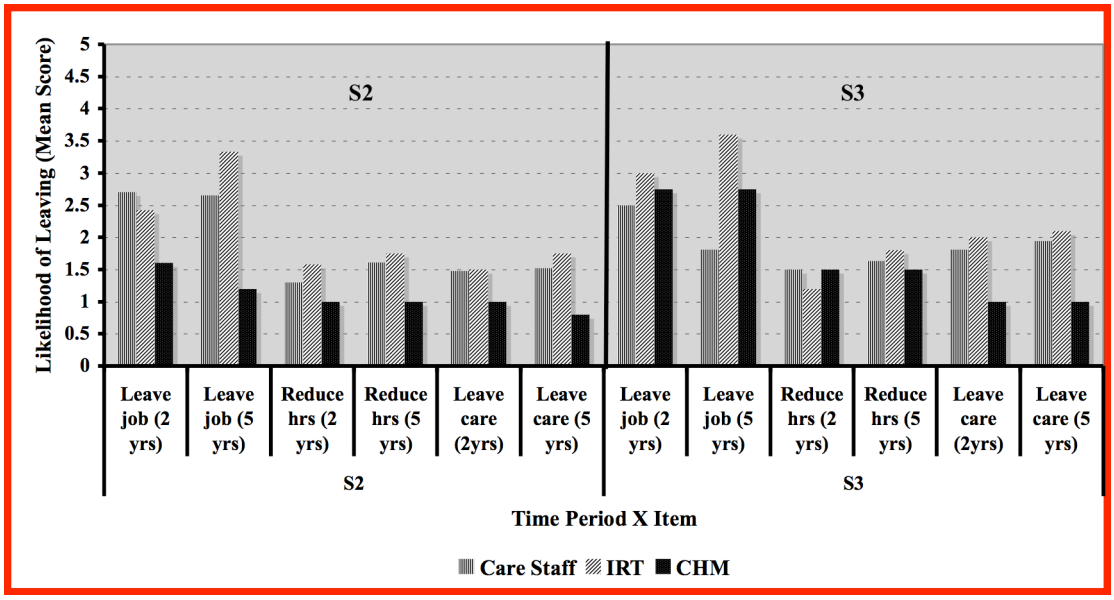

Figure 17. Possible Future Changes to Work Life at S2 and S3

As shown, **S2** scores tended to range from a *zero* to *moderate* likelihood of change and with the exception of care home managers indicating that they were the least likely to make any changes to their job, other sample groups showed largely similar scores. However, when asked to rate *'the likelihood of leaving their job for one similar within the next 5 years'*, those in IRT were significantly more likely to think they would do so than were care home managers or care staff. This makes sense given the short term project funding for employing IRT staff.

At **S3** a similar pattern was displayed, with mean scores again running from a *zero* to *moderate* likelihood of change. However, at this time care staff were the least likely group to leave their job within 5 years in comparison with those in IRT and care homes managers.

Further to the above questions, respondents were asked to rate the likely impact of the IRT project on work change decision-making. Possible responses ranged from *no effect=1* to *a great amount of effect =5.* A score of 3 indicated that they were *unsure* as regards the effect of the project on such decisions. The results in figure 18 below show the impact at **S3**.

Analyses showed that work change decision-making by members of the IRT was significantly more affected by the project than was that of care staff or care home managers. Most likely this was in response to IRT members' lack of certainty as to the future sustainability of IRT.

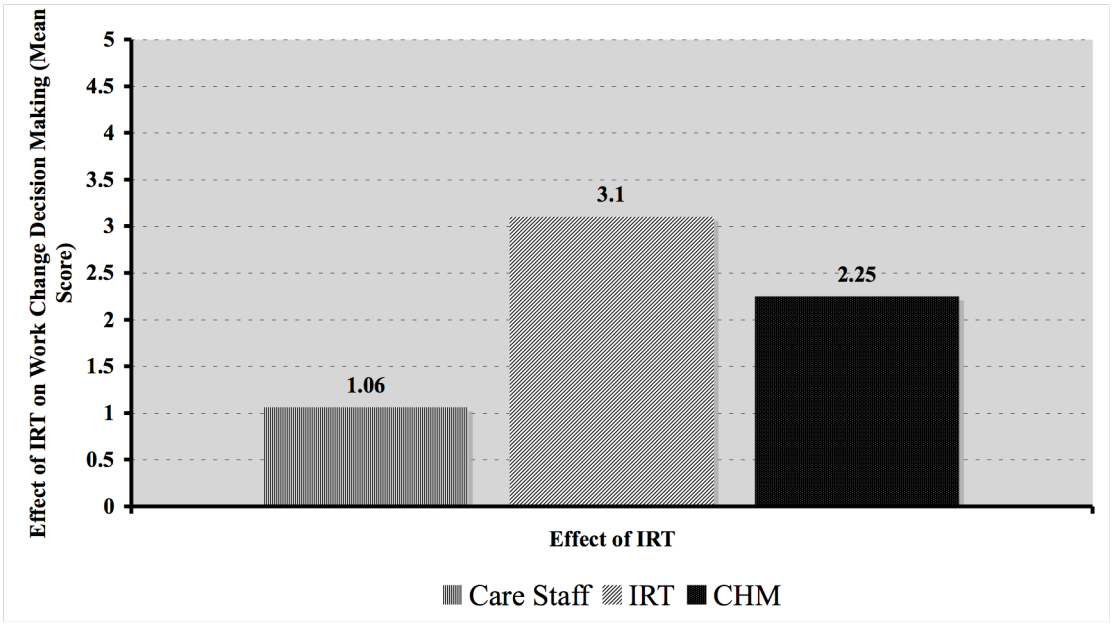

Figure 18. Effect of IRT on Intention to make Work Change Decision-Making

4.12. IRT Activities

As a guide to the way IRT members spend their working time over a weekly period, they were asked to estimate time spent on a variety of activities. Figure 19 presents the estimated mean number of hours per week spent in each activity at **S2** and **S3**, for the team as a whole. These figures can be related to the WTE of IRT over time for the purpose of audit, but for this report, they serve only to identify how much time members spend on IRT-related activities, and whether this has changed over time.

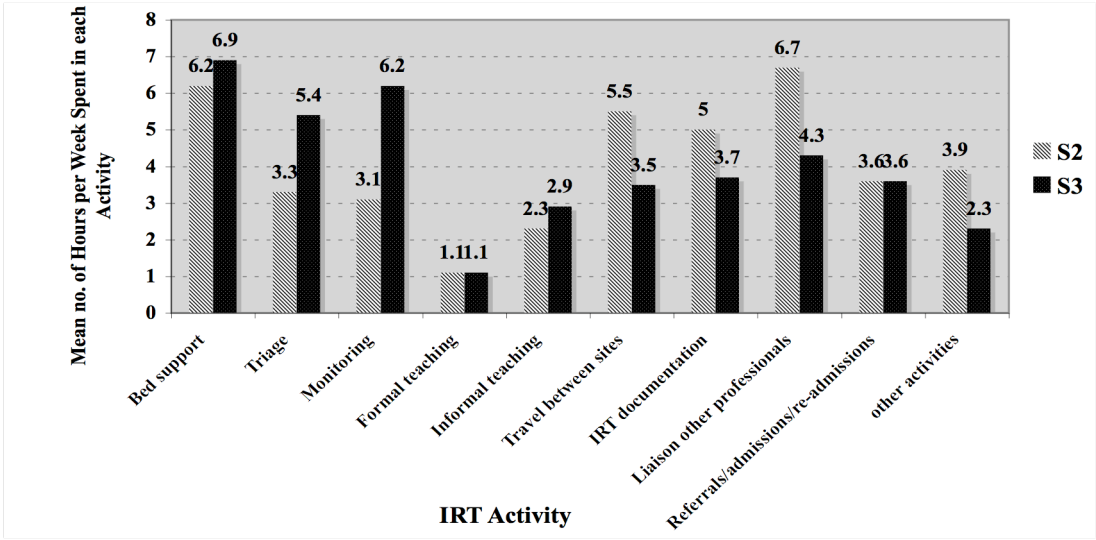

Figure 19. Mean Number of Hours per Week Spent on Each Activity by IRT

At **S2,** the IRT members spent most of their time *travelling* between sites, *liaising* with other professionals, on *documentation*, as well as caring for ill residents in IRT beds (*bed support)*. Perhaps this is not surprising when it is considered that earlier in the Project a large amount of time was inevitably needed for setting up ways of working, including channels of communication, and dissemination about the Project within homes and to other community services. In **S3** however, the largest amounts of time were given to meeting resident-related health care needs, i.e. *monitoring, bed support, triage*. Time spent on referral was constant across both periods and could suggest that even though there was increased health-related activity with residents between **S2** and **S3**, these additional health needs were being met by the IRT supported by new role carers without referral to external community services.

The fewest hours per week in both **S2** and **S3** were spent on *formal teaching* with a relatively larger amount of time spent on *informal teaching*. The fact that slightly more *informal teaching* took place in **S3** is possibly due to the training activity of newly qualified IRT Assessors within the team. Among the nursing aspects taught to care staff by IRT members were: taking **temperature, pulse, respiration, blood pressure, blood sugar**; *and* **urine testing, fluid intake and output monitoring, skin pressure care, catheter care, and dressing**s.

Time spent on *triage* and *monitoring* increased between **S2** and **S3,** possibly due to better use being made of IRT through the increased awareness of care staff and managers of the health needs of residents. Conversely, *liaison* hours with other professionals in the community decreased across time. Together, these findings suggest that with the passage of time, the greater familiarity with IRT systems, increased confidence and uptake of responsibility by new role carers, and increased awareness of IRT members' activities, there was a reduced need for liaisons with external professionals, i.e. GPs and community nurses.

5. Feedback from Focus Groups

The four individual focus groups were conducted between the **S2** and **S3** data collections (December 2006) as follows: i] 4 home managers; ii] 6 IRT members; iii] 5 care staff of whom 2 were new role carers, and iv] 20 residents of whom 14 had had IRT contact. Groups i] – iii] were each given identical feedback from their and other groups' SWOT analysis and the researcher recorded their discussion in field-notes. As these groups were held some months after the individual participants' initial interviews in **S2,** it was possible to discuss both changes from that time as well as ways of resolving issues.

Care home managers, care staff, and members of IRT, all verified their same-sample SWOT feedback as being a "fair' representation of their views and attitudes in **S2**. Further, each of these groups acknowledged the SWOT evidence from other groups as meeting their perceptions of the wider situation. In summary, researcher reports of post feedback discussion of issues arising raised the following key points:

i] Care Home Managers' Group

- Managers largely were supportive of IRT and recognised its health benefits to residents but felt that it would take time to bridge 'cultural' (between health and social care) differences between IRT with care staff.
- The major organisational changes in progress were perceived as having an ongoing impact upon themselves and care staff and thus, the concurrent timing of the IRT project was believed to be unfortunate.
- Some managers felt that more caution needed to be exercised by IRT members to avoid turning residents of homes into hospital patients.
- Some managers felt that IRT would be too expensive to be sustained in its present form as not enough residents were ill and beds were under occupied.

ii] IRT Members' Group

- IRT members were united in the view that they were achieving objectives in preventing hospital admissions through triage and preventative interventions more so than through the use of IRT beds.
- IRT members felt some improvement in relationships with care staff had taken place but this had more to do with the personal attributes of individual care staff than a general acceptance of IRT.
- Some new role care staff were highly regarded by some IRT members for their performance of new skills but doubts were expressed that the former could initiate these without IRT decision-making, direction and support.
- IRT members felt that issues around supervision and assessments for NVQ3 and their other administrative activities had improved over time but completion of resident care documentation by care staff remained inconsistent.
- Some IRT members felt that within the team a few individuals were reluctant to include care staff within a team approach.
- Unresolved future funding for IRT was a major concern for the sustainability of the project and was beginning to have an effect upon some members' morale.
- Some IRT members felt that care home managers were not consistent in showing their support for the project and in particular, this undermined its progress in building good working relationships with care staff.
- Early problems of boundary between IRT activities with those of community nurses were believed to have been largely resolved and often to the benefit of the community nurses by reducing their workload.

iii] Care Staff Group

- Carers who were not in new roles in the IRT homes expressed the feeling of being excluded from the IRT project.
- There was a general consensus that insufficient thought had been given to increasing manpower resources to support the additional workload demands created by IRT, i.e. new role carers were "taken away' from routine care to undertake IRT support activities leaving other carers with additional work.
- The new role carers in the group both said that they enjoyed their new role learning and practice of skills and felt that it had given them better status with other health professionals including GPs. However, both said that the social care system offered little motivation or recognition for the new role and the time they had to give to gain their NVQ3.
- In general, the group expressed a view that difficulty in relationships with IRT was dependent upon the personality of individual IRT staff members and their ability to

appreciate their (care staff's) experience and understanding of social care within a residential home context.

iv] Residents' Group

Twenty residents attended a routine meeting in one IRT home to discuss the home's future plans and activities for residents. The meeting was arranged by the home manager and led by the home's senior care assistant. In addition, the IRT manager and one IRT nurse were invited to attend, accompanied by one evaluation researcher acting as an observer taking verbatim notes. It had been pre arranged that some 15 minutes at the beginning of the meeting would be given to a discussion with residents around the progress of IRT.

Following a short introduction by the IRT manager, residents were asked how many had experienced contact with IRT staff and 14 responded positively and 6 had not had contact. The questions, posed by the IRT manager to residents, closely followed those issued as a part of IRT audit for residents following use of in reach bed services. Prompts to these questions included frequent reminders that negative opinions would be particularly welcomed as these would help the IRT service to improve. The questions and residents' responses are given below:

1. For those of you who have experienced in reach, what do you think was good?

In general, residents appeared to be positive as indicated by nods and murmurs of agreement by most residents. The following vocal comments were recorded:

'First class.'
'Very good.'
'Nice to have 'em come in.'
'Feels well.'
'They changed my medication. It made a big difference. It was quick.'
'More than satisfied - here on the spot.'

2. Was there anything you not like about the in reach service.

Residents did not respond to this question negatively but turned it into positive responses as follows:
'Had a problem and went into hospital. The nurse came into hospital to see me'.
'I had no problem either.'
'Nurse came in – he's a nice man – very helpful'.

Several efforts were made to prompt residents into considering negative perspectives but these did not receive responses.

3. What do you think could help us improve the service?

Responses to this question raised some issues for IRT and its relationship with care home staff, but in general resident respondents were positive about the service.

'Think if they could work closer with key workers. So many residents – key workers don't have time. Have to be patient.'
'Helps having nurses around.'
'Don't think so.'
'We don't know district nurses from in reach – it's a bit confusing.'
Some residents responded to this question by providing observations of the 'ways of working' of the care home staff and the home environment rather than of IRT.

'Not enough staff here to cope.'
'Problem is staff- not enough of them- they can't cope.'
'No cleaners here – some toilets are dirty. I cleaned one myself.'
'Over worked – rushed off their feet.'

4. Would you have preferred to have had your care provided in hospital rather by the in reach service?

The first comment indicated the outcome from what was a prevented hospital admission by brought about by IRT intervention.

'No. It was good- like when my hiatus hernia flared up.'

Another comment reflected the desire of the resident to 'stay put' rather than be moved into hospital if taken ill.

'Rather be here – speaking personally.'

Another comment emphasised a sense of security in having nurses on hand.

'I just feel safer.'

A final comment indicted the perception of a past experience of one hospital.

'I went into hospital – terrible food – I lost a load of weight.'

Validation of the recorded comments*:*

The researcher's transcript of the meeting's recorded outcomes from residents was sent on the day after the residents' meeting to the IRT manager and nurse, and the senior care assistant of the home for comment as to its accuracy. Each of the former responded that the transcript was an accurate record of the meeting**.**

6. Key Findings and Presentation of Key Messages

6. 1. Evidence of Improved Care in Care Homes

The most important finding from the information gathered was its positive impact. Residents were satisfied with the presence of the In-reach Team's service and appeared to hold a sense

of greater security about their health needs being met in the homes as opposed to having to go into hospital.

By the second collection of information, care staff showed a greater sense of empowerment from the NVQ3 training they had received. They reflected a need for more training and seemed to believe that this could be achieved by through the presence of the In-reach Team. These changes could motivate an increase in the up-take of new role NVQ3 training by care staff in the future.

In-reach activities changed over time to being more resident-centred than In-reach development-centred, as the service became more recognised within the homes and by external community care services. As increased resident-centred activities did not appear to result in more referrals by the In-reach Team to external community services, it is likely that residents' health needs were being met within the In-reach system.

Key Message 1.
Residents appreciated the In-reach Team's service over time, and its presence and the up-skilling of new role care staff through NVQ3 had a positive effect upon quality of care in LA care homes.

6.2. The Model's Early Planning and Introduction

The In-reach Team Model was shaped by Local Authority (LA) and Primary Care Trust senior managers coming together to attract funding. This opportunism was set against a background of a drive for greater integration between public sector services. It also coincided with other local strategies concerned with restructuring services for older people in Bath and North East Somerset (B&NES). Importantly, these plans included significant capital investment in new local authority homes.

The report describes the national and policy drivers for the In-reach Team Project and confirms that all of the sample groups (In-reach nurses, care staff, care home managers and senior managers) had an understanding of these. There was therefore a real opportunity to develop a shared and inclusive vision of the In-reach model from the start. However, care staff consistently reported feeling excluded from the development of In-reach Team. Unlike the nurses and care home managers, they had no representation at IRT meetings. Instead, they relied on 'top down' information from their respective care home manager.

The introduction of the In-reach Team also coincided with a number of organisational changes, including the planned closure of some homes, and revisions to staff pay structures. Care staff thus faced uncertainties about future employment and/or relocation at the same time as they were trying to establish the new ways of working related to the In-reach Team model.

Early in the Project's development, some stakeholders recognised the potential for cross-cultural frictions and misunderstandings with the introduction of the In-reach Team. However, at that time there did not appear to be a clear management strategy for dealing with communication difficulties on the '*shop floor'*. In addition, short-term funding raised particular pressures to get the service up and running on time. This might have lessened

cross-group efforts to establish cohesive relationships (between care home managers, nurses and care staff) early in the project.

An essential part of the project was training care staff to NVQ3 as a new role carer (sometimes referred to as a "new type of worker') in new ways of working including the undertaking of nursing skills. However, if care staff did not feel part of the project from the outset, they may have seen no need or incentive to become involved. The reported difficulty in recruiting candidates for the training could thus have been an early indicator of care staff feeling excluded. The delay in recruiting nurses to the project also interrupted momentum and this seems to have reduced care staff interest.

Key Message 2.
A strategy for introducing change needs to take account of structures and processes, but also needs to address the likely perspectives of, and the anticipated effects on, those involved. If too many changes are happening concurrently, receptiveness may be damaged. If this cannot be avoided by more considered timing, it needs to be recognised and mitigation planned.

6.3. Attitudes and Relationships

Over time, only the In–reach Team had a consistent and positive level of inclusion in In-reach consultation and confidence in the Project's success. In contrast, care home managers and care staff in particular, had levels indicating that they felt excluded from In-reach consultation processes. However, this did not appear to mirror the levels of confidence in success of the model over time. For, although care home managers demonstrated consistent levels of exclusion over time, there was a decrease in confidence between the two information-gathering rounds. This could suggest that as care home managers had greater access to In-reach development through attendance at regular joint meetings, their increasing lack of confidence in In-reach could have been due to factors other than their level of inclusion in consultation**.**

Relationships between care staff and the In-reach Team appear to have improved over time, possibly due to more staff up-take of new role NVQ3 training with a closer involvement with In-reach assessors and their activities. Interestingly, at the In-reach Team focus group, although most members felt relationships with care staff were improving over time (as indicated quantitatively), some felt that care home managers were not always supportive towards the project, and that this undermined progress in working relationships with care staff. It is possible that by the second round of information gathering, although care home managers acknowledged the need for closer relationships between care staff with In-reach Team members as being crucial to the confidence of care staff, their articulation of this to the In-reach Team and care staff was not sufficiently robust. As such, it can be said that they could act as either a bridge or a barrier between In- reach Team members with care staff.

Relationships between care staff and IRT members with community staff were generally described as fairly positively over time. Indeed, IRT members consistently reported that their service slightly decreased the workload of community nurses, although GPs' workload remained largely unaffected. Early difficulties with community nurses around overlapping of services seem to be a issue under continuing review across time. For care staff, a continuing

problem was knowing when and who to refer to, and confusion as to which nurse was which (In-reach nurse or community nurse) was raised by some residents. Amongst the rewards from their new role, some care staff indicated greater inclusion by and more meaningful relationships with community staff from their new role ability to give better resident information.

Key Message 3.
Care home managers, care staff, and In-reach Team members need to learn to understand and appreciate the differences between each other's roles and responsibilities. In-reach Team members could spend more time on the 'shop floor' to improve and personalise relationships, but care workers need to understand where the nurses have come from and what their roles and accountabilities are as trained nurses. A review of In-reach Team activities in relation to community services' input to homes will be required as a part of Model development.

6.4. Ways of Working

Information from the first round of information gathering revealed that care home managers described most weaknesses in *ways of working* as due to In-reach Team members' communication difficulties with care staff, including a lack of openness and trust. Care staff described In-reach Team members as presenting mixed messages and a lack of respect for social care knowledge and the care staff's roles. They perceived the Team as being too task orientated and overly medicalised. In contrast, In-reach Team members perceived some care home managers as unsupportive and some care staff as set in their social care ways and with a reluctance to embrace change. However, by the second round of information gathering, care staff began to appreciate the health benefits to residents and their new role in achieving these. Some In-reach Team members also described an increased respect for the new role carers. However, despite these relationship improvements, care staff continued to suggest the need for closer working relationships with In-reach Team members and a greater level of inclusion through representation at the regular In-reach Team meetings.

Although recognised by each group of respondents, the effects of differences between a nursing approach to care with that of social care within the context of residents and 'the home' environment, do not appear to have been communally shared. Hence, over time, In-reach Team members were consistent in perceiving a boundary between nursing care with social care, whereas this became less marked in the responses of care staff and care home managers over the same time period. The opportunity for In-reach Team members to bridge such differences at the project's outset, seen by care staff as In-reach Team members working with them for a short period as social carers rather than as nurses, was not realised. Thus, the strong sense of 'them and us', described by some care staff early in the project**,** remained an unresolved challenge to shared ways of working.

Key Message 4.
Communication difficulties in both information systems and relationships need a team approach and one that encompasses all parties meeting informally and formally.

6.5. Workforce Enhancement

Over time, the In-reach Team members were consistent in their vision of the In-reach model, both in terms of it enhancing workforce development and meeting residents' health needs. However, within the team, some individuals noted the presence of conflict between some Team members. Perhaps this is not surprising given the diversity of nursing experience within a team whose performance has been constantly under internal and external scrutiny. However, as dissension was also raised at a practice level by some care staff, it could have acted as a reason for some care staff to distance themselves from the project.

In general over time, new role carers moved away from descriptions that were negatively framed in the early days of the In-reach Team's development to those indicating enjoyment of their new role learning and their acquisition of practice of skills. By the second round of information gathering, they were requesting more training from the In-reach Team. Some felt that their new role had given them better status with other health professionals, including GPs. While others recognised improvements in the quality of care for residents. However, as little time appears to have been spent overall by the In-reach Team on informal or formal training, this could suggests that care staff were not being fully involved by all members of the In-reach Team in nursing–related care giving. An extension of In reach training to all homes was requested by both new role carers and other carers.

Key Message 5.
As care staff are beginning to move forward in acknowledging personal and resident benefits from training, there is a window of opportunity for the In-reach Team to create a practice-driven learning environment involving all Team members with new role carers and other care staff in all homes.

6.6. Improved Resident Care

Care staff and the In-reach Team members identified meeting policy requirements in terms of early detection of illness and a more speedy activation of home-based treatment either with the involvement of the GP or through the In-reach Team's own decision-making. Residents at a focus group were also satisfied with the In-reach Team's service and declared that they felt more secure with nurses on call to their home and with the potential to stay in their home when ill rather than be admitted to hospital. Although care home managers recognised a major strength of the In-reach Team as an opportunity to improve resident care, their acknowledgment of success in achieving this was less evident. From this, it is possible that some care home managers could have felt some undermining of their previously exclusive role (pre in reach) in decision-making concerning the welfare of residents.

Key Message 6.
Mutual recognition of contributions made by individual groups to the improvement of resident quality of care is needed. The care home manager as the mainstay of the home's environment is ideally placed to act a leader in communicating both successes and challenges within the model.

6.7. Resources and Sustainability of IRT

Care staff raised issues around a need for more dedicated time for training, and suggested that there should be increased pay for those in new roles. Some care staff mentioned the greater time needed for care-giving in these new roles. In-reach Team members also described IRT as increasing the workload of care staff, and in particular, care staff not designated as new role carers mentioned their need to 'cover' routine work for new role carers working with In-reach. Care staff expressed a greater pressure on their work time than did care home managers or In-reach Team members, respectively, but of the three groups, the former were the most satisfied with their work hours and the least likely to leave their present job or care work.

Care home managers questioned the viability of those in new roles maintaining their skills if the In-reach project ended and the Team disbanded. They also questioned the sustainability of meeting the cost of the In-reach Team if, as they seemed to believe, insufficient numbers of residents were ill. Across time, care home managers recorded the highest levels of work pressure and although not extreme, it could reflect the complex challenges faced by managers during a time of change to the structures and processes in addition to their efforts to engage their workforce with In-reach Team activities.

Key Message 7.
The development of the new role carer could have LA resource implications ahead in terms of workforce demand for: i] increased pay for those in this role, and ii] increased staffing levels for those not in this role, who feel that it has put additional pressure on their workload. However, any increase in LA manpower resource could be offset by savings to the PCT created by IRT and improved resident care, i.e. reduced need for hospitalisation of residents, facilitation of early discharges, and early detection and treatment of illness in the home.

7. Acknowledgements.

The research team from both Universities thank care staff, home managers, members of the IRT, and stakeholders for their generous support, time and commitment in information-giving for this study. This has been much appreciated.

APPENDIX 1.

Evaluation Aims and Objectives

Description of the Model

1. To describe the Model's origins in terms of perceived National and local policy, i.e. *'Drivers'*.
2. To identify early challenges to the Model's introduction.
3. To ascertain adjustments made over time to resolve challenges.

Workforce Enhancement

1. To identify the skills, training and qualifications required of staff in this model and to explore the appropriateness of skill-mix versus the range of services to be provided within this model of care.

2. To determine the model's influence upon:
   - *joint working arrangements*
   - *the potential for career development and skills escalation*
   - *staff sickness, retention, and recruitment*

Quality of Care

1. To identify and describe changes to quality of care using specified quality indicators as a reference point (i.e. Key NSF areas, CSCI Indicators etc)

2. To ascertain the extent to which the model:
   - *assists residents to manage their long term conditions*
   - *enables early detection of physiological changes of residents which predispose to disease i.e. blood pressure screening/urine analysis*
   - *reduces infection rates of residents*.

Resources

1. To assess the level of savings realised by the introduction of this model of care and comparing this to the costs of the in-reach team and the new role health & social care worker (including justification in terms of training and rewards for staff who take on enhanced care roles)

2. To understand the extent to which the model of care:
   - *prevents a move out of residential care to a nursing home*
   - *prevents an acute hospital admission*
   - *facilitates return to their placement of origin more quickly following an acute admission*
   - *reduces the demand on community health services*

Sustainability

1. To understand the opportunities and constraints of the proposed model to inform
   - *the roll out of the project.*
   - *the implications for future policy and practice*

2. To explore improvements in stakeholder satisfaction to include residents and relatives, local authority and PCT staff & managers, CSCI Inspectors and other key stakeholders.

APPENDIX 2.

Stakeholder, Manager and IRT Perceptions of Key 'Obstacles' during IRT Development

Stakeholders (N=12)

Key Obstacles	Examples
Cross sector communications	• Getting PCT/LA to agree in the context of increasing financial worries about how the project could be supported after OPDM funding ceased. (LA) • Communication between organisations. (CM • Getting CSCI agreement.(LA) • Registration and policy - CSCI negotiations. (LA • Persuading CSCI of the sense of new ways of working. (IRT) • Agreeing service criteria that is clear between existing services, i.e. DNs and Community Teams Older People. (IRT) • If the project is going to work we've had to get along with people and interpretation of the regulation – a fairly significant barrier. (LA) • To get agreement that this (IRT) could happen - clarification (discussion and debate) about nursing in a care home was crucial.(CSCI) • There were issues around structures; registration stuff; how it would work; management of the team; where they would be based - a bit about how do you monitor it. (LA) • Getting project off ground eventually setting and agreeing a target for delivery.(PCT)
IRT/ Homes' staff communications	• Working or integration between health and care home staff – very different cultures-care home staff are being enhanced along the nursing model and the implications that has in terms of grading/pay.(PCT) • Getting staff on board. (PCT) • Getting managers to support the process. (IRT) • Keeping staff onboard (CHM) • Presenting the project - continuous meetings and keeping people informed and listening. keeping people on board. (CHM) • Dealing with constraints from others not involved. (CH) • Getting the residential workers on board- some resistance because I don't think people understood what their role was going to be - I think there were plenty of sessions to tell what the IRT was about but I think it is resistance to change really – it can feel a bit in the middle of IRT and the home – we have a good rapport with both- from the community nursing point of view it has all been very smooth. (DN) • Getting and keeping staff onboard to see that this had something of value to them as professionals - improving the service for residents that didn't present a threat – you still have those who have done NVQ and those who haven't – (CSCI)
Progressing NVQ	• Being flexible about what could be perceived as healthcare assistant type tasks (PCT) • Not enough staff. (CH) • Having enough NToW staff trained to meet CSCI regulations of 24/7 cover (IRT) • Time in lieu for achievement – extra nurses training to be assessors (IRT)
Recruitment and retention of staff	• Recruitment of staff for the in reach team (IRT) • Commissioning staff [NToW] for the fieldwork stuff and understanding what we're trying to achieve.(LA) • Recruitment but this is resolved now. (PCT) • Recruitment of staff [NToW] early in project. (CHM) • Recruitment of nursing staff [IRT]–adding a lot of management time. (LA) • Loosing 'signed up' NToW staff because of delays in getting things off the ground-signed up new cohorts. (LA). • Loosing NToW staff from one pilot home-partly lack of local leadership as well as co-incidental negotiations with staff over terms and conditions in progress at same time as development of IRT. (LA)

In-reach Team (N=12)

Key Obstacles	Examples
Communication	• Problems with care home staff • Obtaining information from GPs • Poor handover of information for therapy in homes • Communication between two organisations [PCT/LA]
Joint working	• Getting the homes and managers onside. • Home staff hostilities • Being accepted by support workers and managers • Helping carers understand prevention is better than cure • Home staff not wanting to change • Staff resistance to change/new learning.- constant negotiation and bridge building • Getting the homes [staff] and managers onside and work together as a team
IRT Team building	• IRT: personality clashes. • IRT: Forming links with colleagues • IRT: Recruitment took a year – huge resources. • IRT: Working together as a team • IRT: Understaffing due to recruitment probs. • IRT: Friendship and team work with colleagues • IRT: Forming links with colleagues
Cross cultural issues	• Managers not recognising the value of activity. • Breaking the social services culture • Breaking Social Services habits
Progressing NVQ training	• Shortage of staff and time. • Not enough NToW staff trained to meet CSCI regs. for 24hr cover in each home initially-now needs to be mainstreamed by LA.. • Getting staff to take on NVQ • Carers do not have enough time at work to do NVQ • Support workers leave once they become NToW • NVQ need more support • Getting the staff to take on NVQ
Cross Boundary issues	• Access to information from GP • Agreeing service criteria between services i.e. DNs • Drs not aware of us • GPs not sure of how to use service
Raising awareness of IRT	• Takes time • Getting In Reach known and used as a service

Mangers (N=5)

Key Themes	Examples
Communication	• Discussion perceived as criticism • Keeping people informed and listening • Keeping people on board
Joint working	• Work with staff more • Constraints caused by those not involved • 'Them and us'
Progressing NVQ training	• Slow start with NVQ Assessor and IRT appointments • Not enough staff initially • New NVQ standards meant some units had to change
Cross cultural issues (16%)	• IRT lack knowledge of /insight into social care • PCT protocols by to management direction

APPENDIX 3

Stage 2 - Key SWOT Themes and Issues Arising from IRT

S2. Key Themes for Strengths in IRT - Care Managers (N=5)

Key Themes	Issues
IRT Model & Ways of Working	• Enhanced observation of residents • Person-centred care • IRT diversity of skills meeting range of residents' needs • Quick IRT response for ill residents • Increases staff confidence and awareness • Shared knowledge and awareness promotes confidence
Progressing NVQ training	• IRT supports acquisition of NVQ competencies
Long term vision	

S2. Strengths in IRT - IRT (N= 12)

Key Themes	Issues
IRT Model & Ways of Working	• Carers and nurses pick up changes in residents sooner • Residents want to stay put and avoid hospitalisation • Improved quality of life • Residents find comfort in having health needs addressed daily rather than having to wait hours • Access to nursing care almost instantaneous - enabling early detection and prevention of deterioration • Able to liaise with MTD [multi disciplinary team]with more respect. • Between nurses and carers • Breakdown of barriers between cultures • Health/Social Services working- the way forward • Good team work helps achieve goals • Innovative model- First of this kind
Progressing NVQ Training	• Support for NToW skills • Care worker have questions answered and explained daily • To inspire care workers and gain trust • To gain more skills and apply them properly • Educating staff to understand care procedures • Learning new skills from each other • Can transfer skills to NToW • Team has wide skills
Supportive management	• Feel supported • Keeps us focused – inspires us when things go wrong and we feel negative.

S2 Key Themes for Strengths in IRT - Care Home Staff (N=30)

Key Themes	Issues
Models of Care & Ways of Working	**IRT Model** • Providing care skills for early diagnosis • Better quality of life • 24/7 cover/ nurses on call • Resident can stay put/maintain independence even when needing extra care. • Residents know they will stay in home-won't go to hospital • High quality care – palliative care- prevents residents going to hospital • Resident centred care • People remain in home- nice to have backup of IRT • Nurses on call • People with knowledge - take some of the load • Raise standard of care-teamwork in best interest of clients • Motivates staff • IRT takes some pressure off support workers • IRT can do dressings • Good that IRT can do dressings but dressing, washing, care left to care workers-so IRT come in and do 'task' and then go even if heavy workload **Traditional Model** • *Offer high quality of care* • *Care home staff know their residents - teamwork* • *Good team-work/care staff support one another* • *Staff have a lot of patience* • *Caring thoughtful staff* • *Staff able to provide palliative care* • *People used to traditional model, hence they like it.* • *Residents not on their own/safe/secure* • *Normal routines maintained in homes* • *What people are used to- don't like change* • *Good system at present - professionals - DN lots of experience, GP experience and knowledge* • *Continuity of care support for residents* • *Good rapport – care staff picking up problems early alerting on – team here* • *Good communications - if staff here think there is a problem with a resident then call appropriate person e.g. GP* • *Good quality care – Council provides better care than private sector* • *Do what is always done whatever is needed- have a laugh* • *DN good – in for one thing but can ask about anything else* • *DNs good –good teamwork with GPS-think S Worker good at picking up problems. In house chiropodist good.* • *Vigilant –know residents* • *DN good – good company* • *Standard of care client specific-protective safe and secure-personal care-normality* • *Good relationship with DN* • *Prevent loneliness –keep independence Good community services (GP, DN)* • *District nurse fantastic*
Progressing NVQ training	**IRT Model** • *Learning physio/nursing skills* • *Supports care staff skills development* **Traditional Model** • Staff training – up to date /mandatory days

S2. Key Themes for Weaknesses in IRT - Care Managers (N=5)

Key Themes	Issues
IRT Model & Ways of Working	• Poor-no joint meetings • Lack of confidentiality can cause conflict • There was not a very clear message and information to staff kept changing • IRT poor at including our team when attending clients
Resources	• Difficult to maintain staff structure – could have effect on sustainability of IRT • If funding is limited might not be long enough • Homes are spread out-lots of travelling – if 15 residents were in in-reach, nurses would not be able to cope if in 5 homes
Pace of change	• Project is running when staff and residents are coping with lots of changes

S2. Key Themes for Weaknesses in IRT - IRT (N= 12)

Key Themes	Issues
IRT Model & ways of working	• Between support workers and nurses • Not having a medical history we are unaware of possible problems we may be treating • Nursing need in social care setting - non understanding of the importance of our advice and role • Personality clashes [IRT] • No trust –not understanding nursing role – unwilling to change • Reluctance to change – custom and practice of social care sector • We still have to let other services carry out duties which causes overlap • Feel isolated when only nurse on duty, re: decision-making • Too early to define IRT and if it makes a difference
Progressing NVQ training	• Not all staff are involved – quicker training completed the better care will become. • Re-educating long established members of home into new methods and NVQ training
Resources	• Not enough NToW to provide cover and complete tasks

S2. Key Themes for Weaknesses in IRT - Care Home Staff (N=30)

Key Themes	Issues
Traditional and IRT Models & Ways of Working	**IRT Model** • Poor communication • Lack of communication – who does what • Communication not good • Home not the best place for all sick residents • Lack of IRT consistency/ never know when they are coming • Lack of respect for care staff from IRT • IRT prioritises residents –pick and choose to care for- criteria is not who needs it but who will fit in and not be challenging or rude • IRT forget they are in a care home not a clinical setting. • Confusion over who gets called and when-GP? IRT?-one person says one thing and another suggests something else • Lack of communication-lack of respect give the impression they are stupid • Hit and miss- not always obvious when team should be involved • Nurses v care staff- IRT forget care staff not nurses – they're in residential social care situation not a clinical one – friction • Clients need lots of nursing care and more input from Social Worker –not enough staff now clients need changing- we have too use agency staff • No trust • Personality clashes **Traditional Model** • *Institutionalised* • *No medical history* • *GP not good-doesn't listen to care workers –no care puts everything down to old age- sent home too soon* • *District nurses over stretched* • *Social work service in adequate* • *Drs clinic on Friday-feel can't always call before this – GP comes across as too busy* • *GPs –not enough time for older people –not quick enough on medication reviews –difficult to fit in hospital appts. into home routine—due to these care side taken away - little extras now-can't do it.* • *Discharged from hospital too early*
Resources	• Paperwork- too busy too do it/takes time away from resident, gets lost and forgotten • Ways of working – time - workload • Increased case load on care staff • New role staff leaving • Short of staff – too many residents • Staffing levels and time problems • Not enough staff to be pleasurable work • Cleanliness of home • Not enough senior care workers -residents suffer • Not enough homes – residents placed wrongly
Progressing NVQ	• Not all staff included in training • Need IRT training • Need learning/training • Difficult to re- educate long serving staff • Care home staff limited in the tasks they can do • Staff unwilling to change • Residents become institutionalised in the care homes
Pace of change	• Problem with home closures and redeployment

S2. Key Opportunities for IRT - Care Managers (N=5)

Key Themes	Issues
IRT Model & Ways of Working	• Share each others' knowledge • Trust –improves working relationships without fear of recriminations • Away day- to improve morale team-building • To become more open – promote joint-working and decision-making • Inclusion gives staff opportunity to ask questions
Resources	• Project should expand to be cost effective
Progressing NVQ training	• Care staff to gain new skills in working with people

S2. Key Themes for Opportunities for IRT - IRT (N= 12)

Key Themes	Issues
IRT Model & Ways of Working	• Raising Awareness of IRT • Towards a centre of excellence • Current IRT experience will give opportunity in new setting • Learn from other models • Resident/relative feedback • [GP] to achieve insight into what can be achieved through IRT • Falls prevention • Extend to all residents without overlap of services • To practice more effectively • Cut down hospitalisation in times of acute need • Health promotion/illness prevention • Form working relationships with carers • Manager to work clinical shifts to gain insight into issues arising
Progressing NVQ training	• Support workers becoming part of the same team • Recruit more NToWs and continue training • Improves patient care and care staff knowledge • Achieve skilled support workers
Resources	• Needs time to work- re-evaluate when new home set-up

S2. Key Themes for Opportunities for IRT - Care Home Staff (N=28)

Key Themes	Examples of Sub Themes
Models of Care & Ways of Working	**IRT Model** • Improve communication –listen to care staff about residents- communication and respect- need teamwork as carers provide holistic care nurses very task oriented • If IRT staff work shift with care staff- would have a better understanding of what care staff do • Understanding by IRT of what support workers do- were supposed to have IRT doing support worker role for a day - nothing happened • Clearer boundaries of what IRT is for. Who is who and who does what. • Each home needs to be considered as an individual unit -need more involvement of care staff – intimidating –undervaluing. • Better team work between care staff and IRT – work separately rather than in twos • More communication formal/informal- feedback -include non IRT staff-meetings for staff to say what they think –anonymous comments box • IRT nurse to do shifts with care worker- understand daily work –one IRT nurse has done this • Base nurse/IRT base in each home • Continuation of traditional plus IRT-teamwork- more information – who is who **Traditional Model** • *Need quicker referrals in residential care, e.g. falls clinic, incontinence pads*
Resources	**IRT Model** • Project and homes need more money • Pay care staff more-motivation/retention • Better facilities –more staff –no time for quality care anymore **Traditional Model** • *Reduce staff cleaning workload* • *Reduce paperwork to give staff more time to care* • *More resources* • *Smaller groups of residents* • *Staff levels and new buildings* • *More staff/equipment –especially in evenings* • *More staff to think about residents lives* • *More staff, less paperwork-time taken away from clients* • *More staff-less agency and other languages* • *Kitchenettes- time for more activities-staffing levels and residents poorly*
Progressing NVQ	**IRT Model** • New role worker training/ learning the way forward • More training – no bedside teaching space equipment • More training up skilling e.g. dementia care • Care and model will evolve over more time • Bring IRT into all homes-staff training and prevention of hospital admission **Traditional Model** • *Teaching* • *Learning* • *If staff could do things for residents with diabetes –help treat resident* • *Training – make IRT available here rather than staff going elsewhere*

S2. Key Themes for Threats to IRT - Care Managers (N=5)

Key Themes	Issues
Resources	• Project could be stopped • IRT members may look for alternative employment if funding not in place • Limited funding – not enough to train staff • Staffing levels on IR training- can 24/7 cover be remain continuous with NToW?
Progressing NVQ training	• Will staff continue to use knowledge if nurses withdraw? • Not enough residents ill • Policies might say staff unable to carry out nursing procedures
IRT Model & Ways of Working	• Understanding Social Services needs and the ability to run it along side nursing needs

S2. Key Themes for Threats to IRT - IRT (N= 12)

Key Themes	Issues
IRT Model & Ways of Working	• Poor communication results in low numbers of referrals • Not enough information between handovers • Barriers between management and IRT • Care staff still do not act as a team • Some support workers do not like change, other feel that we give them more work. • Staff not willing to accept/use us • Care staff leaving and negativity • Lack of understanding of future changes
Resources & Sustainability	• Only for this 2 years • Without IRT being picked up in someone's budget IRT cannot continue • Cut backs PCT • May not be money to enable continuation of project • Not enough time to evaluate patients • They prefer residential to nursing care – less workload • Understaffing means unable to perform tasks
Progression of NVQ training	• Not able to train carers in limited time – not enough staff to free up NToWs – not enough assessors. • NVQ Assessor Dept. setting criteria.
Pace of change	• New project, pay changes, moving homes and insecurity about jobs

S2. Key Themes for Threats to IRT - Care Home Staff (N=30)

Key Themes	Issues
Models & Ways of Working	**IRT Model** • Poor working relationships with IRT • Lack of commitment • Issues around uniform and elitism • Lack of communication- staff attitudes 'used to do this before' but actually they didn't • Staff dislike change with IRT • IRT make themselves redundant by not being there when needed – problem in IRT team itself. • IRT not great help to Support Worker • Poor relationships with IRT-relationships between IRT and community • Staff reluctant to use it • Poor referral from staff • Traditional and IRT are opposing models **Traditional Model** • *Staff reluctance to change* • *Staff feel vulnerable* • *Lack of commitment from all/any staff* • *Lack of staff team work/co-operation* • *Staff who have worked in care for a long time don't like change – may sabotage any changes- knock one effect to other staff*
Resources & Sustainability	**IRT Model** • Staffing- not enough. Money • If funding removed project stops • If staff pull out-may happen due to pay-no recognition of extra skills/training • Lack of people doing it • Don't have equipment needed • If IRT staff pull out **Traditional Model** • *Too much change at the moment – closure* • *Changes taking place* • *Changing team structure* • *Privatisation- may change. Funding* • *Short staffed at weekends-not enough time to care* • *Money* • *Council funding* • *Home closures*
Progressing NVQ	**IRT Model** • Chaotic unorganised – training and assessing issues –no mentor for care staff • Extra NVQ units to do IRT training – more work puts people off • Not enough assessors affects training **Traditional Model** • *Inadequate training* • *Lack of training*

APPENDIX 4.

Stage 3 - Key SWOT Themes and Issues Arising from IRT

S3. Key Themes for Strengths in IRT – In-Reach Team (N = 11)

Key Themes	Issues
IRT Model of Care and Ways of Working	• Dedication of team • Flexibility • Developmental • Improved care – SW beginning to accept that they are learning from the project. • Residents feel happier that they can approach the team with issues (esp. if they feel that they are not being taken seriously by support carer). • GPs tend to take our concerns seriously (compared with SW who sometimes feel that GPs do not listen to their concerns) • Early assessments of residents' condition – condition easily identified and treated. • Good communication – to all work together for the same goals • Good understanding of each others lives allows for a coherent team that can create a strong bond. • Patient holistic assessment – looks at pt in their social, physical, psychological and spiritual perspective rather that isolated 'problems'. • Home support – enables home staff to feel supported and more confident. • Prevention of hospital admission • Facilitation of early discharge • Flexibility of team • Gap is closing between health and social care – better partnership working – this is needed for project to succeed. • The IRT are very supportive of each other – gives good team spirit and support for decisions made. • Have prevented hospital admissions – by early detection of potential illness such as chest infection/UTI. • (prevention of?) Hospital admission – important for resident to stay in the home • (earlier ?) discharge • Continuity of care • Enabling patients to stay in their own home • Keeps people in the residential homes – main aim is promoting their freedom of choice and quality. • Brought PCT and social services closer together – we are bridging the gap. • Care staff understanding of their role in the project
Diversity of Skills and Experience	• Broad clinical knowledge • Wide experience • Differing skills within the IRT – allows different discussions and outlooks and also offers more diverse care. • Wide range of different sources of knowledge – as community work is variable, good to have knowledge of different specialities.
Progressing NVQ	• NVQ training to improve standards and understanding of care • NVQ training for carers of the future and to create better standards of care • NToW training improves patient care and raises SW self-esteem • A number of NVQ assessors – fundamental to project is NToW NVQ level 3 • Supporting NToW with NVQ – without in-reach they would not be able to do as many clinical units. • More staff have achieved NVQ's as NToW – more staff able to understand reasons for care requested/given.
Supportive Management	• My manager – she can be optimistic and encourages change for the future • Strong leadership of project – to co-ordinate and manage process.

S3. Key Themes for Strengths in IRT – Care Home Staff (N = 22)

Key Themes	Issues
Models of Care and Ways of Working	**<u>IRT Model</u>** • Having IRT here is helpful • Nurse on end of phone • Good to have a back-up as a senior • Keeps residents out of hospital, especially in palliative care. • Increased standard of care • Team work – best interests of client • Can ask IRT for reassurance/advice, personally and for the residents. • Getting prescriptions more quickly for residents • Getting more personal medical care • Get more reassurance for residents • Have access to nurse instead of ringing GP – so don't need to call GP unnecessarily • If want/need IRT (team) they come down • Higher level of care – 3 residents able to die here (at home)/palliative care – best possible end (for resident) • GPs listening more (about residents) IRT liaise with them using medical language • Enabling residents to stay in the home • IRT available just a phone call away so can come quickly • Nurse on every shift if need them (in theory this is a strength but NOT in practice (see weaknesses). • Keeps residents at the home • Earlier identification of illness • Saves time – i.e. if need to call GP/ambulance we have information there for them (BP etc) • Care staff understanding of their role in the project • Improved communication • Easier availability of equipment **<u>Traditional Model</u>** • *Staff doing their best for residents (not linked with IRT)* • *High level of care carried out by Support workers (by SW – not linked to IRT)* • *Support workers work well as a team.* • *Staff able to maintain independence for residents* • *More relaxed in the evening can do activities with residents/staff* • *All staff work together/community here e.g. hold Christmas event – leads to socialisation for residents* • *Call in District nurses when needed – they know what they're doing* • *Don't have the responsibility of doing medical care – Support workers feel safe when DN is in.* • *Regular monthly care planning – increases communication* • *Staff know what they're doing here, they know their role limitations.* • *Good community support (GPs, DNs)* • *Really good rapport with most DNs* • *Excellent staff (good feedback from agency staff who enjoy working here as well as from residents and relatives* • *'It just worked' – we're here to give basic care, washing etc.* • *Care staff understanding of their role in the project Re: traditional model – good that residents can keep their GPs when they come into home*
Progressing NVQ	• Learning more about how to deal with ill residents • More awareness from support workers of how to care for elderly residents/awareness of residents' health. • Understand importance of diet mobility, hygiene, good skin care • Can do urine testing, BP etc • Learning for staff and qualifications gained • Training of support workers – learning from IRT • We know what we're doing now (i.e. increased understanding that IRT training has brought) • Increased training and knowledge for staff

S3. Key Themes for Strengths in IRT – Care Home Managers (N =4)

Key Themes	Issues
IRT Model of Care and Ways of working	• Support staff – able to advise and support care staff • Can gain information from GP and discuss issues relating to ? person. IRT can get additional information from GPA regarding resident and discuss issues.
Progressing NVQ	• NVQ nurse assessors – have built good working relationships with NToW and other staff
Long term vision	• When relocate homes – then can be part of IRT

S3. Key Themes for Weaknesses in IRT – In-Reach Team (N = 11)

Key Themes	Issues
IRT Model and Ways of Working	• Only being able to work in three homes, if it covered more homes there would be more patients. • Boundaries – confusion over who's doing what job i.e. IRT or district nurse • Some members of the team don't seem to understand what project is about – trying to turn residential homes into nursing homes! Or not doing full investigations to identify needs • Too 'nursey' in attitude – supposed to be working in partnership with social services staff not dictation to them. • Some IRT staff are not happy in their role – some have said they prefer the hospital set-up • Insecurity of the team • IR Nurses with diverse experience – this should not be a weakness but sometimes individuals think that their method of care is the only one and alter what another team member has put in place. • Still an overlap of other services – support carers get confused about whether to contact IR, DN or practice nurse. • Reducing enthusiasm • Reminding social care staff of change – we represent new ways of thinking
Communication and Relationship Building	• *Communication - All staff (IRT) need to sing from the same hymn sheet* • *Too high expectations of support workers by some members of IR team – inappropriate communications causing unnecessary friction.* • *Some team members have negative attitudes – we need to spread unity and positivity* • *Some people are not making as much effort as others at building good, professional relationships with Social services staff* • *Lack of meetings between carers and IRT – only managers have meetings so some information may not be passed on.* • *Communication can occasionally be poor – as nurses we're used to sorting situations out but may occasionally forget to involve care staff and keep them fully informed.* • *Attitudes of some (care home) managers – inconsistency of attitudes towards in-reach nursing staff.* • *Inability to change attitudes*
Progressing NVQ Training	• Takes away clinical hours/staff care • Not enough time dedicated to practice development on both nursing and care side – support workers not learning as much as they should which may force stronger relationships. • Some people don't see the point of training NToWs as they will take their knowledge elsewhere. • Not having a dedicated NVQ assessor as planned – nurses are trying to fulfil too many roles – this affect patient care.
Resources	• Lack of resources – not always able to carry out tasks due to lack of equipment • Funding – uncertainty of funding for project, security of job for in-reach team. • Lack of staff, better if two per shift – staff not replaced because of temp. contract. Having two staff creates more opportunities for staff training and more care for the resident. • Lack of IRT carers on shifts – some shifts have not been covered therefore quality of care can be affected. • Unable to cover NToW during the night duty (sometimes) due to sickness. • Insecurity of job future • Some carers not prepared to support IRT due to present pay climate pay rates do not reflect new skills and work put into (gaining) it.

S3. Key Themes for Weaknesses in IRT – Care Home Staff (N = 22)

Key Themes	Issues
Models of Care and Ways of Working	**<u>IRT Model</u>** • Confusion about who gets called and when (GP? or IRT?) • Confusing/conflicting inputs – one person says one thing and another something else. • No 'togetherness' – still work as separate units • High level of care from SW and trying their best, so very upsetting when IRT comment on this in a negative way • IRT itself – team and their attitudes towards residential care staff • Inconsistencies – IRT staff (doing/saying) – same as 6 months ago • What's left for support carer to do (if IRT do everything) • Feel dictated to – for some skills IRT need to work alongside (SW). Some nurses do this but not consistent (? Problem of inclusion as well as one of inconsistency) • IRT not hands on – • IRT not contactable nurses – don't answer phone/mobile • Too invasive – IRT approach traumatised one resident (using 'hospital approach' see below) • Forget holistic approach to older resident (SW not doing a BP 3 times a day for 97 year old resident when resident is scared of it – I presume that SW are not wanting to do the BP as this traumatises the resident ? down to lack of understanding of importance or….are they correct!) • IRT not documenting when they take resident into IRT care or when discharge from their care • Not enough NToW in home: so not one on every shift – especially difficult at night. • IRT have no knowledge/experience of dementia • IRT still have 'hospital approach'.
Communication/relationships	• *Communication between IRT and SW still a problem, not changed in 6 months* • *Communication barrier – IRT staff forget that it's a care home – come out with 'fantastic' ideas – we know they won't work 'cos we know our residents* • *Bickering – IRT and care staff* • *No feedback from meetings*
	<u>Traditional Model</u> • *Sometimes residents can be a little institutionalised* • *Residents have very different needs if one resident has EMI needs affects staff and other residents.* • *Resident frictions at times* • *Can't always get hold of DN immediately* • *Waiting for appropriate people e.g. nurses, GPs* • *No feedback from DN re dressings on residents – don't know how things are progressing.* • *Can only do so much e.g. if someone falls, DN called out. Can't deal with from within (home)* • *Problem getting prescriptions at weekends* • *GPs wonder why staff can't do things here like those done by NToW* • *Sometimes DN comes and goes and Home staff not aware of her visit.*
Resources	• Workload too heavy. • Keeping residents here – increased needs and increased demands on staff • Non-IRT residents suffer because of IRT resident's increased needs • No time for social care • No time to practice new skills become de-skilled/rusty • Takes more staff than normal per client • Increased workload for support workers (IRT come and do their tasks bur SW have to all the 'care') • Constant paperwork has increased in last 6 months (e.g. triage everyone!) • More hands on from IRT staff • Non- IRT home – Building itself, can't use aides here because of small rooms • Paperwork – lots of it – very time consuming, (problem) getting everyone to remember to do it)

S3. Key Themes for Weaknesses in IRT – Care Home Managers (N = 4)

Key Themes	Issues
IRT Model and Ways of Working	• As a control home – lost out on benefits of having IRT (staff and residents) • Staff in IRT from this home learning skills but can't put into practice at present • Poor communication – not informing home staff of what they are doing • Ever changing paperwork – becomes very confusing when managers keep changing the way things are done and recording information. • Having to inform IRT staff before home staff can call GP – can delay treatment • Not understanding about people with dementia care needs – IRT can have expectations that people understand when they don't • Contacting by phone – it is sometimes difficult to get in contact due to area

S3. Key Themes for Opportunities in IRT – In-Reach Team (N = 11)

Key Themes	Issues
IRT Model and Ways of Working	• Identify new, realistic goals • The team working as a united front – any differences of opinion needs to be discussed in our office. • Clear boundaries on what areas of care are in-reach. Support workers remain confused as to what areas of care are for in-reach. • Relationship building with social services staff – important to value and respect their experience. • Innovation for the future – we're 'leading the way' nationally in joint social service and health sector working. • Dynamic role for IRT members – it can be what we make it – preferably, positive and trail blazing. • Improves patient care – the most important thing is to put patient at the centre of everything we do. • Better communication • To be the only nurses working in the homes – we would know our boundaries and there would be no 'cross-wires' or whose job it is. • Take over all district nurse input into homes – avoid confusion and better bonding with GPs. • Another 'away day' to establish the benefits and downfalls of the IRT project – to allow all staff to have a say. To value everyone
Resources	• Finance the team – not sure yet whether contracts will be extended. • Ascertain future job security • To decide swiftly whether IRT to continue or not – staff feel insecure • Carers to be paid for their new skills. This would encourage carers to participate more and more would join as it (money?) is an incentive. • Funding – let us carry on and give more time to develop the project. • New home – moving staff, residents, resources to new build homes so we all work together,
Progressing NVQ Training	• Staff training – improves standards of care, improves self-esteem, promotes respect and value. • More dedicated time to NVQ assessing and practice development on both nursing and care side – teaching and learning takes time!

S3. Key Themes for Opportunities for IRT – Care Home Managers (N = 4)

Key Themes	Issues
IRT Model and Ways of working	• IRT staff to spend more time in the home – This would build relationships and confidence
Resources	• Need more resources.
Progressing NVQ Training	• To encourage care staff to develop practice – This will empower staff to make decisions
'Outliers'	• To make sure that residents get equal opportunities regarding health needs – so that people get the best care. • Being involved in new home – opportunity to look at different models and see how they work

S3. Key Themes for Opportunities in IRT – Care Home Staff (N = 22)

Key Themes	Issues
Models of Care and Ways of Working	**IRT Model** • IRT to be more hands on – physically helping with clients (rather than just doing their tasks) • Have named IRT nurse in each home - more team work and more personal. • Spend a day a week at one home spending quality time with staff and residents. • IRT work alongside SW to se how they work and understand their workload. • More understanding from IRT about support carer jobs – not changed at all in last 6 months. • Staff to be involved in meetings as opposed to (just?) IRT and manager. • Nurses working alongside care staff. • IRT to be involved in care home handovers. • Specific nurse to work alongside support worker. • Designated nurse for home/ per shift (hence on site 24 hours). • IRT have to be more available/flexible and keep up their care. • Still too much inconsistency in IRT team. • More personal care. • More communication 1:1 officers and care staff - 'handover'. • More meetings between NToW and IRT (none at present). • More team building days (NToW and IRT). • NToW need more input as regards running of project. • Improved communication/trust (from IRT towards support carer) – some of the nurses need to come down from their 'Ivory towers'. Our manager trusts us to get on with job, why can't they? • NToW need to get more involved (IRT not involving them enough). Staff left because they feel that it is wasteful doing all the extra training just to do a 'cleaning job'.. • No 1:1 meetings between support carer and IRT nurses – need investment in staff already working in homes and doing a great job. • IRT saying they've done all these things but people haven't stopped being admitted to hospital. Figures not true. • Need to iron out issues. **Traditional Model** • *More back up from GPs.* • *Better working relationships and more understanding from GPs (user 6 different surgeries – also, DN linked to these different surgeries (? Different DNs).* • *Feedback book for DNs to fill in so know who they're visiting and what's happening.*
Resources	• If (IRT) based at home could have more time • Changing to new home – If it (IRT) will work in new homes then it'll work, otherwise, it will never work. • Facilities – space and equipment • More staff – time to do nice things as well as basic care needs • More equipment • More money • More staff • Bigger rooms, more equipment – less risk of staff hurting themselves if have space and equipment (non-IRT home) • More staff – sometimes residents dying alone because of lack of staff
Progressing NVQ /Training	• More training, e.g. dressings • More in house training from IRT • Ongoing learning curve updates • More in house training • Better able to get on courses – keeping up training

S3. Key Themes for Threats to IRT – In-Reach Team Follow-up 1 (N =11)

Key Themes	Issues
IRT Model and Ways of Working	• Poor staffing in homes – carers feel increased workload due to increased needs of clients. • Funding – staff unsure of job security • No funding for the future – In-reach team would not be able to continue. • Funding hangs in the balance – performance and morale affected, team could be split up. • Lack of financial backing/PCT lack of money – The project will end and the team disbanded so all our good work will be lost. • Temp. contracts – insecurity financially and psychologically. • Staff leaving from post • Single status – no pay supplement for NToW – SW feeling that they are having to do a lot of extra care and training with no incentive. • Temp contracts – staff feel insecure • No funding • Staff loss • No funding – we can't carry on • Poor management support – some carers feel that the managers do not support them enough in their new roles. • Staff boredom – some staff are becoming very bored, as at times there is very little to do.
Attitudes towards IRT project	• Management attitudes – ill effect/attitudes distance staff etc. • Lack of interest from some GPs – lacking insight into prevention and better quality of care. • Other services (DNs etc) – they may feel that we are taking work away from them. • Managers in new home preventing progress • Ongoing lack of co-operation – we rely on the care staff: they are the other half of IRT.
Progressing NVQ/ Training	• NVQ – staff caseloads. Some staff more clinical than others. • NToW not undertaking skills. If the NToW do not undertake the skills they have learnt they are going to become unconfident.

S3. Key Themes for Threats to IRT – Care Home Managers (N = 4)

Key Themes	Issues
Resources	• Financial aspect • Numbers of staff prepared to take part – need incentives for them e.g. increased pay • Inflexible – because it is a funded project • Not cost effective – because of the number of residents referred to them from the home • Lack of funding – If B&NES LA and PCT don't feel that project is cost effective. • Change in organisation – closure of homes
IRT Model and Ways of Working	• Not enough referrals – The IRT have not prevented any admissions to hospital or been able to facilitate early discharge

S3. Key Themes for Threats to IRT – Care Home Staff (N = 22)

Key Themes	Issues
Models of Care and Ways of Working	**IRT Model** • NToW pulling out as have enough of it – increased workload, no incentives, no chance to use 'IRT activities' • Lack of people doing it • No great need for the IRT • Constant inconsistencies and bickering • Paperwork – everything takes much longer. Resident may have a problem but may not be flagged up due to amount of paperwork to do re IRT (care staff may choose to wait and talk to DN linked with the resident to save on paperwork. If problem is a priority they will of course contact IRT) • Good idea they just need to sort out problems, need to establish what is wanted from IRT project. • Have not had the resident numbers to justify existence of IRT. • Staff frightened of new things – people don't like change (from SW in non-IRT home) • People not wanting to take on new roles • Younger people not coming into the profession – they often have distorted view of what job involved – think it's all about sitting down and talking to 'nice old ladies'. When they see what it's really like – they leave. Down to money and incentives. Many go on to do nurse training. • Keeping people interested. **Traditional Model** • *Lack of staff especially weekends. Less staff in evening that in the morning.* • *Staff feel role not so valued (SW in non-IRT home)* • *Not got facilities or staff to cope with increasing dependency of residents*
Resources	• Lack of funds • Money • Funding • Increased need for IRT but not enough staff • Support carer very overloaded with work anyway let alone IRT needs. In this house have to do all 'housekeeping' tasks • Funding – team of nurses on nurses salaries and sometimes no clients! • Money • Lack of resources – how long will it go on for? • Money • Finances • Not value for money • All about money – may not have enough money to carry on. • Don't know when funding will come to an end • Building – but this will change when more (new?) homes. • Money/funding
Employment issues/'Outliers'	• (from non-IRT home) Problems arise with some families of residents – bad behaviour/rude and managers aware but not doing anything. • People having to apply for jobs – pressure/upheaval for staff. • Staff worries and residents uncertainty, uncertainty for the future. • No assistant manager post to go to so have done lots of work but for what? – no role to go to. • Redeployment of staff into new buildings and wages – worried about how this will be handled. Very stressful. These worries are affecting staff enthusiasm for IRT.

APPENDIX 5.

Measures for Care Home Managers, Care Staff and IRT Members

Section 1 – Work Satisfaction

Using one of the numbers 1- 7 with 1 = extreme dissatisfaction and 7 = extreme satisfaction, please indicate you level of work satisfaction against each of the following items A-J

Number

A) Satisfaction with physical working conditions.

B) Satisfaction with freedom to choose own method of working.

C) Satisfaction with recognition you get for good work.

D) Satisfaction with your colleagues and fellow workers

E) Satisfaction with the amount of responsibility you are given.

F) Satisfaction with your pay.

G) Satisfaction with your opportunity to use abilities.

H) Satisfaction with your hours of work.

I) Satisfaction with the amount of variety in your job.

J) Overall satisfaction with your job.

Do you think that the introduction of the IRT has *positively* influenced your job satisfaction in any of the items A-J above? If 'yes' to any item can you write the item letter and the extent of your positive feeling about it below under the following headings:

Item letter	A lot of benefit	A fair amount of benefit	A small amount of benefit

Do you think that the introduction of the IRT has *negatively* influenced your job satisfaction in any of the items A-J above? If 'yes' to any item can you write the item letter and indicate the strength of your negative feeling below under the following headings.

Item letter	A lot of benefit	A fair amount of benefit	A small amount of benefit

Section 2 – Sources of Job Pressure

Using one of the following numbers, please indicate against each of the following items A-Z, your level of job pressure.

1 = no pressure
2 = slight pressure
3 = moderate pressure
4 = considerable pressure
5 = high pressure

Number

A. Increased demands from residents.

B. Inappropriate demands from residents.

C. Dealing with problem residents.

D. Dealing with very ill residents and their relatives.

E. Dealing with earlier discharges from hospital.

F. Worry about complaints/litigation.

G. 24 hour responsibility for residents.

H. Working environment and home set-up.

I. Insufficient time to do justice to the job.

J. Fear of assault at work.

K. Disturbance of home/family life by work.

L. Dividing time between work and spouse/family.

M. Unsociable hours.

N. Unrealistic high expectations of role by others.

O. Insufficient resources within the home.

P. Dealing with conflict within the home.

Q. Long working hours.

R. Paperwork.

S. Organisational changes in the homes

T. Adverse publicity by media.

U. Lack of support within home.

V. Emphasis on resource issues in the home.

W. The pace of change within LA homes.

X. Professional isolation.

Y. Increased workloads.

Z. Lack of appreciation from residents.

Do you think that the introduction of IRT has educed your work pressure in any of the items A-Z Above? If 'yes' to any item can you write the item letter and indicate the extent of your pressure reduction below under the following headings:

Item letter	A lot of pressure reduction	A fair amount of pressure reduction	A small amount of pressure reduction

Do you think that the introduction of the IRT has increased your work pressure in any of the items A-Z above? If 'yes' to any item can you write the item letter and indicate the strength of your negative feeling about it below under the following headings.

Item letter	A lot of stress increase	A fair amount of pressure increase	A small amount of pressure increase

Section 3 – Possible changes to your work life

Using one of the following numbers,

1 = not likely
2 = slightly unlikely
3 = moderate- neither likely nor unlikely
4 = fairly likely
5 = very likrly

Please indicate against each of the following items A-D, how likely do think that you will:

Number

A. Leave your current job for similar one within two years

B. Reduce current job hours within two years

C. Leave current job for a similar one within five years

D. Reduce current job hours within five years

D. Have a complete job change from care/ health work within two years

E Have a complete job change from care/ health work within five years

F Retire within two years

G Retire within five years

What effect has the IRT had upon your intention to make work change decision- making?

1. **No effect** ☐
2. **Little effect**
3. **Unsure**
4. **Fair amount of effect**
5. **Great amount of effect**

N.B
The above measures have been adapted from:

Simoens S, Scott A, Sibbald B *et al* (2001). *Job Satisfaction, work-related stress and intentions to quit of Scottish GPs.* Health Economics Research Unit, University of Aberdeen, Foresterhill, Aberdeen AB25 2ZD, *and*, National Primary Care Research and Development Centre, Williamson Building, University of Manchester, Oxford Rd, Manchester.