Developing Advanced Clinical Practitioners as part of the care home workforce: A ‘grow your own’ approach.

Final Report

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Please note that from July 2022, responsibility for commissioning healthcare services for North Tyneside transferred to the NHS North East and North Cumbria Integrated Care Board (ICB). In this report, we will refer to North Tyneside Clinical Commissioning Group (CCG) which ceased to exist upon the formation of the new organisation of NHS North East and North Cumbria ICB on the 1st of July 2022.

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Abbreviations

ACP	**Advanced Clinical Practitioner**
CCG	Clinical Commissioning Group
CH	Care Home
CHM	Care Home Manager
CHS	Care Home Staff
CQC	Care Quality Commission
EHCH	Enhanced Health in Care Homes
EnCOP	Enhanced Care of Older Persons
GP	General Practitioner
HEE NEY	Health Education England North East and Yorkshire
MDT	Multi-Disciplinary Team
NEWS	National Early Warning Score
NHS	National Health Service
OSCE	Objective Structured Clinical Examination
PCN	Primary Care Network
SALT	Speech and Language Therapy
TACP	Trainee Advanced Clinical Practitioner

Executive Summary

Introduction

Care home workforce development is key to improving care. There is a need for advanced or further developed roles to facilitate working across health and social care sectors, to provide seamless, personalised care for residents. Advanced Clinical Practitioners (ACP) have been introduced in other settings but are relatively new in the care home sector, with few currently in post. How these roles develop in practice, the remits, and responsibilities they fulfil, and the ways of working that develop both within and across the social care and health sectors these roles straddle, are yet to be identified and examined. This study set out to gain a detailed understanding of these developmental processes in order to enable sharing of best practice and awareness raising regarding issues and difficulties that may arise.

Research aims and process

This research project aimed to explore and evaluate the development and implementation of new ACP roles in care homes in one clinical commissioning group area in the Northeast of England. The study used:

- a longitudinal, qualitative approach to track development of the new role
- Thirty-six people (TACPs, care home managers, nurses and carers, GPs, university educators and CCG staff) participated in forty-five single interviews and one group interview (three participants), at different points over an eighteen-month period
- data was analysed thematically to explore and unpick themes which included development of the ACPs, their roles, relationships, working patterns, socialisation, identity formation and experiences.

Findings

Understanding and acceptance of the new role by care home staff was hampered throughout most of the first year by a lack of effective communication about its purpose. Communication in care homes can be difficult because of the high staff turnover and pressurised working environment, especially following the difficulties of working through the Covid-19 pandemic.

Once stakeholder (care home managers, GPs, university educators and TACPs) meetings to define the role and its development took place, tensions started to dissipate. Similarly, the differential value of the role (cf. to existing roles in the care home) became more apparent to care home managers and GPs.

Most staff in care homes valued having any additional help in the care home and the fact that TACPs were already skilled and experienced nurses was welcomed, despite the lack of knowledge or ongoing scepticism about the new role by some staff. Three key factors started to change both TACPs and care home staff understanding of the ACP role. These factors were:

1. gaining access to 'Tools of the Trade' that enabled TACPs to perform tasks others could not and which added value and/or helped others with their work.
2. meetings between each group of stakeholders (care home manager, GP, TACP and university educators) to start defining the development of the role.

3. ‘Seeing the difference’ that TACPs made e.g. research-informed care quality improvements, encouraging care staff to change the way they worked and were of value to CHM.

Aspects of the new role that concerned some care home staff included sensitivities about exposing the care home to outsiders (e.g. comments about the role being ‘spy for the GP’ or a ‘spy for the CCG’). There were also concerns that the new role risked eroding nurses’ roles and skills, when recruiting care home nurses is already difficult and morale is low. TACPs taking over the GP/ward round and communications with the GP can contribute to this, although it is a useful learning experience for TACPs. Some TACPs struggled to establish their authority with care home staff and thought the timing of CH placement should be after access to the ‘Tools of the Trade’ is in place. This might have helped to establish the nature, scope, and authority of the role more quickly.

Care home manager buy-in and support for the role is key – without this TACPs will struggle to establish the role and fulfil the scope of all four pillars of the ACP role as set out by Health Education England (2017). The Leadership pillar is the most likely to be contested, especially by care home managers but also deputy managers and nurses, unless clarity and consensus around role boundaries and responsibilities is established.

TACPs perceived disadvantages, both professionally and financially to being employed by care provider organisations. This could have implications for retention of TACPs after qualification (or recruitment in future). There was some evidence that being employed from within the NHS would be preferable for recruitment, retention, developing professional identity, and logistics in terms of organising training from staff within GP practices. However, the value of being embedded in the care home was recognised and care home managers felt TACPs would be diverted into other work if they were based in GP practices. Although GP supervision time for TACPs was funded, other primary care staff time is not. Furthermore, the issue of finding GPs to backfill supervising GPs time away from practice duties could be a barrier to future participation.

Impact

Emerging impacts arising from introducing the ACP role into CHs were largely positive and effected through:

- better continuity, consistent, and/or co-ordination of care
- earlier assessment and treatment
- availability of more expert knowledge and skills
- providing training to other care home staff

However, the potential of the TACP role to contribute to role and skill erosion for other roles, especially nurses, requires careful future consideration.

Points for consideration

Factors affecting the introduction, development, and implementation of the new ACP role which may be relevant for other similar projects include:

1. External context - any endeavour to introduce the ACP role into CHs will take place in an ever-changing political context. Funding and structures may morph or change, and lead to lack of, or lost, clarity regarding who has the authority and who drives things forward (e.g. move of CCG to ICB).

2. Communication about the new role in the care home context - communication needs to be short, simple, direct, and repeated constantly to catch new staff and create a shared organisational understanding. Shared understanding of the process to define and develop the scope of practice for the new role needs to be developed early and maintained. The differential between the new and existing roles should be clearly communicated to staff with an emphasis on the distinctive 'medical/clinical' contribution of the role.

3. Barriers to fulfilling the four pillars of Advanced Clinical Practice

    - the ability of CH staff to support ACPs to work across all four pillars to their full scope can be constrained by workload pressures.
    - the Leadership pillar is the most likely to be contested, especially by care home managers but also deputy managers and nurses, unless clarity and consensus around role boundaries and responsibilities is established.
    - timely access to the 'Tools of the Trade' should help to establish the nature, scope, and authority of the role more quickly.

4. Identity of the employing organisation - there was some evidence that being employed from within the NHS would be preferable for recruitment, developing professional identity, retention, and logistics in terms of organising training from staff within GP practices.

5. Recruitment and retention

    - retaining qualified ACPs with enhanced skill and autonomous professional standing may be impeded if the existing tensions between CHMs and TACPs regarding balancing authority and responsibilities, with TACP professional autonomy, are not resolved.
    - Senior/regional managers identified that the ACP role needs to allow the full range of ACPs training, skills, and experience to be implemented or ACPs may seek role fulfilment elsewhere.

Introduction

Care home staffing and workforce development is long overdue for attention and was brought into sharp focus during the pandemic. There is a need for advanced or further developed roles and remits to facilitate working across health and social care professional groups and provide seamless, personalised care for residents (Thompson *et al.*, 2020; Pearce and Breen, 2018; Swan *et al.*, 2015). Advanced clinical practitioners (ACP) are one such role. In 2017 Health Education England (HEE) published a capability framework to encourage consistency in the development of ACP roles (Health Education England, 2017). To assist development of such roles to a consistent standard, university accredited ACP courses have emerged, such as the ACP Master's Apprenticeship run by Northumbria University.

Furthermore, previous related research by some of the current research team explored the implementation of the Enhanced Health in Care Homes (EHCH) framework, including the introduction of a Frailty Nurse role - which can be viewed as an advanced role (Wilson *et al*., 2020). This study found that there was a clear desire for workforce opportunities that would enable development of staff from within homes into new or expanded roles – rather than, or in addition to, external appointments.

Within this context and background, the North Tyneside Clinical Commissioning Group (NT CCG)1 developed plans to fund seven staff across four nursing home groups in North Tyneside to develop ACP roles and undertake Advanced Clinical Practitioner qualifications via the Northumbria University programme. https://www.northumbria.ac.uk/study-at-northumbria/courses/master-of-science-advanced-clinical-practice-dtpdln6/

This research explores and evaluates the development and implementation of these new ACP roles in care homes: in practice, the remits, and responsibilities they fulfil, and the ways of working that emerge. Understanding the development and implementation of the ACP roles in this way will inform future ACP developments, appointments to such positions, inter- and cross-sector working and education programmes.

NT CCG project planning, recruitment and launch of the TACPs in care homes.

Planning

The NT CCG project aimed to educate nurses placed in care homes to an advanced clinical practitioner level:

- to improve the quality of care and pro-active care that residents receive
- bridge the health and social care systems; and
- provide a visible career progression pathway to staff who work in care homes.

However, NT CCG also wanted to build ownership of the project by the care provider organisations from the beginning (rather than it imposing it from outside) and provide a model to promote career

[1] The responsibilities and functions of North Tyneside CCG were taken over by North East and North Cumbria Integrated Care Board (North East and North Cumbria ICB) on 1 July 2022. This report uses the abbreviation NT CCG to refer to the original commissioning source for the project but recognises that this responsibility has been taken on by North East and North Cumbria ICB)

progression and staff development by using the HEE ACP apprenticeship model (Craig, 2021). These were therefore important factors in shaping project design.

The project was discussed and agreed at senior levels in both NT CCG and care provider organisations, after which NT CCG staff worked with managers at the next level down e.g. regional managers, to provide project information about what a trainee ACP was, and what the job description contained. The project was structured so that NT CCG would contract with each care provider separately, to supply funding for the care provider to employ a trainee ACP (TACP). The care provider organisation also drew down funding from the apprenticeship levy they contribute to, to fund apprenticeship related training. Essentially, NT CCG were commissioning care providers to deliver workplace-based training and experience to support the training of ACPs, with NT CCG managing the organisational and contractual aspects of the education and training provision.

Recruitment and employment

NT CCG had hoped to recruit TACPs from existing nurses in care homes. However, it transpired there were not enough eligible qualified and experienced nurses working in care homes[2]. Therefore, all the initial appointees were recruited from NHS organisations (one care home nurse was subsequently identified by a care home GP as a potential candidate and was successfully recruited, replacing an appointee who withdrew). NT CCG staff report that there was a lot of 'internal interest' in response to the job advertisement but once potential candidates understood what was involved, and that they would be employed by the care provider organisations, many 'backed off'.

Ultimately five TACPs started in five care homes, rather than the intended seven. Each trainee ACP was employed by a different care provider organisation. One of the five subsequently withdrew and was replaced by another recruit. However, a further TACP subsequently withdrew, leaving four in post at the time that research interviews commenced. During the period of the research study, a further trainee resigned within the first four months of being in post. Thus, at the end of the period covered by this study, three TACPs remained in post.

NT CCG prepared template employment contracts, based on NHS 'Agenda for Change' terms and conditions which were intended to allow TACPs equivalent NHS terms and conditions and differed from care providers normal contracts with respect to things like hours of work, pay enhancements, working on Bank Holidays. A key contractual aspect in both employment contracts and contracts with the care providers was that the TACPs would be supernumerary. Regional managers commented that 'Agenda for Change' terms and conditions were also important for retention once TACPs qualified.

[2] Registered nurses have only had to have a degree since 2013. Between 1990 to 2013, nurses gained Registered General Nurse status with the Royal College of Nursing through a diploma qualification gained at a university and which that lasted two - three years. Prior to 1990, nurse training had taken place through an apprenticeship system based in hospitals and nurses were known as State Registered Nurses. A history of nursing in Britain: the 1990s to 2005 | Nursing Times

Education and supervision

Simultaneously with the recruitment of TACPs, NT CCG were negotiating with GPs to organise GP supervision. The aim was for GPs from the practice aligned to the particular care home to supervise the TACP placed in that home. NT CCG promoted the scheme by emphasising the medium-term benefits of having an ACP, who could relieve pressure from GPs and assist in providing smoother flowing integrated services, in return for a short-term training input. Running parallel with the recruitment process and negotiations with care providers and GPs, NT CCG staff organised honorary contracts with Northumbria Healthcare NHS Foundation Trust that enabled the TACPs to go on placements at health or care services/sites within the trust e.g hospitals, palliative and end of life care service.

NT CCG organised infrastructure and training to support TACPs training and education including:

- induction period
- education supervisor
- clinical supervisor
- honorary contract with Northumbria Healthcare NHS Foundation Trust
- NHS email account and address
- laptops of appropriate specification to allow access to NHS patient information management systems such as EMIS or SystemOne

The induction period (Oct-Dec 2021 – see Figure 1 for timeline of activities) enabled TACPs to familiarise themselves with the care home context where this was needed. TACPs worked in the care home for 3 days a week (Mon, Tues, Weds) and attended training sessions at the NT CCG offices and/or online on the other 2 days (Thurs, Fri). Training activities included mapping their skills and experience against the Enhanced Care of Older People (EnCOP) competency framework to determine their development needs. Invited external speakers included staff from Health Education England Northeast and Yorkshire[3] (HEE NEY - an NHS organisation who plan, recruit, educate and train the health workforce) and the Care Quality Commission (CQC - the health and social care regulator that inspect and rate care homes).

NT CCG established two series of meetings to facilitate joint stakeholder oversight of the development and implementation of the TACPs during their 3-year programme and after qualifying:

1. weekly operational meetings on Fridays with regional managers, care home managers, deputy care home managers from the care home provider organisations were all invited together with NT CCG staff to discuss day-to-day operational issues.
2. monthly educational and operational meetings with GPs, university educators, training representatives from HEE and EnCOP implementation team, regional managers, care home managers, deputy care home managers from the care home provider organisations all invited together with NT CCG staff to discuss higher level issues of relevance to this wider group.

[3] Health Education England merged with NHS England on 1 April 2023. NHS England » Health Education England and NHS England complete merger

Study Aims and Objectives

The research study aimed to explore and evaluate the development and implementation of new Advanced Clinical Practitioner roles in care homes in one clinical commissioning group area in the Northeast of England.

The research objectives were to:

1. Map and describe the development and evolution of the ACP role(s) (remit, responsibilities, and ways of working)
2. Gather and analyse the experiences of the TACPs (including role development, and educational experiences, ways of working)
3. Explore the implementation process and approach

Research Process

Methodology and Design

The research design drew loosely on the complimentary approaches of realist and illuminative evaluation. Realist evaluation aims to understand '*what works, for whom, under what circumstances and how'* (based on the work of Pawson and Tilley, 1997), while illuminative evaluation seeks to illuminate the benefits and disbenefits as perceived by participants, rather than judge against some external criteria (based on the work of Parlett and Hamilton 1972,and later Macfarlane 2004, Burden 2008). Thus, the emphasis is placed on description and interpretation rather than measurement and prediction. Using the underpinning tenets of these two complimentary approaches enabled the study to explore the rationale, development, operations, achievements, and difficulties of the TACP initiative. The study used a longitudinal, qualitative approach to track development of the new role, exploring how upskilled staff in new roles work in practice and are socialised as part of the system. Ethical approvals were granted from Northumbria University (ref: 34006) and HRA (IRAS project ID 305599).

Participants and recruitment

Three groups of people were eligible and invited to participate in the study:

1. TACPs working in nursing homes in the NT CCG area
2. Care home staff working in nursing homes where TACPs had been placed
3. Working relationship stakeholders - a range of health and social care staff in job roles who have an interest in, will be affected by or who can affect the development and embedding of the new role. Stakeholders were identified in conjunction with TACPs, care home managers and NT CCG staff and included:
    a. GPs
    b. University educators
    c. NT CCG staff

Residents and families of residents were not included in this project which focused on working relationships.

NT CCG forwarded research team emails containing information leaflets and posters about the project to each group of potential participants, asking them to contact the research team for more details. The research project was also presented by researchers in several online meetings to target participants . Participant personal data such as name, job role etc. were collected and stored in a password-protected file. Neither age nor gender was collected. A unique identifier was allocated to each participant to anonymise all data collected.

A total of 36 people participated in 45 single interviews and one group interview (3 participants), totalling 48 data collection events (Table 1).

Participant role associated with one of the four participating care homes	**Number of Participants**
TACP 1st interview	4
TACP 2nd interview	4
TACP 3rd interview	3
TACP 4th group interview	3
Senior/regional managers	2
Managers (inc. deputy managers)	6
Nurses	4
Carers (inc. nursing associates, senior carers, carers, health care assistants, activity-coordinators)	15
Supervising GPs	3
Total in care homes	**44**
Other interviewees not specific to one care home	
GP	1
Educator	2
CCG	1
	48

Table 1. Total number of data collection events by participant category.

Year	**2021**	**2022**												**23**	
Month	Oct-Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
TACPs	-	1 (4)	-	-	2 (4)	-	-	-	-	3 (3)	-	-	-	-	4 (3)
Care staff & GPs	-	-	1 (16)					-	-	-	-	2 (18)	-	-	-
Survey	-	-	-	-	-	-	1		-	-	-	-	-	2	

Table 2. Data collection time points (and number of participants interviewed at each time point).

Data collection

TACP interviews took place at four points over the first year of training (Table 2**Error! Reference source not found.**), timed to capture key developmental points. These time intervals were:

- First few weeks and months – TACPs had been in post for six-twelve weeks (January 2022)
- After starting university – TACPs in post for up to six months and attending university course for nearly three months (April 2022)
- After one year – TACPs in post for one year and had completed two terms of their first year at university (September/October 2022)
- After first placement – TACPs in post for nearly eighteen months and completed placements in relevant hospital settings (February 2023)

Interviews with 'working relationship stakeholders' took place at two points during the year.
These two points were:

- Five months after TACPs started in post to capture emerging and changing views of care home staff during the role development process and embedding of TACPs in the care home setting (some interviews took place up to nine months after TACPs had started due to operational availability) (February -June 2022)
- Twelve months after TACPs had started in post to explore changes in care home staff attitudes, views, and experiences as the TACPs progressed through their training and developed into their new roles (November 2022)

One member of the research team attended weekly and monthly meetings between NT CCG staff and care home staff, GPs, and educators. Researchers also met with NT CCG staff at least monthly (and sometimes more frequently) to discuss ongoing progress or issues arising in the implementation of the project. Notes from these meetings were maintained as a contemporary narrative providing a chronological context against which to situate research findings.

A survey was sent to key 'working relationship stakeholders,' identified by ACPs, care home managers, CCG staff who were also asked to forward it to relevant contacts. A 'snowball 'method of recruitment (Johnson 2014) took place therefore the exact number of surveys distributed is unknown. However, at least 20 emails were sent out to potential participants at each time point, June 2022 and January 2023. The survey's purpose was to explore and track changes in components of the four generative mechanisms undertaken by individuals and groups that operationalize implementation.

Training element	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Working	TACPs start working in care homes - 3 days a week in care home to familiarise with care home context			TACPs working 3.5 days a week in care home (4.5 days a week during university holidays)													
Training incl. CCG, HEE, EnCOP	2 days a week at CCG offices or online			0.5 days a week (self-study; HEE; invited speakers)													
University course	-	-	-	TACPs start uni course - 1 day a week during term-time													
Clinical training	-	-	-	Supervising GPs - 1 hour a week											TACPs on placement - 4.5 days per week (tbc)		
Research data collection points																	
TACPs	-	-	-	1	-	-	2	-	-	-	-	3	-	-	-	-	4
Care staff & GPs	-	-	-	-	1					-	-	-	-	2	-	-	-
Survey	-	-	-	-	-	-	-	-	1		-	-	-	-	-	2	

Figure 1. Timeline of TACP role development and data collection

Data analysis

All interviews were recorded, transcribed verbatim and stored in the NVivo Software. Analysis of interview and focus group data used a thematic analysis developed by Braun and Clarke (2006) to allow the researcher to code data, explore and examine patterns and develop sub-themes and themes. The aim of using this approach was to explore and unpick themes including: the development of the ACPs, their roles, relationships, working patterns, socialisation, identity formation and experiences. Analysis was iterative across the life of the project to develop coding and findings as they emerged and developed over time. All transcripts from the first round of interviews were read by MG and AS, then initially coded by MG. A sample of transcripts were also then 'blind' coded by AS and JW. A research team meeting was held to share, discuss, challenge, and agree the coding. MG then re-applied the agreed coding frame to the initial interview transcripts. As data was collected in each 'round' MG applied the initial coding frame whilst also being vigilant for new and emerging aspects. In the second half of the project MG and JW worked together to code new transcripts and develop categories and preliminary themes reflecting the research objects. Team workshops and discussions were held on a regular basis with AS to interrogate the data and coding, explore the relationships to previous rounds and track the journey and development of the TACPs. In the last 6 months of the project JW and MG undertook data mapping exercise to 'double check' coding, consolidate themes and conceptualise the main findings. A final research team meeting was held to discuss and agree the main findings and reporting structure.

Unfortunately, the survey data yielded a very low response rate (n=7 at time point 1, and n=3 at time point 2), and as these results did not alter the emerging research findings, the survey was not included in the project or the report.

Findings (Main Themes)

The findings of this study are presented in five sections:

1. Role development
2. Ways of working
3. Educational experiences
4. Implementation issues
5. Outcomes and impact

Understanding the development and implementation of the ACP roles is key to informing future ACP developments, appointments to such positions, inter and cross sector working and education programmes.

Role Development

This section describes key aspects of role development during the first year of TACPs in post. This chronological narrative synthesises perceptions and experiences of the different stakeholders (TACPs, care home managers (CHM), nurses, carers, activity co-ordinators and GPs) at different points. TACPs perceptions and experiences are reported at four time points, the perceptions and experiences of other stakeholders are reported at two time points, loosely corresponding to TACP points 1 and 3 (see Table 2Table 1. Total number of data collection events by participant category.).

First few weeks and months

During the first few months, there was a considerable and collective doubt about the development of a new TACP role. These doubts centred around four points.

1. First steps in enacting a new role
2. Tensions emerging from leadership and research pillars
3. Role confusion impeding relationship building
4. Deskilling CH staff?

First steps in enacting a new role

Despite new role preparation and information, many care home staff said they knew little or nothing about the new role or what TACPs should be doing. TACPs being supernumerary, had been told by NT CCG staff, HEE staff and some CHMs, that they should not be carrying out routine nursing and personal care tasks. However, nurses and carers still asked them to help with nursing and personal care tasks. TACPs walked a careful line between helping as a means to familiarise themselves with residents and trying to explain and reinforce that routine nursing and personal care was out with their role. The attitude and active support of the CHM was crucial in reinforcing this. For TACPs recruited from a care home, a conscious and reflective turn away from their previous role and activities was required.
As most TACPs had previously worked within the NHS, adjustment to a care home rather than a clinical environment, including differences in style and authority in working relationships was required. For example, hospital nurses would expect cleaning staff to follow requests for room deep cleaning without

question but found that these types of requests from a TACP could be challenged and refused as this quote illustrates.

> *"I have actually spoken with the domestic… the Head of the domestics about it. And I have told her that I want this [room] to be deep cleaned, and then she challenged me [..] 'I'm not going to deep clean this, because it has already been deep cleaned'"* *TACP*

TACPs were also adjusting to being novices/students/apprentices again whilst trying to understand and navigate towards their more advanced role, a role at a higher skill level than that of CHMs. New activities such as patient examination, clinical decision-making, and new levels of responsibility accompanied the role. It also involved thinking and behaving in other unfamiliar ways for some TACPs e.g enacting leadership. TACPs described the emotional demands on them as they were constantly trying to work out their role and new professional identity at the same time as negotiating the boundaries of the new role with others (e.g what GPs do vs. what TACPs do or what care home nurses do vs. what TACPs do) .

> *"But I think they very much have a protected role from the day-to-day running of the home. I guess, on the other side of things, you would not want them to take on too much of the medical role, and be making too many decisions that are out with their… their training."* *Supervising GP*

Tensions emerging from leadership and research pillars.

Senior/regional managers identified the leadership and research pillars of being particular interest, anticipating that ACPs would contribute to changing the way the social care sector offered care and lead a cultural change around older people's care**.** However, senior/ regional managers could see the need for ACPs leadership to align with the direction of organisational strategy. Likewise, senior/ regional managers valued the potential contribution that research-informed care quality improvements could make but were clear this was something they wanted the TACP role to take ownership of and drive forward. Senior/ regional managers perceived potential confusion about the role, skill levels and functions which would need to be carefully managed. Similarly, they foresaw tensions that might arise between care home staff, including:

- CHMs managing ACPs who will be more highly qualified and skilled than they are themselves; and
- differentiating the ACP role from other roles such as the deputy managers.

Critical to the role's success, senior/ regional managers identified that buy-in, and support of the CHM from the care provider management, was essential alongside TACPs developing effective relationships with CHMs and nurses in the care home. Otherwise the TACP may be perceived as a 'spy'. Issues of accountability and boundaries between the TACP role and other staff, especially deputy managers, were also of concern. For example, if trainees took over the ward round as a training opportunity, if things went wrong the accountability could still lie with the deputy manager. Similarly, they could foresee issues associated with TACPs being employed by the care provider organisation but having a close

training mentor type relationship with the GP. Thinking about the longer term when TACPs had qualified, senior/ regional managers felt they needed to ensure there was a fulfilling role that made use of the full range of ACPs training, skills, and experience as otherwise ACPs would just leave to find that elsewhere. Uncertainties remained concerning funding sources for a role at this level post-qualification, as well as the accountability, reporting and control issues between ACPs and CHMs, deputy managers and nurses.

Role confusion impeding relationship building.

Senior/ regional managers in care provider organisations were supportive about both the new role and the way that wrap-around support had been built in from the start to develop multiple facets of professional development and the role simultaneously. At the CHM level knowledge and support for the new role was variable. It ranged from negative and actively obstructive, through supportive in principle (but concerned about existing resource capacity in the care home to support training the new person), right through to active engaged support and knowledge. Supportive, informed CHMs already had a clear vision of the skill level of the role, noting that the ACP role was more of a medical role whereas nurses are more about care.

> *"A nurse with advanced skills and knowledge, on a training programme to function ALMOST as a junior doctor". CHM*

Some CHMs were supportive and felt fully informed, recognising the purpose and benefits of the role, which for some, most importantly related to educating and training other care home staff as well as enhancing life for residents and preventing hospital admissions. Other CHMs commented that the lack of clear and accessible information about the new role was a real constraint to building effective working relationships and support for the role. They wanted information from the start that clearly defined what the new role covered and did not cover and that made the reporting lines very clear. Tensions between some TACPs and CHMs existed concerning whether the new role covered both nursing and residential beds, with some CHMs wanting the role to focus on just the nursing floor.

Deskilling CH staff?

Care home nurses continued to feel uncertain about the purpose of the new role but were grateful to have a spare pair of skilled hands available and a reduced workload. Specifically, nurses appreciated TACPs ability to take bloods and deliver them for analysis (strictly speaking not a TACP's role), help with emergencies and TACPs' sound working relationships with doctors and multi-disciplinary team (MDT) members. One highlighted the difference between their role and the TACP role at this point saying the latter had time to focus on improving care and service quality standards, unlike care home nurses. Another anticipated the value of having someone available in the care home five days a week who could prescribe, thus eliminating communication delays with the GP. Similarly, the TACP sharing their training with the nurses could considerably benefit both nurses and residents. Already this nurse expected that a qualified ACP role would have greater levels of responsibility and accountability than nurses, as the role was closer to a doctor than a nurse.

In care homes, where the TACP role had not been well received and the placement had either ended prematurely or not gone ahead at all, there was some evidence that resentment from care home nurses had been an issue, as described here:

> *"But I guess, maybe, their role is something that any care home nurse would want to be doing. And maybe they're somebody… their nose is slightly put out of joint because somebody else has been thrown in with the time – and protected time – to do that"*. *Supervising GP*

More than one GP commented that staffing levels and ratio of skill level of staff to residents needs seemed to be less than that they might feel was needed.

While expressing little awareness of the role or understanding its purpose, carers appreciated the value of additional help and as they observed the TACPs in action, quickly noted their availability and skilled knowledge and experience. Carers identified: improved communication between GP practices and the care home; the ready availability and expert knowledge of TACPs; continuity in the care home; and TACPs as a source of training and advice as key benefits they had noticed arising from the role.

After university course started

University education provided a turning point for TACPs providing some clarity and understanding of their new role. Meeting student ACPs from other health care contexts, the course content and the support provided by the course tutors validated TACPs aspirations even though the demands of the course and coursework felt overwhelming. However, CHMs, and some GPs continued to feel insufficiently aware or prepared for developing a new advanced role. Key points at this stage were

1. TACPs gaining new clinical skills
2. Repercussions of a developing a new role

Gaining new clinical skills

Six months after most TACPs had started in the post, they had familiarised themselves with the staff, residents, and care homes functioning. They had just completed the first few months of their university course, and most said they had developed good working relationships with their supervising GPs.

Most TACPs were beginning to work across, and understand, their role in terms of the four pillars of advanced clinical practice - although the clinical and education pillars were more familiar at this point. Trainees reported enjoying gaining and practicing new clinical skills e.g clinical examination, managing emergency situations, training, and upskilling staff in topics such as catheterisation and wound care. Likewise, providing expert advice and guidance (Education pillar) to other staff was something TACPs reported doing most days. The leadership pillar of the role was still an emerging one for some TACPs. Others, however, were able to identify specific examples of their leading changes in practice to improve care e.g conducting audits to identify service improvements or improving systems and processes to communicate resident health care information when admission to hospital was necessary. The research pillar remained one that most TACPs were least sure about, but the research module of their university course had yet to commence.

Repercussions of developing a new role.

Some CHMs continued to struggle with understanding the new role because of a perceived lack of available information. It is also worth noting that not all were in post prior to the launch of the TACPs initiative. Accepting the prospect of a more highly skilled and qualified role could be daunting, particularly one which exposed the inner workings of the care home to external scrutiny e.g by GPs or NT CCG.

> "*She was a bit threatened. A bit intimidated. Of the role itself. She actually said in words, there is no room for an ACP in this home. You know, the role doesn't fit here. Yes, in a general practice, but not in a care home*." *TACP*

Most GPs were supportive of the project and were willing to become involved, seeing actual and potential benefits. However, some had reservations or negative responses. Essentially, funding to cover GPs' time for supervision was provided by NT CCG, however, not all GPs comprehended the scale of the commitment involved, with one GP not having fully grasped that they would be required to supervise the TACP. Even if the extent of supervision had been recognised, the issue of finding GPs to cover or 'backfill time' was potentially problematic. In one instance, the GP delivered supervision in their own time, on days off, with the practice paying them for this time. While not an ideal situation, this GP felt they could not justify taking more time out of their working week.

GPs were offered several training sessions about the supervision role expectations – delivered by the apprenticeship organisation, the university and HEE. GPs initially attended training delivered by the apprenticeship organisation but reported not finding it particularly helpful. Some commented that HEE training that started before the supervisory relationship may have been more useful. NT CCG staff thought that perhaps not all GPs had attended every training session, which may have influenced their understanding of what was involved.

Some GPs questioned the choice of care homes to benefit from the TACP role, in one case querying whether care homes that may be 'struggling' offered the best training experience for TACPs. GPs noted that TACPs needed confidence to tackle issues in 'poor performing' care homes and if support from the CHM was insufficient (or there had been changes in management), that made the task harder. For example, where a TACP had tried to lead care quality improvements by training staff to use recording and monitoring tools (e.g., hydration, nutrition, or excretion charts) care staff resisted, perceiving this as an unnecessary addition to their workload. CHM support was required in such instances. GPs commented on how care home staff culture can be emotionally charged, with strong characters and political infighting. They felt that in some care homes such cultures may influence the likelihood of a TACP role being introduced and/or how well it would be received. For example, one GP described how the CHM in one CH had seemed excited about the TACP role but feeling unsupported and constantly needing to make a case for more staff, had left their post. A further GP felt that there may have been inadequate communication and information at times about the planned arrival of a TACP.

In relation to the purpose of the ACP role, GPs understanding of this seemed consistent with the NT CCG objective. One GP articulated this as working at a level similar to an F1/F2 (junior) doctor:

- being able to manage chronic disease properly
- manage straight-forward exacerbations of chronic conditions
- being able to prescribe
- consider and escalate prescription and deprescription needs appropriately
- developing working relationships with range of relevant health and social care professionals
- identifying and leading care quality improvements
- training care home staff

Many of the activities GPs envisaged the TACPs undertaking were duties that GPs would normally undertake but which are time-consuming. In addition to reducing GP workload, given the TACPs were present in the home most days, meant they had a key role in: noticing and acting on deterioration; being involved in palliative care; and building working relationships with community health staff and allied health professionals. GPs identified activities that TACPs should not be doing as those related to meeting basic care standards, nursing standards or any people or performance management issues.
University educators had a firm grasp of the emergent nature of the new role, its broad purpose and hybrid nature between nursing and medical care for the elderly, where ACPs would

> *"try to manage some of their clinical complexity in the care home, without having to then refer them on to either the GPs or having to be admitted to secondary care environments". University educator*

They also commented that uncertainty in the scope of practice of the role was normal and consistent with what had happened in other areas when a new ACP role was introduced. However, they noted that whilst the employer was responsible for identifying what they expected the ACP role to do on qualification, the introduction of the role in care homes had an additional layer of complexity in that GPs were involved and part of the role specifying process. There was also a feeling that although building the communication network between the various stakeholder groups (both care home specific clusters as well as the larger joint groups) had been challenging and somewhat disjointed prior to the university educators becoming actively involved, they felt their previous experience of this, and their independent role would facilitate this going forward.

In summary, TACPs had a varied perception of the role remit and responsibilities at this point. This varied from a slightly vague role understanding for some trainees, through clearly contributing to the upskilling of care home staff and undertaking 'junior doctor-like' diagnosis and treatment for others. Some recognised the enormity of the role and its demands, and the intensity of the training to become qualified and were somewhat daunted at the prospect. Amongst care home staff and some GPs, understanding the role of the TACP continued to be limited or absent. In one case, a replacement care manager arrived, uninformed about the role which created difficulties. An 'emergency' meeting

between each stakeholder group for each care home, orchestrated by the university educators, much improved the situation.

One year into role

Three key factors started to change both TACPs and care home staff understanding of the ACP role during this period. While these factors enabled a positive perception of the new advanced role, there remained a strong undercurrent of tension that in part was aggravated by external contextual issues. These are all described below:

1. Access to 'Tools of the Trade'
2. Planning meeting facilitated by University Educators with relevant Health Staff
3. Seeing the difference
4. Tension in the Care Home
5. External contextual factors

'Tools of the Trade'

Access to key infrastructure changed both TACPs and care home staff understanding of the role, remit, and responsibilities as it highlighted the differences between a nursing and the ACP role. For example, access to EMIS[4] (an electronic patient record system) for TACPs involved with the 'ward round' meant they were able contextualise clinical information and decision-making. This contributed to them feeling much more supported and confident in their advanced clinical role and was something that no-one else in the care home could access. EMIS access allowed one TACP, with CHM and GP agreement, to take on responsibility for full assessments for all new admissions, considering information that gave a much more whole-body system profile and facilitated a health prevention role. This welcome aspect of role development enabled the CHM to see the differential and added value of the ACP role for perhaps the first time. Likewise, for nurses and carers hearing about this, was also the first time some of them saw any differential benefit for them in the new role. Learning that TACPs would be able to prescribe and make specialist and other health professional referrals, care home staff began to understand and appreciate what the role could deliver e.g cutting out lengthy delays between requesting and receiving antibiotic treatment.

TACPs reported that feedback received from GPs they worked with, indicated that key aspects of resident care planning, such as emergency health care plans, were being processed more promptly. This triggered a key change in TACPs own understanding of the purpose and importance of the role as they perceived how important it was that they spend time in the care home, getting to know residents and how this benefitted the care they received. TACPs were feeling more confident about juggling the role across all four pillars of advanced clinical practice, through different types of activities and focused on service improvement. For example, some TACPs spoke confidently about doing audits (research pillar) or leading change (leadership role).

[4]widely, but not exclusively, used by primary, secondary and community healthcare practitioners to view and contribute information to patients record. Link: EMIS (emishealth.com)

Despite access to 'Tools of the Trade', in some cases there remained resistance by staff to implementing care quality improvements. In one case, a TACP struggled to get care staff to implement any of the changes they tried to introduce, despite support from the CHM. Other staff questioned TACPs authority or ignored their requests even though, as one trainee commented, the role on qualification would be equivalent to Band 8 in a hospital setting, far exceeding the banding of most care home nurses (typically equivalent to a Band 5). Some staff would follow their instructions if a TACP invoked the authority of the CHM or (sometimes) the GP. Another trainee felt that an improvement they had started to implement had initially been blocked by the CHM but subsequently implemented whilst the trainee was away from the care home. The trainee felt this may be related to the CHM feeling threatened, suggesting that role boundaries were still an issue.

Additional barriers to practice were identified, including lack of clinical supplies e.g swab sample sticks, and delays for some TACPs in accessing NHS electronic patient record systems (which in England are either EMIS[5] or SystmOne[6]).

Other frustrations were evident. One disappointment was the loss of time trainees had together at the CCG offices - this occurred between six-nine months after starting in post. At this point, trainees spent time with Health Education England for half a day and the other half day in the care home. The time in the care home was not viewed as sufficient to feel productive. One TACP expressed frustration, wanting to be trusted to manage their time professionally between working in the care home, study time, course work. For some, the extra stress at challenging times like submitting the first essay, prompted reflections as to whether the demands of the training programme, comparative loss of earnings, loss of access to NHS pension, and increased travel time was worth it.

Planning meeting facilitated by University Educators with relevant Health Staff

Joint planning meetings facilitated by the university educators, (to get the CHM, GP and TACP for each care home together to talk through and agree their expected outcomes for the role) had a significant positive influence on role implementation and embedding. University educators had previously met with some CHMs individually and together with the joint meetings these discussions helped: clarify the role; simplify the different pillars of advanced clinical practice; and set out how the TACP care home work would achieve what was required for qualification in each of the pillars. Some CHMs who had previously struggled with the role reported a significant turnaround at this point as a result of these meetings and wished they had been held earlier.

> *"I don't think we would've been a year down the line and not knowing where we were going. And it's taken one three-hour meeting to sort everything out". Care Home Manager*

[5] Sector | Primary care | EMIS (emishealth.com)
[6] Products – TPP (tpp-uk.com)

The potential benefits of the role from a care home perspective became evident to CHMs, rather than it just being an additional demand on care home staff time to train a role that essentially reduced GPs workloads. For some, it was the first time they saw evidence of what the trainee had been doing, heard feedback from external people about the value of this work and realised how this could be used as evidence for the CQC, the independent regulator and inspector for care homes. One CHM commented that the initial project documentation received was overwhelming, full of jargon and *"doesn't make sense half the time"* (CHM). Crucially, these meetings allowed for dialogue (often lacking in the weekly and monthly operational and educational meetings). CHMs would have valued these meetings much earlier during the first year and felt they could have taken place every couple of months in the first year and quarterly thereafter. Even well-informed and supportive CHMs found these meetings transformational and having sight of clinical outcomes for residents in the short, medium, and long term had been especially helpful. One CHM reported how the planning meeting had been the point at which one of the GPs understanding and attitude to role transformed from being very negative and unsupportive.

Even so, not all CHMs were supportive of the role with one CHM describing their encounter with the TACP role as 'disastrous'. The positioning of the TACP as similar to a 'junior doctor' seemed particularly inflammatory to some CHMs. This was exacerbated where communication between the TACP and GP felt as though it excluded and circumvented the CHM and nurses.

In addition to CHMs, GPs felt these planning meetings made a big difference to understanding the ACP role in the specific care home they worked with and therefore what was needed from them in their supervisory role. After these meetings, GPs began to feel the role was

> *"building towards something that I think we all feel will be really helpful" GP*.

Specific benefits that GPs anticipated included:

- enhancing communication between the care home and GP practice
- improve GP work efficiency through streamlining communications through one ACP who has reviewed CH staff concerns to discuss with the GP in one conversation; reducing the burden of calls between GP practice and CH
- improving the daily quality of care that residents receive
- earlier assessment and treatment of deterioration, resulting in better resident care and health and reduce paramedic / out-of-hours calls
- better communication with families as TACPs able to have longer conversations e.g about care planning, as GPs constrained by time.

Supervisory GPs were not always the GP regularly working in the care home (conducting ward rounds) in all trainee placements, which they felt was suboptimal. Extra effort was required to liaise with the CH GP to identify training needs and offer more contact with the trainee in a clinical context. Despite this, GPs felt the arrangement was still workable. Better direction and clearer guidelines were required about

the TACPs training needs, particularly more structure about end points for competencies i.e. level trainees were expected to achieve, and at what time point for any given competency . This was also problematic for CH staff, GPs thought, who sometimes asked the TACP to undertake activities beneath current level of competency or assessments beyond the current level of competency, which did not support the TACPs specific learning needs.

Some GPs were unaware of the need to provide 78 hours of dedicated supervisory time to support TACPs during their non-medical prescribing course. Expressing surprise and frustration about this, GPs felt this was not realistic given current pressures and the level of their existing clinical time.

> "*literally I was told it was, like, about an hour a week extra to, sort of, support and be an educational supervisor. Which is completely different than now being told I've got to find three and a half extra hours of dedicated supervisor time for this extra course that, you know, wasn't sort of discussed initially*". *GP*

Seeing the difference

When care home managers, nurses, and the trainee ACPs understood what was involved in preparing for and passing the OSCEs, many nurses began to understand that the ACP role was more medical than nursing:

> *"once we realised, you know, the OSCEs were coming up and exactly what that entailed, I think the nurses then realised this is like the junior doctor's course" CHM*

Observing how the research pillar role contributed to identifiable care quality improvements such as falls and falls management, behaviour, and anxiety management was very valuable to CHMs. The research-based practice TACPs were able to contribute was highly valued and made a visible and measurable difference, even though regular monthly service improvement audits routinely took place. This enabled the care home to demonstrate the results of service improvements to care home staff, thus reinforcing and encouraging all staff to adopt changes in the way they provided care. Other CHMs mentioned system improvements to collate and communicate key health and personal information about residents to health professionals.

Most carers, despite having varied understanding and knowledge of the role, had observed trainees had useful skills and knowledge and commented how valuable this was because trainees were available and not tied to a specific workload.

> "[*TACP] has got that flexibility to kind of float around the building and… [s/he] might not be stuck with a strict timetable of, I've got medication at this time, and things like that. So, [s/he] can have the freedom, while the nurses might be busy with things like medication or if they've got any other responsibilities, such as PEG feeds – [TACP] can stick to just doing, like… getting the information across to the doctors*". *Carer*

In contrast to nurses and carers in some care homes, some carers felt that having the TACP as a single point of communication between the GP and nurses was a benefit because nurses shift work did not provide the more constant presence that TACPs did. Several carers commented that the research-based evidence the TACP used to support new or improved ways of caring really helped them understand why it made a difference and see the effect it had. This had helped to transform end-of-life care provided by some carers with grateful feedback from families but also transformed the experience for carers themselves. Carers also reported seeing immediate and measurable care quality improvements when they learnt about how to communicate with non-verbal residents or how to use sensory enhancement equipment and spaces for residents with dementia. Carers really valued the benefits this had for residents but also for their own job satisfaction and learning new skills e.g how to take and record observations, motivating them to think about future education and training opportunities.

Tension in the Care Home

Despite these findings in supportive CHs, some CHMs and deputy managers were not supportive of the role, believing that it did not add anything beyond that which nursing staff already delivered. Even the education the ACP role delivered to CH staff could be achieved by bringing in trainers, it was thought. Limited understanding of the ACP role by some managers persisted, even after a year in post, who conceived the ACP role as a type of 'general practice nurse'. For them, the main benefit they could foresee was that it reduced the workload for existing nurses (but this could equally be achieved by just employing an additional nurse). The ongoing difficulty the concept of developing the role *in situ* to suit the needs of each care provider presented in practice for care home staff, is highlighted by one CHM's comment that they

> *"don't have a job description or know what they are supposed to be doing. It's like a cloud" CHM*

which fostered that sense that *"the role is just a spy for the GP"*. Sensitivity about exposure to external scrutiny was not unique as TACPs in other care homes described being told by the CHM that they would not have access to detailed data held in the care providers various data systems unless they were employed by the care provider.

The perception that CH staff were being deskilled, (as described in Deskilling CH staff – see First few weeks and months), continued. Understandably, nurses felt aggrieved and side-lined, particularly when GPs routed all communication through the TACP. This created problems for nurses (and carers) if TACPs did not share information in a way and at times that worked for nurses and carers particularly because the TACP was not in the care home all the time.

> *"I'm the one who checks the residents in the mornings" CH Nurse*

Nurses and senior carers (who run residential units on their own) felt the important resident knowledge which GPs needed to know for the ward round had now been completely blocked off. Some nurses and carers felt that the TACP role was just about supporting the GP in which case,

> *"they should work in the GP practice"* *Carer* and *"why can't the TACP do more to support me?"* *Nurse*.

Nurses welcomed any opportunity to upskill and could see that the TACP had access and, importantly, 'free time' to access new skills and share that with others. They would have liked those opportunities for themselves. To some CH staff, TACPs sometimes seemed not to be '*doing'* anything, which in the context of many under-staffed, over-stretched care homes detracted from their value. This was compounded by a lack of clear boundaries between the nurses and TACPs role.

External contextual factors

The post-pandemic timing of the introduction of the TACP role in care homes added to role confusion as described here.

> *"… everyone in the care system is understaffed and stretched and post-pandemic fatigue and emotionally drained from everything we've been through, which the care homes have really had the brunt of in very many ways. And then you get someone who's kind of parachuted in, nobody kind of seemed to be aware that this was happening, who they were, what they were doing, why they were there… And then, one minute they're there, one minute they're not and what on earth are they doing?"* *University educator*

Added to this, the complexity of knowledge and skill that TACPs were trying to apply to complex situations was often somewhat invisible to others. University staff had provided support to TACPs to develop the confidence to assert themselves in their role. Despite tensions, university educators started to see a change in TACPs as they gained confidence about what was and was not part of their role. Some TACPs now felt confident to identify when they needed specific training experiences and assert themselves in explaining that

> *"I'm not shirking work, I'm doing something [as] important as actually being here because it's broadening my horizons, and this is my training time"* *University educator*

University educators described the teaching level of subjects such as anatomy and physiology as at medical school level. One example of this difference between what the ACP role needs to be able to do and their previous role related to listening to somebody's heartbeat.

> *"As an ACP, what you need to know is why is that happening, what are the other things I should be looking out for, what in their history should I be really making a note of and having that kind of higher-level thinking about that patient and being able to tie that in. How will that affect all their other medical conditions?"*. *University educator*

The private /NHS divide also complicated the development of the ACP role. Mostly, GPs perceived clear benefits to a care home role being situated in the care home, rather than being situated externally and 'visiting' the care home. But accessing support from staff in GP practices and allied professions,

particularly in terms of the forthcoming non-medical prescribing course, was harder. GPs questioned how they could legitimately ask practice managers to block out pharmacists and practice nurses time to discuss cases and provide a formal learning experience, without this time being funded. Currently, at best, TACPs might have to just sit and observe others doing their work.

In summary, one year after the TACPs started in post, continuing development and refinement of the ACP role is taking place. Another trainee chose to leave during this period, leaving three TACPs in post. TACP comments about their experiences traverse the range of role requirements; from developing clinical judgement, directing, and leading care home staff, to focusing ultimately and wholeheartedly on improving service provision. Health care professionals such as palliative nurses, GPs, and district nurses appear to grasp the nature of the TACP role, possibly because they have encountered the ACP role in other situations. However, care home staff seem less sure, (possibly because they have comparatively less experience of hybrid roles at this level) constantly questioning the authority and decision making of the TACP or not being able to see how the TACP role can fit into the care home environment. Where the role had been clearly explained, carers did understand the TACP role.

After first placement

There are 2 points to note at this stage of the TACPs training.

1. TACPs increased confidence and role understanding
2. Persistent authority and role conflicts

TACP increased confidence and role understanding.

This is neatly summed up by one TACP who said

> *"I would say it's jumped to that from, like, just working within the home, within the care team. Which I'm taking, like, a lot more work on for the GP". TACP*

TACPs reported that they had now taken on more responsibility and that the role had changed from just working within the care home to taking over some of the work of the GP.

Persistent authority and role conflicts

Care home staff continued to ask TACPs to undertake nursing tasks such as taking blood tests. These requests were prompted by workload demands, lack of confidence and sometimes flat refusal to do the blood tests themselves. This could result in blood test delays of up to 3 weeks if the TACP was not in the care home. TACPs tried to work with nurses to improve their confidence and skill and took blood tests to avoid residents experiencing long delays. Similarly, some TACPs were actively trying to train carers to take vital signs observations, both in response to being encouraged by NT CCG to roll-out Whzan training and to help them triage multiple emergencies when the care home was short-staffed. However, in some care homes this then conflicted with regional managers saying carers should not be doing observations.

Communication issues also continued to affect some TACPs doing ward round reviews and assessments. This prompted a GP to meet with care home management staff to reinforce the role responsibilities yet

again. In one case, the GP had to ask care home management to ask care home staff to copy the TACP into all communications between the care home and GP practice (although compliance was still not universal).

Role Development Conclusion

In sum, prior to the University course starting, there was a lot of uncertainty about the ACP role. Moving away from 'hands on' care was recognised, to make room for leadership and management, where the TACP could act as a link between the external services and the care home, e.g., diabetes, SALT, GP, or upskill other care home staff to be that link. Familiarising themselves with the residential care ethos enabled recognition of maintaining a home environment and not creating an extension of a hospital. This distinction between private / NHS care context was also apparent in providing the learning experience important to the TACP role, and the accompanying working expectations of the Care Home. Within the care home setting, many care home staff reported having no understanding or knowledge of the new role, despite preparation work by NT CCG with CHMs to inform staff. There was some recognition by some nurses and other senior staff in care homes of the additional responsibilities, knowledge and accountability that qualified ACPs would have. Most staff in care homes valued having additional help of any type in the care home and the fact that TACPs were already skilled and experienced nurses was generally welcomed. Nevertheless, lack of knowledge, scepticism of the new role, and fears of CH nurses themselves becoming deskilled persisted. As TACPs gained in confidence and skill, they were subject to a constant and sometimes strong undercurrent of resistance to change and challenge to their authority.

Ways of working

The way that TACPs work in practice, together with the ways that others work with them, offers an insight into how this new role is perceived, by both TACPs and others, and how the role is socialised as part of the system. This is likely to change over time, so this section reports ways of working as reported by the TACPs at each interview point.

First few weeks and months

One TACP, asked about the activities they were involved with, talked about how they had made a strategic decision to avoid the type of nursing activities they had been doing before in their previous nursing role. This implied that for them, the mental work involved in conscious decision-making about which activities were appropriate or not, was an important part of the activities they engaged in during the first few weeks and months.

Aside from the mental shift required, TACPs described their activities as involving giving clinical advice to care home nurses and carers. Most TACPs were reviewing residents who had been referred to the ward round, determining reason for referral , gathering background information, making treatment decisions if they felt able, or liaising with the GP. Other activities TACPs talked about included identifying deteriorating residents, assessing residents that care staff had expressed concerns about and educating care staff. Even at this relatively early stage, TACPs were aware of the new types of activities they would

become involved with, as their clinical skills developed. One TACP identified the biggest change would be physiological assessment and diagnosis, making treatment decisions.

Activities TACPs said they did not get involved with included:

- medication round
- ongoing routine nursing care
- gap-filling staff absences or short-staffing on a regular basis

After university course has started

Trainees were spending 3.5 days a week in the care home (4.5 days if they were not attending university during university holidays). For most TACPs, their time in the care home continued to involve preparation for the ward round as described previously, and attending the GP/ward round with the GP (and sometimes other staff). Not all TACPs participated in the ward round. Additional actions included:

- following up on actions arising from the ward round
- doing audits e.g care audits are a systematic assessment of how well services meet evidence-based standards (Health Quality Improvement Partnership, 2017). For example, TACPs mentioned catheter audits
- service improvement activities e.g one TACP streamlined the process of assembling resident information for admission to hospital by training staff to use '*Is My Resident Unwell*?' to capture key information and collate this together with the emergency health care plan and any DNR information
- checking medication stocks

TACPs were starting to use higher level skills. For example, trainees described how they were now examining people, sounding chests, advising staff on collecting urine samples and how a more autonomous professional role was beginning to emerge. TACPs continued to try and avoid involvement with routine residential care, medicine rounds, and sometimes blood tests. This varied according to the care home and ambiguity remained around what was appropriate to ask the TACP, or not ask. Negotiating role professional boundaries took place with families also. Dealing with complaints and direct challenges to clinical practice can be a more direct and personal experience in care homes as families may challenge care home staff directly and then continue to see them regularly around the care home.

One year into role

At this point, the TACP role was expanding their clinical activities further across the four pillars of advanced clinical practice to include education, leadership (in terms of championing and leading changes to improve care quality) and some research. For example, the NT CCG had suggested TACPs work with staff in the care home to introduce "Is My Resident Unwell?[7]" (a physical deterioration and communication tool that includes taking clinical observations) and Whzan's Blue Box[8] (a telehealth

[7] https://ahsn-nenc.org.uk/wp-content/uploads/2020/03/WCCH_is_my_resident_unwell_A4_single_pages.pdf
[8] https://www.whzan.uk/blue-box

case). TACPs started training staff and one trainee had even started to think about developing a research project connected to the interventions.

Some TACPs were still developing confidence and knowledge about issues they could deal with themselves and those that were appropriate to be escalated for GP review. This varied according to each TACPs prior clinical/job role experience. All the trainees had passed their advanced (level seven) OSCE at this point so were able to clinically examine residents. For some TACPs, this step contributed to a more autonomous professional identity involved in clinical decision-making emerging. It is worth noting that whilst most TACPs had taken over doing the 'ward round' with the GP, as part of their learning and training, this was not universal. In one care home, nurses still did the ward round with the GP and the trainee could attend as well, if they were free, as a learning opportunity. Alternatively, the TACP might clinically examine residents that nurses were concerned about and send the information to the GP in advance of their clinical examination, again as a training opportunity. This approach may have allowed more time for the TACP to undertake activities that enhanced existing care and was felt to be important to avoid de-skilling or eroding the role of the nurse in the care home, a point raised earlier in the section Deskilling CH staff? in Role Development. This was viewed as especially important given the shortage of care home nurses and the fact that morale was already very low.

After first placement

By the time, the first placement had been completed, TACPs had gained some practical experience of working in the CH. The TACP interview at this stage, clearly yielded a sense of uneasiness and disagreement of how their developing role was unfolding. 3 strands were evident.

1. Timing of Care Home placement
2. Financial and professional disadvantage
3. Lack of Care Home support

Timing of Care Home placement

Some of the TACPs felt that the timing of placement in the CH seriously disadvantaged them. Without access to the 'tools of the trade', for example NHS patient information systems and not having completed their non-medical prescribing course, led to some CHS 'pitching' the TACP role below nurse practitioner (NP) level. This was because CHS had worked with NPs who had these 'tools of the trade'. This may have contributed to the difficulty TACPs had in establishing their role boundaries and authority. Indeed, authority clashes with CHM were still being experienced by some TACPs, potentially rooted in CHMs feeling threatened by the role, especially as the TACP skill and experience level advanced.

Financial and professional disadvantage

The issue of non-eligibility for travel expenses during placements (see below: Financial and Personal repercussions) exacerbated existing feelings of financial and professional disadvantage. TACPs were aware they were employed at a lower pay band than NHS TACPs on their course, were not paid bonuses that NHS TACPs received and felt penalised by difficulties with access to NHS pensions. CHS showed

greater respect to visiting NHS staff e.g. district nurses, nurse practitioners from the GP practice, palliative team. This was manifest by, for example, the way care home staff spoke to TACPs compared to these NHS staff. Some TACPs felt that being employed by the NHS and having a home base, external to the care home, where they could meet in the morning/specified times for briefings, writing-up notes, meetings with supervisory GP, before going out to spend the rest of the day in their care homes would have helped them gain the authority and respect from care home staff that the role should have. This would also provide them with a valued opportunity to meet with each other, developing a shared sense of belonging to a professional identity. They reflected that this had worked well initially when they used to meet up at NT CCG offices on a weekly basis and observed that other similar professional health staff e.g. frailty nurses, operated successfully using this model.

Lack of Care Home Support

TACPs felt quite strongly that a lack of support from within CHs was a major factor that could prevent them from fulfilling the TACP role. TACPs had become aware of the weekly Operational meetings and felt aggrieved that comments were made about them, without TACPs being involved in the meeting with the opportunity to respond.

> *"This caused a lot of animosity. Why was just the managers and the CCG having these meetings? Because us as TACPs, we didn't know what they were discussing about us. And we thought it was quite underhand to do this."*. *TACP*

Additionally, they sometimes received conflicting messages from university educators and NT CCG or CHMs. Being employed from within the NHS would have resolved some of the role boundary and authority issues they were struggling with, TACPs thought. It may also have provided greater feelings of security for them.

Overall, by the time the placement was completed, with over a years' experience of being employed by, and working in the CH, TACPs were beginning to feel markedly disadvantaged, both professionally and financially. These findings could have serious implications for retention of TACPs after qualification.

Educational experiences

There are multiple strands to the training and education programme for TACPs. These consist of:

1. university course
2. self-directed study
3. supervision by a clinical supervisor (typically a GP) who can sign off to confirm the trainee has reached a given level of competency in skills (agreed between each GP, trainee and care provider organisation and as being needed for the ACP role)
4. acquisition of on-the-job skills and experience, overseen by the educational supervisor (typically a CHM and agreed between the CHM, GP and trainee as being needed for the ACP role)
5. NT CCG/HEE NEY organised clinical placements
6. acquisition of skills and experience through other opportunities e.g shadowing other health professionals

The following section reports on TACPs experiences and perceptions at each sampling time point tracking their development and experiences in relation to each of these strands.

Educational experiences: first few weeks and months

The first few weeks and months of TACPs educational experiences consisted of:

- familiarising themselves with the care home context
- time spent on NT CCG co-ordinated training e.g invited speakers, learning to use Whzan (tele-health care system to capture clinical observations and NEWS scores)
- HEE NEY co-ordinated training activities e.g EnCOP assessments
- starting to work with the supervisory GP for some of them
- self-directed study

For trainees unfamiliar with the care home context this included aspects of care they had not previously been involved with e.g working with kitchen staff to oversee adaptation of meals to dietician recommendations for specific residents. Understanding that their new working environment is somebody's home rather than a clinical setting was another important adjustment. Other aspects included getting used to differences in protocols for referrals and taking a more holistic approach (what is the best action for this person as a whole considering everything about them, their preferences, their co-morbidities, and complexities), rather than a narrow focus on specific clinical problems.

After 3 months of CH working, TACPs commenced their University course. All trainees felt overwhelmed and daunted by the workload ahead laid out in this first session, although they were unsurprised given that it is a Masters' level qualification. However, starting the university course also provided an affirming experience with a focus and structure to help TACPs make sense of their induction experience and imagine their route forward. For those qualified overseas or out of education for some time, the additional pressures of returning to education or adapting to a new style of education triggered anxiety and feelings of insecurity. Anecdotal evidence suggests these concerns may have contributed to some potential candidates not applying for the role. Likewise, similar anecdotal evidence suggests concerns about how applying for the role could affect the stability of the care home may have discouraged some CH staff from applying or being asked not to apply.

Education through supervising GPs had also started for some TACPs, mostly in the context of the CH ward round. Some GPs endeavoured to separate the two to ensure that learning, day-to-day clinical assessments and follow-ups could be kept distinct. One trainee felt they were being used by GPs as a substitute for a nurse, rather than the ward round being a learning experience. For some, the GP clinical supervision had yet to begin, related to misunderstanding about what was involved. GPs also felt that the HEE training for GP supervisors was timed later than they felt was useful, although the training itself was very helpful once received.

In summary, while attending University helped to clarify the nature of the ACP role, the volume and intensity of study, combined with working in the care home was daunting. Some trainees doubted their

ability to manage the differing demands. This was especially the case for those who felt their previous educational experiences may not have prepared them as well as others. Interviews with supervising GPs illustrated several disjunctions. For example, in communication between all levels in the service (NT CCG down to care workers), in co-ordination between GP supervisory training and introduction of TACPs, and in role clarity of supervising GPs. Individually and collectively, this disadvantaged the introduction of TACPs by slowing down the process and causing confusion.

Educational experiences: after university course started

Several themes arose during interview.

- Quality of Educational Experience
- Appropriate supervision
- Management of Studying requirements
- Space to fulfil the TACP role

Quality of Educational Experience

Several months after TACPs had started in the role and three months into their university course, they described the university course as demanding but enjoyable and felt the tutors provided good support. However, some trainees talked about the difficulties in balancing demands arriving from multiple sides from the course, the GP, the NT CCG and CHMs without everyone being aware of what others were also asking for. Trainees were also continuing to get to grips with the nature of adult learning and the demands of Masters' level education. Meeting with TACPs from other disciplines and settings on their course had been a positive and affirming experience and there was evidence that the trainees were beginning to embrace their professional identity.

> *"For me, I think the professors and the teachers actually made this the right, like, hybrid healthcare… yeah, we are somewhere in between, you know, between a doctor and a healthcare professional". (TACP)*

Part of their 'on-the-job' training included linking their University learning to their Care Home experiences. Some TACPs felt there were fewer opportunities to gain practical experiences of some University education, compared to their fellow students. For example, TACPs in acute care were constantly exposed to new cases, medical conditions and scenarios and were thus more likely to see examples of their academic learning. Nevertheless, GPs felt this 'on-the-job' training was about becoming familiar with the common conditions present in the care home population e. g pneumonia, urinary tract infections, delirium, dementia, depression, strokes, angina, as well how these could present differently in this group of people.

TACPs really valued spending time with other health professionals outside the care home. For example, one trainee had spent time in the GPs surgery with physician associates and paramedics and found it very helpful watching them demonstrating consultation skills or making differential diagnoses.

Appropriate supervision

Not all CHMs are registered nurses, and this meant that some TACPs felt they did not have the support of an educational supervisor. Initially, supervising GPs were labelled as education supervisors and care home managers as clinical supervisors. Clinical supervisors would sign off skills like clinical audit, risk assessment, ordering of medications, some education and leadership skills. GP education supervisors would sign off clinical assessment, diagnosis, and prescribing skills. However, these labels were reversed[9] following discussions with university course leaders and all stakeholders (April 2022). This contributed to tensions between some TACPs and CHMs as to the latter's role.

Management of Studying requirements

As previously mentioned, TACPs felt quite strongly that they were disadvantaged compared to other students on their course because they were less able to arrange their working days to optimise study and working time. Ideally, they would have liked the flexibility to work longer days in the Care Home to reserve their study hours for a whole day to allow for concentration, focus and continuity. They had initially been told they would be allowed to do this although this was subsequently retracted.

Space to fulfil the TACP role

TACPs new to the care home context also found it difficult to adapt to not having private and quiet office space, regarded as important for several reasons:

- to follow-up GP ward round learning experiences
- to write up care planning documents, resident notes, ward round summaries, talk to residents
- to signify their developing professional status (one trainee commented that in the NHS, roles at an equivalent level would have office space)

This situation was hard to resolve as any space created e.g. in the administration office was often temporary, shared spaces or other users of the space resented the presence of the TACP. The lack of dedicated office space was unproblematic for trainees recruited from care homes who were used to office space in care homes generally only being provided for the manager, administration team and nurses station.

Overall, as TACPs settled into University education and meeting fellow TACP course colleagues, a deepening understanding and appreciation of the value of the TACP role was beginning to emerge. This provided support but also highlighted disparities in experiences such as different exposure to clinical scenarios and therefore learning experiences, diminished control over TACPs work hours and study time, and appropriate physical space to fulfil role demands with the care home. Appropriate supervisory roles were also questioned. The distinctive context of the Care Home environment was clearly evident in these disparities.

Educational experiences: one year into role

At this point, there were three TACPs still in post and enrolled on the university course. This remained well-regarded by TACPs who described university tutors and staff as very supportive, although the

[9] The HEE framework for advanced clinical framework requires that the clinical supervisor(s) is competent and capable to sign off the competence statements in the practice environment. Thus, the educational supervisor is not necessarily somebody with clinical expertise, but they oversee the whole of the learning programme.

course continued to feel intense and the workload heavy. TACPs unhappiness at not being able to organise their working time to optimise their study time continued to feel disadvantageous compared to other course students.

Similarly, there was some discontent related to feeling that CHMs did not fully understand or support off-the-job training that TACPs felt they should be able to undertake. For example, one TACP had a very supportive CHM who supported them being absent from the care home while they gained experience through shadowing roles such as frailty nurses, orchestrated by the supervising GP. Other TACPs felt that support for this was still lacking and that the CHM was more concerned with exercising control over the trainee's movements and activities.

It was also clear that TACPs were receiving different clinical education experiences from their GP supervisors. One GP supervisor, not realising the scale of the supervisory commitment, had spent less time with the TACP than others. Another TACP received GP supervision from a GP who did not routinely care for Care Home residents. Although the supervising GP was happy that the clinical education was not affected by this, the care home GP did not understand the purpose of the TACP role and was initially quite negative about it.

Interestingly, one CHM described developmental changes that a TACP needed to undergo regarding contextualising clinical decisions in the specific care home context. For example, moving away from narrow clinical perspectives and decision-making about health-related situations, towards a more holistic approach that considers resident's and family's wishes and the wider impact on a person's end-of-life care and treatment. The CHM described using the scenario with the TACP as an opportunity to reflect and learn how to adapt clinical care to the care home context.

In short, one year into the role, TACPs were continuing to learn how to apply their university education to their specific care home environment. Tensions and unhappiness persisted over management of ACP time and the broader educational experiences important to the enhanced role. Not all care home contexts appeared to be able to adapt and incorporate the alternative approach that the ACP role appeared to require.

Educational experiences: after first placement

Placements were scheduled for 12-14 months after the TACP post commenced and were intended to provide additional clinical experience of conditions and treatment typical of older people that TACPs did not already have and that the stakeholders wanted the role to develop. In practice, TACPs placement experiences were mixed with three areas of dissatisfaction identified. These were

1. Financial and Personal repercussions
2. Appropriateness of Placement timing and setting
3. Absence of Partnership approach

Financial and Personal repercussions.

Placements, organised at three local hospitals, required additional travel costs and time for some TACPs. With just two weeks' notice of the placement date commencing, TACPs had little time to organise their

work-home commitments and finances to accommodate these changes. Unable to claim for travel expenses, and with no parking arrangements organised, TACPs dissatisfaction increased. One TACP resolved the issue following considerable querying and consultation with their employer and NT CCG. For some, the financial and travel time cost was both burdensome and a disincentive to attend.

Appropriateness of Placement timing and setting

TACPs ability to attend placements was limited when the university term restarted. Thus, TACPs continued to attend the care home on days they did not attend placements. The perceived usefulness of placements varied with some finding them helpful while others would have preferred more specific and relevant experience. TACPs had been expecting placements to provide this as they were previously asked to identify areas they needed more exposure to e.g palliative care, frailty nurses, SALT, dermatology. None of the TACPs knew whether there would be further opportunities for placements in these areas, or indeed any further placements at all, during their course. Teaching quality varied.

Absence of Partnership approach

For CHMs, not being involved in the discussions about the placement felt like a failure of the 'partnership approach'. CHMs felt excluded from the process and one commented that this prevented the CHM from supporting the trainees learning on placement with relevant experience once back in the care home.

> "*How am I supposed to know what [TACPs] learning is going to be and what [TACPs] learning could be back here*?". CHM

From an educational experience viewpoint, the placement had mixed value and came at a financial and personal cost to TACPs. Late notice of placement start date, created an impression of either last-minute arrangement or difficulty securing a suitable venue, evidenced by TACPs variable learning experiences and timetable clashes with university learning.

Implementation in the care homes

This section highlights some key issues that emerged which influenced implementation of the project in care homes, including:

- Communication issues
- Contractual issues
- Balancing CHM authority and responsibility with TACP professional autonomy
- Ongoing Joint stakeholders dialogue and oversight meetings.

Inevitably, there is a slight repetition in the findings describing role development and implementation, however it was felt to be important to draw out and highlight these issues separately.

Communication issues

Communication issues impacted the implementation of the project in a range of ways and at different times points: around recruitment, understanding the purpose of the TACP role, role implementation, and to whom the TACP answered to.

During recruitment there appear to have been delays between the time of the interviews and care home providers sending offer letters to successful candidates post-interview. This caused a flurry of emails to NT CCG staff from the candidates reflecting their confusion and the lack of timely information. This uncertainty and delay was perceived as having possibly influenced two successful candidates to withdraw before the start date.

Initial discussions and agreement between NT CCG leaders and senior management did not always trickle down to CHMs or staff. Consequently some CHMs were unclear about the TACPs role purpose, inevitably leading to tensions. High staff turnover levels, including those at managerial level, e.g. regional and CHMs, impacted upon information and knowledge sharing regarding the project design and role purpose. These factors may have impeded acceptance and understanding of the TACP role purpose, functions, and reporting relationships. Communication needed to filter through many complex organisational layers in order to include individual care home staff. Consequently, TACPs were able to negotiate role boundaries and activities more easily in care homes with consistent communication, knowledge, and support for the role, than in homes where CHM support was lacking, perceived as negative, or where communication was inconsistent.

Once in post, communication continued to affect role implementation. On occasions TACPs were perceived as not having fully communicated 'ward round' information to other care home staff. As noted in the Tension in the Care Home section, this may have added to nursing staff tensions as they may have felt their clinical expertise was being side-lined. Conversely, where clear communication appeared to already exist, after an initial hesitancy, CHMs felt that nurses welcomed being freed up to deliver resident nursing care by the TACP taking over the ward round. Ward round information was discussed and shared in detail with all staff so that everyone was informed, and feedback could be integrated into patient care plans. In these situations, when the TACP was absent, nurses found it "a big miss" and had to find time to take 'ward round' responsibilities back on.

A persistent communication issue was a lack of clarity around who employed the TACP prompting confusion around who TACPs were ultimately accountable to. At the recruitment stage some TACPs perceived the role as reporting to the NT CCG and this had been a positive influence in their applying for and accepting the role. Realisation that they would be care provider employees only occurred once in post, with some reporting that they might have reconsidered applying had they realised this. This was an essential point for some TACPs and is potentially pertinent to any future recruitment process (as well as retention post-qualification).

Contractual issues

Contractual issues seemed to impact on the implementation of the project for at least the first six months of year one of the project, including the integration of NHS and Care Home contacts and the formulation of GP contracts. Contractual issues also impacted the process of collaborative stakeholder process designed to define the full scope and functions of TACP role in each care provider organisation.

Integration of NHS and Care Home Contracts

It was anticipated by the CCG that employment contracts for TACPs with each employing organisation (each care provider) would need to match 'Agenda for Change' terms and conditions similar to those of the NHS. This would enable suitably qualified and experienced candidates currently working in the NHS to consider the role and, once qualified, remain in post. However, this proved more difficult in practice because employment contracts for specific roles/pay levels in care provider organisations are standardised. This meant an exception for TACP roles had to be made and the procedural aspects of this requirement (e.g. getting the exception approved/signed off through each care providers management and HR structure) took longer than anticipated, prompting tensions.

Dissatisfaction with employment contracts persisted, with some TACPs unwilling to sign contracts as they continued to negotiate with care providers, involving NT CCG in the discussions throughout the first year of employment. There was a feeling that care provider organisations wished to amend the contracts in line with those they normally issued (e.g. to include weekend working, carrying out nursing duties, access to NHS pension, recognition of previous qualifying and eligible NHS employment periods). However, this meant the contract no longer matched the recruitment offer of 'Agenda for Change' terms and conditions. In some instances this 'negotiation' situation continued for nearly a year.
The impact of these issues for those involved is not to be underestimated as it created an ongoing sense of anxiety and feelings of lack of security in the role for TACPS, and for some was extremely stressful.

Lack of parity with other TACP course participants

Misunderstandings and changes in organisation of work and study time also created tensions and this have been described in some detail in Educational Experiences. These ongoing issues, suggest that clarification and resolution of these before the project is rolled out further or elsewhere is required.

GP contracts

A range of unanticipated issues also emerged which contributed to delays (until three months after TACPs had started) in successfully negotiating GP contracts (for supervision etc) and seems to have created a hiatus in the collaborative stakeholder process to develop the TACP role. A key factor in creating ownership and commitment to the project's success, was the ability for each care provider to develop the ACP role to meet their particular care home needs (e. g specialist skills depending on resident types). This was described in the NT CCG project specification,

> *"the full scope and function of the role will evolve and develop based on service and patient need. Therefore, there needs to be an understanding that the scope of the ACP once qualified will evolve depending on current and emerging needs"* ***NT CCG project specification***

However, the stakeholder participatory process to define the full scope and function of the role in each care provider organisations could not commence until supervising GPs were 'on board'. Furthermore, it seemed initially unclear in which care home each TACPs would be based and in one case, a TACP was placed in three care homes within the first sixteen days of being 'on the job'. Given GPs are aligned to specific homes this also prompted delays with regard to GP contracts.

As late as nine months after TACPs had started in post, there still seemed to be some GP uncertainty regarding what their role involved, with some confusion also from the CCG regarding when GP supervision was required (e.g. before or only when TACPs started their university course). Furthermore, it seemed not until university education leads prompted meetings with each separate stakeholder group cluster (care provider staff; GP; TACP for each care home and university educators) that the participatory negotiation process (anticipated by NT CCG to be the main mechanism to define the ACP role) seemed to begin to take place successfully to define the ACP role.

Balancing CH authority and responsibilities with TACP professional autonomy

CH authority and responsibilities

Senior/regional managers in care provider organisations were supportive about both the new role, and the way that wrap-around support to develop multiple facets of TACP professional development and the role, had been simultaneously built in from the start. In one case, it had been instrumental in persuading some care provider organisation owners to participate in the project. Senior/regional managers championed and supported the new role and resisted pressure for it to be used to fill staffing gaps once the role holder was in post. However, some senior /regional managers were then inevitably drawn into other areas of work, leaving the day-to-day management and implementation of the new ACP role to the CHMs.

Issues of control and responsibility potentially linked to the usual employment hierarchies and accountability may have underpinned some tensions exhibited by CHMs and TACPs. This was an issue regularly discussed at weekly Operational meetings. CHMs felt that TACPs had aligned their organisational commitment to NT CCG and did not understand they were care provider employees. Other care home staff shared similar feelings evidenced by TACPs weekly attendance at NT CCG offices, appearing to report to the NT CCG. TACPs stopped attending NT CCG offices after three months, working closely with the GP. Consequently, some care home staff felt TACPs had aligned themselves with the GP, rather than the care home and care home staff. CHMs authority and control felt challenged when TACPs behaved as though NT CCG or GPs were the employer. This was evidenced when TACPs refused to participate or sign off routine employee supervision meetings (believing they did not apply to them), informing the CHM, rather than requesting annual leave, changing days off at short notice and without consultation or specific

approval. A related aspect was that CHMs were sensitive about what TACPs were saying to external people and who these people were. CHMs described having to exercise control over these situations.

> "*Does it mean that it kind of washed our dirty linen in public*". *CHM*

CHMs (and other senior/regional managers) were also endeavouring to navigate how the ACP role, potentially more senior and with more advanced skills than the CHM, would ultimately fit into the hierarchical power structure of the care home context in which CHMs are the apex position.

TACP Professional Autonomy

Functioning as an autonomous professional was key to TACPs role identify and attempts by CHMs to exert control felt inconsistent with this. From TACPs perspective, there was a clash between the trust accorded to autonomous health professionals that they would self-manage their time and effort to deliver role requirements and the close monitoring and control of daily activities by CHMs. As responsible professionals training to a senior level, TACPS felt they were already working as flexibly as possible to accommodate care home needs. The issue of study time and not being physically present in the care home illustrated this point.

TACPs also struggled with the professional autonomy required to lead change in practice to improve care quality. Some supervising GPs had also noticed this and sought advice on how other care homes had resolved this issue. TACPs resorted to using CHM endorsement to get care home staff to do what they asked but this depended on whether CHM and support for the role existed. Even so, some care home staff who had experienced constant turnover of CHMs had little faith or energy to invest in changing how they worked (which often felt like being given 'extra work') or a new role and TACPs struggled to establish any authority.

TACPs initially perceived ultimate role control and authority lay with NT CCG as this is where the funding lay , taking any unresolved or unsatisfactory issues to the CCG for resolution or discussion. For example issues with CHMs or care provider organisations such as contracts or working, and study arrangements, and querying with NT CCG the need to complete care provider timesheets to trigger payroll services. NT CCG staff participated in discussions with both TACPs and care home staff where they felt this was appropriate. However, as time went on NT CCG endeavoured to step back from day-to-day management issues, encouraging TACPs and care home staff to resolve issues within the normal staff management procedures. During this process of stepping back NT CCG the TACPs expressed feeling abandoned and unsupported as this quote illustrates.

> *"We feel as though we've just been, like, dropped in the care home now and that's it. Because the CCG are not involved with us…Like, no support. So, in the care home, underneath the care home management."* *TACP*

Trainees were concerned about a future as qualified ACPs where they would no longer be able turn to the NT CCG or university educators to intervene in discussions with care provider staff in these sorts of situations.

Ongoing Joint stakeholders dialogue and oversight meetings.

NT CCG established two series of meetings to facilitate dialogue between joint stakeholders and oversight of the development and implementation of the new role. Attendance at these meetings by care provider managers and/or GPs (as appropriate to the invitation list for each meeting) was a contractual requirement. Weekly or monthly project meetings organised by NT CCG were rarely attended by some care managers (or nominated substitutes). This meant that some CHMs missed project updates and were unable to contribute to the shared problem solving and peer networking. Despite meeting attendance by care provider managers and/or GPs, being a requirement, attendance was mostly by staff from the same two care homes each week (some care homes barely attended meetings). For CHMs who were struggling to get to grips with the TACP role, the weekly reporting of positive feedback from one care home only served to reinforce negative experiences and perceptions in other homes and added to feelings of frustration. Similarly, monthly Educational and Operational meetings were not well attended, with some care provider staff and GPs attending few meetings. One CHM felt that the meetings, Terms of Reference and attendees all needed to be reviewed and reset.

> *"Too many meetings … too many different people for too many different reasons, with too many different agendas". CHM*

The CCG expected that CHs and GPs would regularly meet in their own small group (one per care home) to negotiate and develop the ACP role required for their CH. However, this did not transpire as neither CHs nor GPs were aware that they should be doing so. Their absence up until that time was a key barrier to acceptance, integration, and progress. Eventually these deep communication issues were somewhat resolved when the university educators organised what the TACPs called an 'emergency' meeting to initiate this process.

The low meeting attendance amongst stakeholders, lack of clarity of the ACP role, remit, and contract, plus the fear of 'spies' suggests a difficult power imbalance between stakeholder groups that adversely affected their collective ability to negotiate and decide the role of the ACP in Care Homes.

Impact

During the period of this study, the impacts of the TACP role were becoming evident. Improvements to care quality were identified by TACPs, care home managers, nurses, carers, and GPs. These improvements were mainly affected via:

- better continuity, consistent, and/or co-ordination of care
- earlier assessment and treatment
- availability of more expert knowledge and skills

- providing training to other care home staff

One negative impact relating to side-lining skilled staff was raised.

Better continuity, consistent, and/or co-ordination of care

Continuity can be an issue in care homes because of shift patterns, high staff turnover and use of temporary staff which can fragment information and care. TACPs helped improved continuity by acting as a constant in the communication channels between medical and care home staff, holding and sharing information about residents' health, well-being and treatment and ensuring follow-up actions are carried out.

> *"it's been really valuable because we've gone through a transition with nurses… But it's sort of been, like, that holding things together. Making sure that the continuity is there".*
> *Regional/senior manager*

One carer described an example where a resident had been referred for poor eating and possibly requiring adaptations to diet. The carer had been able to discuss with the TACP what they thought was actually happening (resident blew bubbles and made noises whether or not they were eating). The TACP shared the information with the GP, thus preventing unnecessary or inappropriate treatment. For the carer, the key difference the TACP had made was the continuity link between the GP and carer. TACPs also have time to build networks with other health professions, and MDTs, gathering contact details which was valued by care home staff, as it reduced staffs workload and enabled smoother lines of communication.

A range of staff noted the improved communication, including some regional/senior managers, GPs, care home nurses and carers. In particular, the advantage of having a member of staff who can maintain the momentum of the diagnosis and treatment is clearly illustrated by this GP.

> *"I've got someone in there who can do things and follow things up and ring relatives and find out things – [TACP] can ring hospitals and find out things". GP*

Whilst continuity of care is clearly advantageous to individual residents, the additional learning gleaned by the TACP is shared with other staff with the potential to benefit other residents. The TACP role, enabling closer links with the multidisciplinary team, and time to review paperwork, also assisted to CH staff to keep abreast of changes "*So, we're all on the same page*" *Carer.*

Earlier assessment and treatment

The impact of earlier assessment and treatment was observed by some CHM, GPs, care home nurses and carers. For example, a care home manager identified that TACPs could sign off CHC checklists for people transferring from residential care to nursing care, granting the resident earlier access to nursing care. Previously, CH staff would have to wait two-three days for the GP. Nurses and carers particularly appreciated access to clinical advice from the TACP given their experiences of decreasing availability of GPs – "you can't get the GP out unless it's their day to visit". Contacting a Nurse/carer – or even services such as 111, often involved waiting for 45 -60 minutes on the phone, which took staff away from caring for other residents. It is not just the speed of the TACP's response which is important but also the follow-on advice the TACP provides

> *"So [TACP] had kind of helped with that scenario, gave me a lot of guidance, told me to do this, that and the other"* ***Nurse***

Availability of more expert knowledge, skills, and training

CH staff time pressures sharpened their appreciation of the availability of the TACP to; provide clinical knowledge and support, particularly during periods of heavy nursing demand, research clinical backgrounds and explain to staff the purposes of changes to the Care Plan, to provide training, and to sharing their advanced clinical skills and knowledge. CH nurses had little time to do this.

The presence of the TACP also reduced the level of GP involvement in the CH as TACPs were able to assess residents and guide staff in providing care. One GP described the impact of TACPs in this way.

> *"And honestly, we were getting eighteen patients twice a week to review.... now, one GP, [can] do that once a week and… in terms of time, I don't think they've spent anywhere near as much time as they were at [Location]* ***GP***

Clearly, the advanced TACP role in the CH impacted positively on both CH residents, staff, and GPs. The next section refers to the potential for other staff to feel undermined by the presence of the TACP.

Potential to side-line other staff

The potential for negative impacts of the role was evident at several levels as some CH staff felt diminished by the TACP presence. These opinions ranged from the CH managers who felt ignored by GPs through to nurses, who felt their own role was being side-lined or eroded.

> "*I used to run unit [X] and now I feel side-lined. I was the only nurse in this building but now it's as though I'm not good enough*". ***Nurse***

Feelings of resentment surfaced as Nurses perceived that it was the constraints of the CH environment that limited their opportunities to learn and develop as this nurse describes

> *"Our skills are deteriorating, you see. Yeah, we've been stuck in the home. We have less training. We have less… How do you call it? Experiences from outside this kind of set up"* ***Nurse.***

Some nurses and carers did acknowledged the opportunities that having a TACP offered for updating and expanding their skill set. However, it did not escape some CHM's notice that any training provided by the TACP could have been brought in directly without the need for a new role that could erode existing members of staff jobs and skills. This is an area that needs careful consideration and management as staff morale was quite low and it was essential not to in this CHM's words *"de-skill or erode the role of the nurse in the care home"*.

In sum, the impact of introducing the ACP role into CH's was largely positive with clear benefits to both residents and staff. The negative undercurrent of the potential to deskill and erode the moral of existing staff, needs sensitive consideration.

Conclusion: Points for consideration

In conclusion, the ACP role was introduced into CHs to improve the quality of care and the integration of health and social care. This study highlights several areas for consideration by others wishing to progress such roles.

There is no set pattern that will work for all care homes as many aspects of individual care homes are so variable e.g business model and ownership, size, level of care provided, funding, facilities (British Geriatric Society, 2021, p. 5.). Care homes can be a difficult working environment. This is reflected in the adjectives used by some people interviewed in this study to describe some aspects of the care home contexts into which these new TACP roles were introduced:

> "*stressful; strained; under-staffed; stretched; post-pandemic fatigued and emotionally drained; sparsely-nursed; time-pressured; heavy workloads; chaotic; hierarchical; personality-driven; blame culture*". *Project participants across all professional levels*

On top of this, workforce recruitment and retention issues at all levels in the care home sector, which were already an issue for many care homes before the pressures that Covid-19 added, can affect the functioning and quality of care in care homes (National Institute for Health Research, 2021). Despite these difficulties, there were also positive comments. For example, the quality of care provided, how hard care staff worked to maintain levels of care, even as they struggled with staffing levels. Contrary to prejudices about CH nursing, participants commented that CH nurses must be multi-skilled to manage a wide range of conditions and co-morbidities without immediate medical back-up.

Against the reality of the current CH context, this study highlighted several factors affecting the introduction, development, and implementation of the new ACP role and which may be relevant for other similar projects.

1. External context
2. Communication about the new role in the care home context
3. Barriers to fulfilling the four pillars of Advanced Clinical Practice
4. Identity of the employing organisation
5. Recruitment and retention

1. External context

The NHS system of primary and secondary care is complex with national, regional, and local variability in organisation types, processes, systems. These processes complicate co-ordination between CH and Healthcare systems and NHS/Private provision. For example, Thompson *et al.* (2020) p. 253 report on the difficulties ACPs in primary care face when they are expected to make referrals to secondary care but find secondary care providers will not accept referrals from ACPs. It can also change and during the lifetime of this project, most people in the NT CCG who had championed and funded this project were subsumed into the new NHS Integrated Care Board for the North East and North Cumbria on 1 July

2022.[10] Any endeavour to introduce the ACP role into CHs will take place in this ever-changing political context- where funding and structures may morph or change, and lead to lack of or lost clarity regarding who has the authority and who drives things forward (e.g move of CCG To ICB).

2. Communication about the new role in the care home context

The collaborative development of the TACP role would have benefitted from earlier, and more effective communication. This was evident at the collaborative stakeholder meetings which, when eventually undertaken, were effective at successfully communicating and disarming tensions. As discussed before, the NT CCG had designed the project so that role definition and scope of practice would evolve through the collaborative efforts of the stakeholders involved. University educators noted that uncertainty in the scope of practice of the ACP role was normal and consistent with what they saw in other areas such as primary care (e.g Thompson *et al*., 2019; Thompson *et al*., 2020) when a new ACP role was introduced. However, understanding by stakeholders that this would happen was lacking and initiation of the process did not start until half-way through the first year. Clear, simple, ongoing communication about the new distinct role is crucial in the context of high levels of staff turnover and high dependency on agency staff. This would have reduced some staff feeling resentful or threatened about the new role.

3. Barriers to fulfilling the four pillars of Advanced Clinical Practice

The ability of CH staff to support ACPs to work across all four pillars to their full scope can be constrained by workload pressures. Staff shortages and high turnover impacted the willingness and ability of staff in the care home to cope with change, such as a new role. Furthermore, unclear role boundaries and authority issues threatened some CHM and CH staff and diminished the ability of TACPs to fulfil the leadership role. The clinical, education and research pillars did not appear to present this type of conflict.

Some of what TACPs were 'doing', like taking over the GP/ward round, was already part of someone else's job that they did not necessarily want to relinquish. CH staff struggled to 'fit' the new role into the structure of the care home compared to similar roles they were familiar with[11]. This was compounded by the fact that the new role sometimes seemed not to be "doing" much (in a workplace where 'doing' can be highly valued given the workload pressures). Much of the early messaging from managers and TACPs about their role in the early days was about what they "could not do", as they tried to establish the boundaries of the role. This highlights the importance of early and consistent communication. Earlier timing of access to the 'Tools of the trade', such as access to NHS patient information systems and non-medical prescribing could have helped TACPs establish their new identity, boundaries, scope of activity and authority. However, these were not in place during much of the first year or even second year. Once

[10] (https://northeastnorthcumbria.nhs.uk/news/posts/icb-kick-starts-plans-to-support-communities-to-live-happier-and-healthier-lives/).

[11] Care staff in this study spoke of experiences with Nurse Practitioners and Advanced Nurse Practitioners they had previously worked with eg either substituting for GP on GP/ward round or otherwise attending from primary care. To the authors knowledge, only one other ACP role, employed by a care provider organisation, has been introduced in a care home (Boyd, Barron and Maule, 2019).

most staff realised what these 'tools' would enable the TACP role to do, some of their negative feelings transformed.

4. The identity of the employing organisation

There can be a perception that nursing and care in care homes is not as 'good' as in the NHS, although for those familiar with the care home context this is rejected. Study participants acknowledged that nurses, carers, and care in care homes are often 'looked down on' by staff working in the NHS. TACPs are more likely to be recruited from NHS backgrounds (as evidenced in this study-see Recruitment and employment). TACPs in this study, felt that recruitment information had been ambiguous (TACPs recalled phrases like "NT CCG in partnership with… ") and were surprised to find that they would be care provider employees, rather than CCG employees. TACPs perceived reputational, professional, and financial disadvantages as a CH employee, such as lower pay band levels, absent NHS Christmas bonus, and access to NHS pensions.

Access to primary care health systems and staff for training was also affected by the identity of the employer as time allocated to training ACPs by GP practiced based staff e.g. pharmacist needs funding (currently undertaken on a goodwill basis) as the funding streams were separate. Reconciling these factors can be problematic and needs to take account of the advantages being part of the CH team offers, for example, knowledge of and understanding of the care home and its residents. Some care home staff commented that if TACPs were employed by GP practices there was a risk they would be diverted into other duties. The employer identity may need careful consideration to encourage recruitment and retention.

5. Recruitment and Retention

In their study Wilson *et al.* (2020) found that there was a clear desire for workforce opportunities that would enable development of staff from within homes into new or expanded roles. Given the difficulties this project experienced with recruitment from within CHs, future projects may need to consider providing additional support and information tailored to the concerns of potential candidates e.g. whether the university will recognise and support the return to education, adjustment to new style of education and study.

Retaining qualified ACPs with enhanced skill and autonomous professional standing may be impeded if the existing tensions between CHMs and TACPs regarding control and authority, are not resolved. Furthermore, senior/ regional managers identified the need to ensure that during training and after qualifying, that the full range of ACPs training, skills, and experience could be implemented or risk ACPs seeking role fulfilment elsewhere. TACPs expressed a preference to be based outside the care home, regarding it as important to their emerging professional identity. The advantage of having a 'home base' included a place to meet and study, on the same basis of similar roles e.g. frailty nurses.

Study Limitations

This study was only able to include a very small number of TACP's in 4 CH's in a specific area of England so the issues raised here may not be relevant to other areas.

The eighteen-month research phase did not last for the duration of the TACP three-year training period which meant that the research captured a snapshot in time for participants.

Unfortunately, the survey data yielded a very low response rate which prevented inclusion in the study findings.

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Appendix 1. Care home context

A search of the Care Quality Commission webpage Find and Compare services lists 4,267 nursing homes in 2023 (residential care homes do not provide nursing care to residents whereas nursing homes do) (Care Quality Commission, 2023). Twelve of these are located within the NT CCG boundaries, currently run by a mix of seven care providers and one local authority home (the ownership of the care provider organisations is a mix of private equity and private or family-owned businesses). The TACP role is being piloted in nursing homes within the North Tyneside CCG area.

Care homes are required by regulators (CQC) to staff with suitably, qualified, and experienced people to meet the needs (dependencies) of the residents. A typical care home in this study might provide a home for 50 residents (50 beds), split into nursing and residential wings/floors. The nursing wing will typically have one nurse on duty (24 hours a day), with one Care Home Assistant Practitioner (CHAP) and three carers during the day. The residential floor may be staffed by one senior carer and two carers. In addition, there may be activity co-ordinators, kitchen staff, cleaning staff, maintenance staff. The total workforce of such a care home would be about 45 if fully staffed. Not all care homes are fully staffed and care homes rely on using temporary staff (bank staff) to fill absences and vacancies (particularly during outbreaks of covid). Although staff turnover and vacancy rates in care homes decreased during the pandemic, both have increased again[12].

External events also affected care home and health care staff significantly during this period with Covid-19 pandemic affecting staffing sickness levels, staffing levels, working hours, staff turnover, workplace stress and morale[13] on top of concerns about staff recruitment issues related to the UKs exit from the EU (Brexit) on 31 December 2020[14]

[13] Beyond COVID: New thinking on the future of adult social care. Negative impacts of COVID-19 on social care. (2020). Negative impacts of COVID-19 on adult social care (scie.org.uk).
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[14]There was considerable concern that Brexit would deepen recruitment difficulties in the sector. England is facing another needless Brexit disaster: care home staff shortages | Simon Jenkins | The Guardian. Before Brexit, turnover in the sector was already higher than the national average (39.4% in care homes with nursing cf. to a sectoral rate of 29% with a national average around 15% in 2019/20) The State of the Adult Social Care Sector and Workforce 2021 (skillsforcare.org.uk). After Brexit, EU workers could no longer be recruited to work in care homes as they generally earned below the £25,600 threshold for skilled workers. Existing EU care workers were eligible to apply for settled status. In 2020/21, 84% of the adult social care workforce identified as British, 7% as having EU nationality and 9% as having non-EU nationality The State of the Adult Social Care Sector and Workforce 2021 (skillsforcare.org.uk), p. 84. In February 2022, care workers were added to the shortage occupation list and are therefore became eligible to apply via the Health and Care worker visa route. Providing workers exceed the £20,480 salary threshold and have a licenced sponsor, they can come to the UK to take up care worker jobs.