NORTHUMBRIA UNIVERSITY

An integrated system based approach to workforce development for Enhanced Care for Older People with Complex Needs

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Acknowledgements

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1: Background

The national Vanguard initiative was set up to identify and test new care models with the purpose of developing blueprints for the transformation of National Health Service (NHS) community and primary services in England (NHS England, 2017a). One of the five types of Vanguard is Enhanced Health in Care Homes. These programmes recognise that care homes are caring for older people with increasing levels of frailty, disability and multi-morbidities; and who are highly dependent, have complex conditions including dementia, have limited functional reserve, and require end-of-life care (Salisbury et al, 2011; Barnett et al, 2012; Cornwell, 2012; European Commission, 2015). The Enhanced Health in Care Homes programmes aim to make health services for care home residents more accessible, cost effective, and tailored to their needs, so that quality of life and quality of care is improved and unnecessary hospital admissions are avoided.

In recent years, the Gateshead Care Home programme has provided enhanced healthcare in care homes through integrated multi-sector working. This involves aligning general practitioner (GP) practices and older people nurse specialists (OPSNs) to care homes. This allows these care homes to access multi-disciplinary community virtual wards, and wider health and social care services. Locally, this multi-disciplinary approach is leading to improved quality of care, and reductions in avoidable hospital admissions. These positive outcomes led to the Gateshead Care Home programme becoming a Vanguard Enhanced Health in Care Homes site, enabling it to build and develop this model of care (NHS England, 2017b).

The Gateshead model cuts across traditional health and social care boundaries and focuses on transforming the whole system. This involves developing new care pathways and systems/services for care delivery, so that high quality care for residents can be provided. This transformation requires a workforce that is highly competent, and appropriately skilled.

An initial research study was commissioned by Newcastle Gateshead Clinical Commissioning Group (CCG) in early 2016 (Cook et al, 2016). The aim of this study was to explore the experiences and competencies of the current Gateshead Care Home workforce team to inform workforce development for the delivery of the Gateshead service model. The findings of this study suggested a need for a workforce competency framework that is standardised and integrated**,** specific to the needs of residents, and covers the whole workforce from those providing essential care to specialist and advanced practice levels. As a consequence, Newcastle Gateshead CCG commissioned the development of a workforce

competency framework for Enhanced Care for Older people with Complex Needs (EnCOP) (Thompson et al, 2017).

Development of the EnCOP workforce competency framework

The emphasis on competency rather than on role allows the framework to be both standardised and flexible, enabling it to encompass and support the development of all health and social care personnel who provide services for residents, regardless of role, or employing organisation. The purpose of competency frameworks is to provide a system-wide coherent approach to: determining what competencies are required within the workforce; identifying 'competency gaps'; identifying, commissioning, and providing learning opportunities, education programmes and assessment processes to support competency development; developing clear career progression opportunities and pathways within and across organisations; facilitate the adoption of high quality practices; pursue innovative service strategies, and informing service users what competencies they should expect staff to have (Staron, 2008; Roche, 2009; McNall, 2012).

The most effective competency frameworks are co-produced by practitioners and educationalists/academics (Anema and McCoy, 2010). The ENCOP framework was developed via a collaborative process involving academic staff from Northumbria University with expertise in the care of older people and workforce development, and practitioner stakeholders with expertise and experience in providing care for older people and care home residents with complex needs.

The study design consisted of two interrelated stages. Stage one involved the development of a draft workforce competency framework by a team of researchers from Northumbria University. This involved:

- review of existing workforce competency research literature relevant to the care of older people
- analysis of existing competency frameworks that have relevance to the care of older people
- discussions with the multi-disciplinary, multi-sector Care Home Vanguard 'Pathways of Care' (PoC) team from Gateshead and Newcastle localities to identify competencies required at each practice level (essential, specialist and advanced). The PoC team consists of representatives from a wide range of health and social care professionals and organisations. The aim of the team is to improve healthcare services for local care home residents and their families by identifying practice areas

requiring improvement, then designing, implementing and evaluating new care delivery models to address these improvement needs.

Stage two involved a stakeholder workshop to discuss the draft framework, and to provide an opportunity for attendees to contribute their views on its further development. Attendees numbered 65 and represented a broad range of professions and service-users, and stakeholder groups from the NHS, private and voluntary care sectors.

The involvement of individuals from a range of groups ensured that many perspectives were brought to the discussions. This was important, as care homes are located at the intersection of health and social care, and public, private and voluntary sector care services – locations where cross-organisational working and the enabling of seamless transitions across services is essential.

Structure of the EnCOP workforce competency framework

The framework consists of four inter-related domains, and each domain is comprised of sets and subsets of competencies:

A: Values and attitudes: Includes values and attitudes competencies; and also includes competencies requiring staff to be aware of their own values and attitudes, and acknowledge that residents and their families and friends will have their own sets of values and beliefs that influence their choices and decisions.

B: Workforce collaboration, co-operation and support

B1: Inter-professional and inter-organisational working and communication: Includes competencies requiring staff to engage in inter-professional and inter-organisational working and communication, and develop collaborative, co-operative working relationships with all members of the care team.

B2: Teaching, learning, and supporting competence development: Includes competencies requiring staff to acquire and maintain evidence-based knowledge and skills, and support others in the development of knowledge and skills on an ongoing basis in order to increase scope of practice and ensure a highly competent workforce.

C: Leading, organising, managing and improving care

C1: Leading, organising and managing care: Includes competencies requiring staff to use principles of leadership, organisation and management in order to facilitate provision of safe, effective and efficient practice. This involves engaging with care systems and clinical governance, and managing services and resources including staffing and skill mix. Staff also

require competence to understand, negotiate and apply contractual and financial arrangements to maximise sustainability of services.

C2: Improving care: Includes competencies requiring staff to be committed to service improvement, by engaging with assessment, monitoring and evaluation of services, service improvement initiatives, evidence-based practice and research, and by early adaption and adoption of change.

D: Knowledge and skills for care delivery

D1: Communication with residents, families and friends: Includes competencies requiring staff to use a range of communication methods to support safe, quality care decisions that account for residents' preferences and choices.

D2: Care process:

D2.1: Assessing, planning, implementing and evaluating care: includes competencies requiring staff to engage in ongoing comprehensive assessment, planning, implementation and evaluation of individual resident's health and care needs. This requires having in depth knowledge of common health problems within their own level of practice, and competencies in carrying out a range of diagnostic and clinical interventions, monitoring progress against expected outcomes, and amending care plans where necessary.

D2.2: Pharmacology and management of medicines: this sub-domain highlights the requirement for competency in pharmacology relating to older people.

D3: Promoting health, wellbeing and independence

D3.1: Promoting and supporting independence and autonomy

D3.2: Promoting and supporting holistic health and wellbeing

Includes competencies requiring staff to promote residents' health, wellbeing and independence by providing enriched environments which accommodate residents' choices about their life, health and activities, and their decisions about end-of-life. Also included are competencies to facilitate equal access to health services, self-care, healthy lifestyle choices, and rehabilitation and reablement opportunities; and risk management, and effective utilisation of the Mental Capacity Act, best interest decisions, and safeguarding. The following sub-domains include additional competencies required to meet the specific needs of residents with particular problems:

D4: Management of dementia (these competencies are in addition to D1,2 and 3)

D5: Management of mental health (these competencies are in addition to D1,2 and 3)

D6: Management of frailty (these competencies are in addition to D1,2 and 3)

D7: End of Life care (these competencies are in addition to D1,2 and 3).

Although all domains and competencies are inter-related, findings from the literature review and analysis of the discussions from the PoC meetings highlighted that the ability of staff to deliver quality care very much depend upon a whole workforce ability to:

- Establish and maintain a culture of compassionate, relationship-centred values and attitudes.
- Work collaboratively, co-operatively and supportively.
- Lead, manage, organise and continuously improve systems of care, and sustain these improvements.

When developing the framework, the decision was made to emphasise these core workforce requirements by creating domains that comprise of competencies that specifically address these (domains A, B and C). These domains precede domain D because the study findings suggest they are prerequisites for the development of knowledge and skills for care delivery, and quality, seamless care delivery practice. In other words, having knowledge and skills in care delivery is not enough on its own. Practitioners need to have the right values, be able to work together, and lead and improve care if the care delivered is going to be effective.

Figure 1: Competency domains for a care home workforce

Levels of practice

The framework includes three competency levels: essential practice, specialist practice and advanced practice. The competency levels are progressive and cumulative i.e. as levels advance, they integrate and expand upon competencies from the preceding level. Some individuals may have competencies from more than one level. For example, a registered nurse working in a care home may have all essential practice competencies and some specialist practice competencies; a care home manager, an OPSN or a GP may have most specialist practice competencies and some advanced practice competencies. By comparing existing competencies and competency levels with the framework, areas for development can be identified. On an individual basis, this knowledge can support personal development and career progression.

On a whole workforce basis, this knowledge can support understanding of workforce education and development needs and workforce planning.

B: Workforce collaboration, co-operation, communication and support			
B1: Inter-professional and inter-organisational working and communication	In order to provide integrated, seamless care for older people that is relationship-centred and values personhood, it is essential that all individuals involved in the care of older people are able to work together towards a shared philosophy of care that extends across the whole system. Inter-professional and inter-organisational working and communication underpin integrated care. Staff need to develop, engage in, and sustain collaborative, co-operative working relationships with all members of the care team, including older people, families and friends.		
	Essential practice	**Specialist practice**	**Advanced practice**
	Commit to a shared philosophy of care that extends across the whole system.	Commit, implement and facilitate a shared philosophy of care that extends across the whole system.	Lead, develop and maintain a shared philosophy of care, and develop and implement strategies to embed it across the whole system.
	Aware of, respect and value, the scope and practice of the roles and responsibilities of staff, agencies and organisations, and local referral arrangements. Use this awareness to ensure appropriate, safe, effective, timely, efficient referrals that support relationship-centred care and promote personhood, and contribute to the seamless transfer of care between services.	Work inclusively, using, valuing, and embedding into practice, the full scope of knowledge, skills and abilities of staff from a range of agencies and organisations to provide care that is safe, seamless, timely, effective, efficient and equitable.	Effectively lead/chair multi-disciplinary meetings. Include, integrate, and value, the knowledge, skills and experience of a range of staff, agencies and organisations to inform workforce skill mix, and practice development and improvement.
	Understand own role and recognise role limitations. Use this understanding to make decisions about when to practice autonomously and when to collaborate with, and refer to,	Evaluate the appropriateness of autonomous practice and/or collaborative practice to meet older people's needs and wishes.	Proactively collaborate with health and social care providers, patient groups, local authorities and voluntary organisations to ensure engagement in improvement strategies for services across the

Figure 2: Example of a page from the EnCOP framework

2: Aims and objectives of 'assessing the state of workforce competency'

The knowledge, skills and competencies required across the whole workforce have been agreed, culminating in the collaborative development of the EnCOP competency framework (Thompson, et al 2017). The current project, aimed to understand the current state of workforce competency in the Newcastle Gateshead area to inform future strategic workforce development within the regional Sustainability and Transformation Plan (STP). This was achieved by addressing the following objectives:

1. Develop understanding of the existing competencies of care home staff and NHS professionals working in 2 pilot care homes by mapping staff against the relevant level of the EnCOP competency framework (gap analysis) to understand workforce development need and priority areas for development.

2. Develop understanding of capacity, capability and agreement for cross system practice based learning and assessment through; the identification and development of staff from different organisations within the pilot sites as mentors/practice based supervisors/ assessors of competence, and collaborative exploration of the agreements/policies needed to enable cross system learning and assessment.

3. Engage employers in the sector (including care homes, foundation trusts, community teams, local authority, social care provider organisations) in collaborative exploration of the findings, identified priorities, proposed workforce competency development solutions and sustainable funding options including the apprenticeship levy, HEE Continuing Workforce Development (CWD) monies and the European Social Fund (ESF).

3: Methodology and methods

To address the above aim and objectives a mixed method study informed by collaborative action research was undertaken. The primary purpose of action research is to bring about change in specific situations, in local systems and real world environments, with the aim of solving real problems, which was the intention of this project. A core principle of collaborative action research is that researchers collaborate with practitioners and other stakeholders, and research with, rather than on the researched, and embed the perspectives of key stakeholders within resulting change. Aspects of a model developed by McNall (2012) guided the process (please see Figure 3).

Figure 3: Workforce development approach (McNall, 2012)

This model commences with defining the knowledge, skills and competencies required of the current and future workforce. This was achieved by the development of the EnCOP framework (Thompson et al, 2017). Following this, the competencies of the workforce are mapped across all sectors and professional groups delivering services to a specified population. This generates knowledge of what competencies and gaps exist. Through

stakeholder collaboration, solutions to address gaps are developed. The findings provide an evidence base that underpins future workforce planning which is integral to the Sustainability and Transformation Plan (STP) following completion of the Vanguard programme.

The study had 2 phases. Phase 1 had 2 parallel strands – strand 1 sought to develop knowledge of competencies of care home and NHS staff working in 2 pilot care home sites, and strand two explored with key stakeholders the issues that need to be addressed and agreed to achieve cross system agreement for mentors/assessors to operate across organisational boundaries (addressing objectives 1 and 2). In phase two recommendations for a workforce strategy and delivery plan were developed with health and social care employers and commissioners (addressing objective 3).

Research ethics approval to undertake the study was secured from the Faculty of Health and Life Sciences, Northumbria University on 14 December 2017.

3.1 Phase 1, strand 1: competency gap analysis

A competency gap analysis was undertaken to identify existing workforce competency, and identify workforce development need and priority areas for development. This was achieved by using data collection methods to map participants' competency against the relevant level of the EnCOP competency framework. Data was collected via 2 methods:

Method 1: competency survey

Method 1 data collection: 3 online survey tools were developed reflecting the three competency levels included in the EnCOP workforce competency framework (i.e essential, specialist and advanced levels). Participants were required to complete the survey they felt was relevant to their competency level. The surveys were 2-part. The first part was common to all 3 surveys and collected quantitative data including: demographic information; consideration of role, experience, personal and professional development; access to education, training, statutory and mandatory updating; support, appraisal and supervision; perceived workforce competency need; preferred learning approach; existing and required infrastructure to enable practice based learning and assessment of competence. The second part of the surveys were specific to the 3 competency levels and required participants to record their perceived competence and confidence against the relevant competencies within the EnCOP framework on a scale of 1 to 5 – 1=not sure what this means; 2=not at all competent; 3=not very competent, 4=somewhat competent; 5=very competent (web links to the surveys are provided in appendix 7.1).

Method 1 sample: The study was located within the geographical area served by Newcastle Gateshead CCG. In total, there are 81 care homes within this area. Inclusion criteria for the study care homes were:

- Mixed registration status (residential, nursing, and/or EMI).
- Offer services to older people with complex physical, cognitive and mental health problems.
- Offer student nurse placements (in order to explore the potential requirements for sustainable future workforce).

After applying the inclusion criteria, the sample population was 22. Members of the Newcastle Gateshead Vanguard Pathway of Care team who work with these 22 care homes identified homes in which staff were likely to be in a position to make the significant commitment that will be required for participation. A sampling matrix using a purposive sampling approach was applied to the responding care homes. The criteria for the sampling matrix included homes in different localities, variety of health and social care professions working in the homes, and variety of competency levels of staff (i.e. essential, specialist and advanced levels). From the sampling matrix, 2 care home pilot sites were identified. In total, 122 health and care staff work in and into the pilot care homes.

The surveys were circulated as both online and pdf hardcopy surveymonkey questionnaires to care home managers and Older Person Specialist Nurse team leaders. Managers and team leaders were asked to distribute the surveys to staff, and participating staff chose the survey which they felt was most relevant to their competency level. To enhance the response rate, members of the research team visited the care homes to raise awareness of the questionnaires. This resulted in a total of 36 responses – a 30% response rate: 10 health care assistants, 4 nursing assistants, 3 care home management team (2 registered nurses, 1 non-nurse), 9 OPSN Band 6, 5 OPSN Band 7, 3 registered nurses, 1 GP, 1 allied healthcare professional. All health care assistants and nursing assistants, and the non-nurse management team member completed the essential level questionnaire (n=15). All RNs, 8 OPSN Band 6, 4 OPSN Band 7 and the OT completed the specialist questionnaire (n=16). Both management team nurses, the GP, 1 OPSN Band 6 and 1 OPSN Band 7 completed the advanced questionnaire (n=5). Although the response rate was low, this rate is not unusual for external surveys (Gray et al, 2017).

Method 2: observation of practice

Method 2 data collection: Members of the research team who have in depth knowledge of the EnCOP framework observed participants' practice using an observation survey tool. This

tool was used to collect quantitative data to identify and record observed levels of competence and confidence against the relevant EnCOP framework for each participant. The tool was supplemented with observers' notes used to record examples of observed practice that illustrated competency levels. In order to check interrater reliability, all research team members involved in the observations used the tool to assess a simulated ward round prior to using the tool during the study (a copy of the observation tool is provided in appendix 7.2).

Method 2 sample

All health and care staff working in and into the pilot care homes were informed about the observation study and invited to take part. Staff that agreed to participate were requested to sign a consent form. During the observation periods, individuals who were not participants were sometimes present (for example, staff who did not wish to be participants in the study, and residents/families). The researchers asked these individuals' permission to observe participants' practice in their presence, and made it clear that only observations of participants would be recorded. 21 episodes of observation of practice involving 71 individual health and care workers took place. These included 26 health care assistants, 3 nursing assistants, 4 OPSN Band 6, 10 OPSN Band 7, 11 registered nurses, 2 allied healthcare professionals, 5 GPs, 6 consultants, and 4 care home management team (all RNs). In line with questionnaire participants' self-reported competency category, health care assistants and nursing assistants were mapped against essential level competencies, and GPs and care home nurse management team members were mapped against advanced level competencies. In line with all RNs, allied healthcare professionals and the majority of OPSN questionnaire participants, RNs, AHPs and OPSNs were mapped against specialist level competencies. Consultants did not complete questionnaires so the research team decided to map consultants against the advanced level.

Strand 1 data analysis

Data from the questionnaires completed online were imported into SPSS, and data from the hardcopy questionnaires and observation tools were entered manually into SPSS in preparation for inferential and descriptive statistical analysis. For consistency, part 2 of the advanced level questionnaires completed by the 2 OPSNs were removed from the data set, and part 1 was transferred to the specialist level data set.

Descriptive frequency analysis was used to analyse part 1 of the questionnaires. Part 2 of the questionnaires was analysed as follows:

- The questionnaires required participants to self-rate their competence against each individual competency of the EnCOP framework. Competencies ratings within each domain/sub-domain were calculated via mode. This method was chosen as it was considered to be consistent with the method of rating observations i.e researchers rated practice according to most common competency levels observed within each domain/sub-domain.
- A Mann-Whitney U test was used to compare differences between self-reported and observed domain/sub-domain competency ratings. Consultants were not included in this comparison of difference as they did not self-report. Likewise, the non-nurse management team member was not included as no observations were undertaken of this participant. There were no statistical significant differences between the self-reported and observed data sets, except essential level 'improving care' whereby self-reported competency (mean rank = 18.64) was found to score statistically significantly higher (U = 54, p = 0.018) than observed competency; and specialist level 'teaching, learning and support' whereby self-reported competency (mean rank = 23.63) was found to score statistically significantly higher (U = 54, p = 0.000) than observed competency. The data sets were therefore combined, but the significantly higher self-reported data for essential level 'improving care' and specialist level 'teaching, learning and support' were removed.
- Mann Whitney U tests were used to compare differences in pilot site competency, and differences in NHS/non-NHS competency.
- Spearman rho correlation calculations were used to determine possible relationships between highest academic level and competence, and to determine possible relationships between competence in interprofessional working and clinical competence; teaching, learning and support and clinical competence; and leadership, organization and management and clinical competence.
- Domain/sub-domain ratings 2-5 were assigned nominal numbers, and means and standard deviations were calculated (rating 1 'not sure what this means' was not included in these calculations). This facilitated descriptive analysis of the workforce and identification of priority areas for competency development for competency level (essential, specialist and advanced) and role.

3.2 Phase 1, strand 2: stakeholder perspectives of cross system assessment of competency and proficiency

An area of specific relevance to this current project is the development of capacity within Newcastle and Gateshead care homes for the supervision and mentoring of staff, and capability to assess competence. This is an emerging and ongoing area of development which includes consideration of the use of accreditation of prior learning (APEL) to recognize prior learning and meet the mentor standards (NMC 2008) to become registered mentors. In acknowledgement of this ongoing workforce development, the following methods were applied to develop knowledge of the existing situation and explore barriers and facilitators to progress:

Method 1

The identification and development of staff from different organisations within the pilot sites as potential or actual mentors/practice based supervisors/assessors of competence.

Method 2: stakeholder interviews

Method 2 data collection: The original plan was to complete uni-organisation focus group interviews with professionals from care home, NHS and social care services who have responsibility for staff learning and assessment. While individuals were keen to participate, however existing commitments limited availability to take part in group interviews. The research methods were therefore adapted to include dyad and individual interviews as well as uni-organisational group interviews. Focus group interviews are conducive to promoting rich discussion and sharing of experiences between participants. The uni-organisation group interviews enabled staff from each organisation to articulate their own perspectives. In contrast, and complementary to the group discussions, individual interviews facilitated in-depth discussions of particular situations that occurred with regard to competency development and assessment. During the interviews, issues that need to be addressed to achieve cross system agreement for mentors/assessors to operate across organisational boundaries were explored. Also options for preparation of supervisors and practice-based assessors were discussed.

Method 2 sample

Professionals from a wide range of care home, NHS and social care organisations across the North East region who have responsibility for staff learning and assessment were identified and invited to attend an interview. In order to optimise participation in the study, these interviews were held within participants' work places. Staff that agreed to participate

were requested to sign a consent form. In total 29 individuals agreed to participate in the study and all were interviewed. Interview methods were 2 focus group interviews (n=9 and n=10), 2 dyads and 6 individual interviews. Individuals from 6 care home organisations, the NHS, and a local authority took part:

Care home organisations:

- 2 x operational managers
- 12 x care home managers
- 1 x clinical lead nurse
- 2 x practice development nurses

Local authority:

- 1 x social worker

NHS:

- 2 x GPs
- 1 x consultant geropsychiatrist
- 1 x nurse consultant for older people
- 3 x OPSNs
- 2 x clinical educators
- 1 x lead nurse (quality)
- 1 x nurse lead (Vanguard)

In order to maximise confidentiality, when reporting data in the form of participants' verbatim quotes, their employing organisations only are given.

Strand 1, method 2 data analysis

Audio recordings were made of the focus group interviews. The audio recorded data was transcribed verbatim, and was then open coded by individual members of the research team. This allowed elucidation and description of the participants' experiences of competency assessment, while creating meaningful themes. Thematic analysis was chosen as it is 'a method for organising, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail' (Braun and Clarke, 2006, p.79). The approach taken was inductive, in other words the analysis was data driven, rather than theory driven. The 6 phase guide to conducting thematic analysis, as outlined by Braun and Clarke (2006) was used. This process has the following phases: familiarisation with the data; generating initial codes; organisation of the initial codes into patterns to generate themes;

reviewing themes; defining and naming themes; interpretation. During this process, all transcripts were then independently coded by another team member, and the outcomes were compared with the original coding to validate themes. A further level of rigour was inbuilt into the data analysis process through discussing preliminary themes emerging from data analysis with workshop participants in phase 2 of the study.

3.3 Phase 2: stakeholder perspectives of developing a workforce development strategy

Data collection

Two stakeholder workshops were attended by employers and commissioners in services providing care for older people. These were held on 9 February 2018 and 12 February 2018. Two workshops were held to maximize opportunities for participation. The workshops provided a forum to explore the findings from phase 1, and exploration of issues regarding the existing and required infrastructure for practice based learning and competency assessment. The workshops also provided opportunity for participants to make recommendations for a workforce development strategy, workforce development solutions, and options for sustainable funding options of identified solutions. All participants were also encouraged to record their views on post-it notes as the discussions progressed. This provided a further opportunity to capture individual views. Summary points from the group discussions were recorded on flip charts by members of the research team.

Sample

Invitations to take part in the workshops were distributed by the Gateshead Vanguard team and the research team. Invitations were distributed to the following categories of potential participants across Tyne and Wear, North Tyneside and Durham:

- Workforce leads in Newcastle Gateshead CCG
- Community team managers
- Community teams linked with the Pathways of Care of the Newcastle Gateshead Vanguard programme
- Commissioners of services for older people
- Integration lead in Local Authorities
- Care home managers in Gateshead and Newcastle
- Regional managers from care home companies
- Health Education England (education commissioners)
- NHS England North, Director of nursing/independent sector, regional lead

Individuals that agreed to participate were requested to sign a consent form. In total 23 individuals agreed to participate in the study representing 16 organisations (including care home companies, CCG's, commissioning, NHS services, Local Authorities). The involvement of employers from different organisations ensured that diverse perspectives were brought to the discussions.

Data analysis

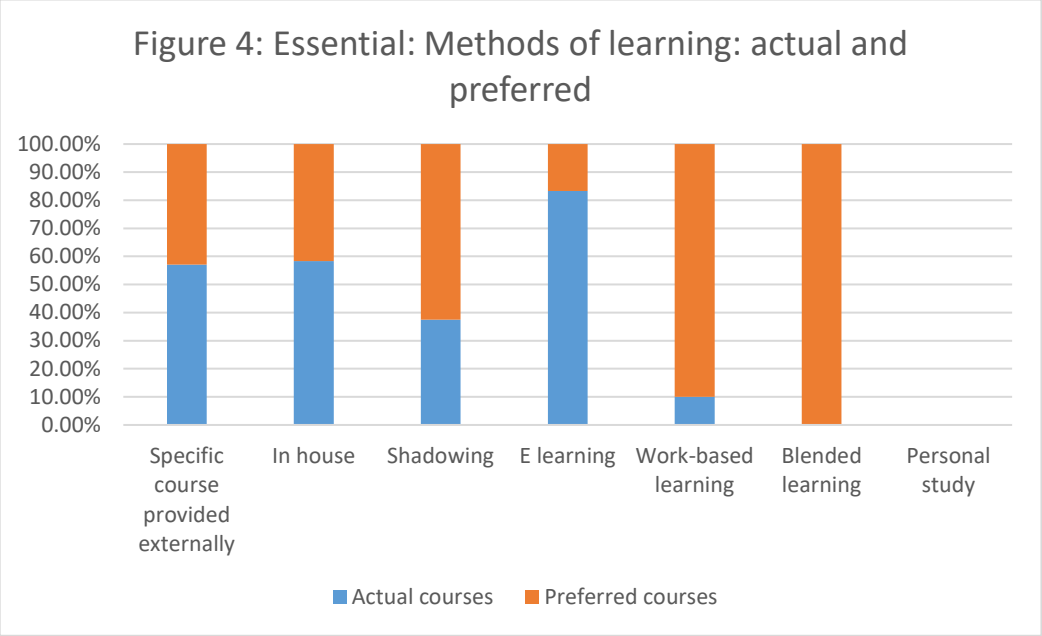
Data collected via post-it notes and flip charts was transcribed in preparation for analysis. Content analysis was used to systematically categorise the data and capture the themes and main ideas expressed during the group activities (Mayring, 2000).

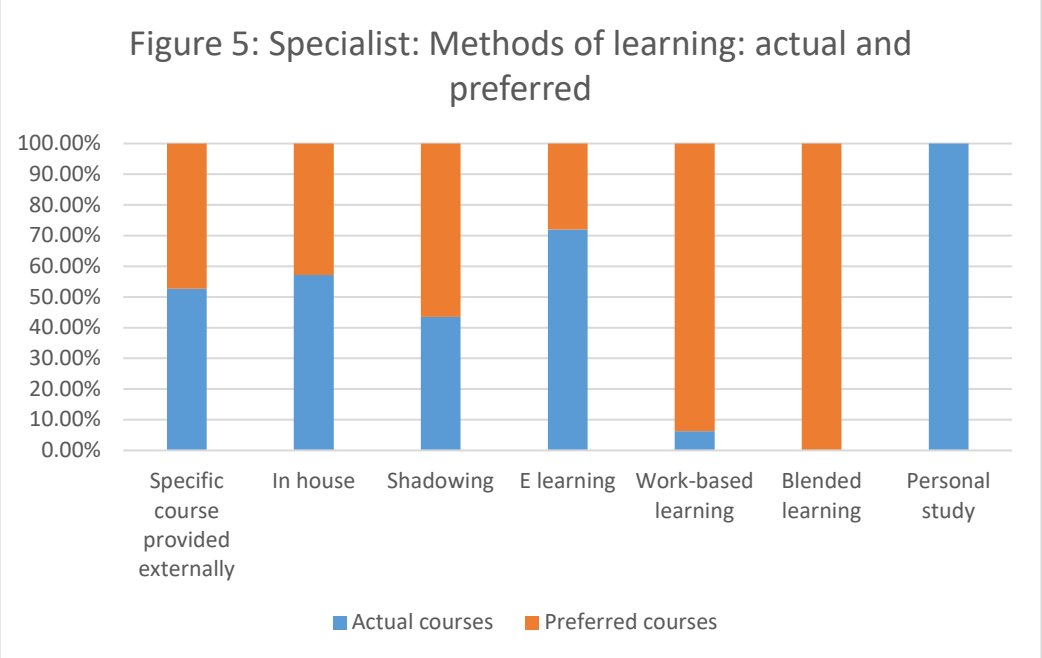
4: Findings

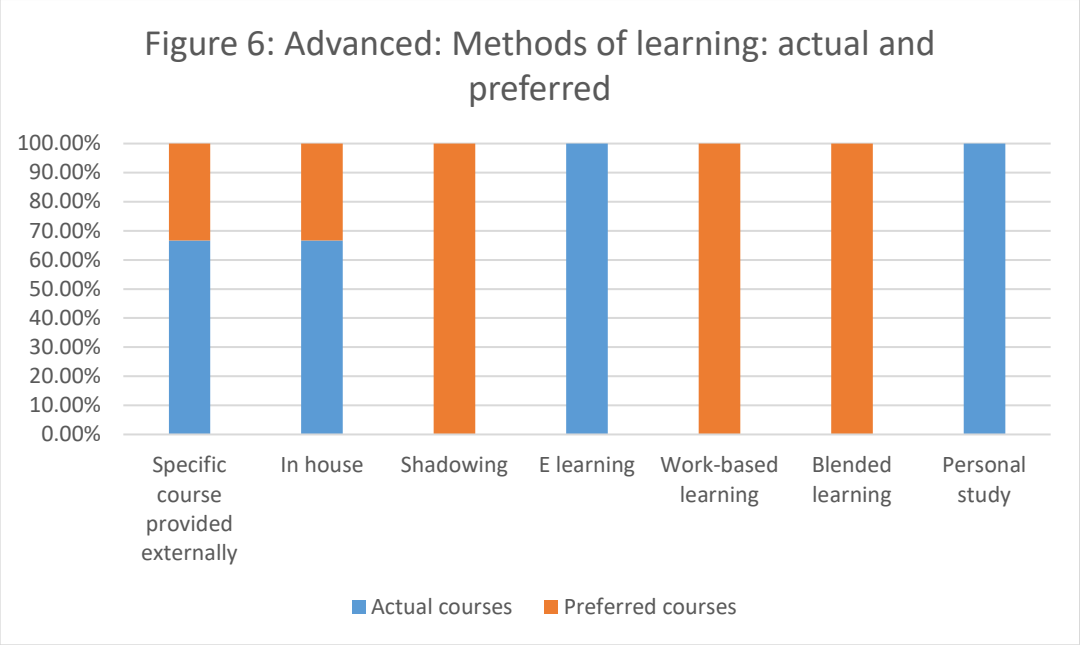
4.1 Phase 1, strand 1

Learning

Participants were asked about their actual and preferred methods of learning. The following figures illustrate these methods at each competency level:







The findings show that:

- External and in-house learning rates were between 50% and 65%, but preferred rates were between 30% and 50%.
- Shadowing rates were between 0% and 50% but preferred rates were between 50% and 100%.
- E-learning rates were between 80% and 100% but preferred rates were between 0% and 30%.
- Personal study rates were between 0% and 100% but were not preferred by any group.
- Worked based learning rates were between 0% and 10% but this was a highly popular learning method with preferred rates between 95% and 100%.
- Blended learning was reported by participants not to occur, but all participants said this would be a preferred learning method.

The results suggest that preferred methods of learning and professional development are not reflected in available programmes of learning or support. However, during observations of practice, it was apparent that work-based learning does occur during the virtual ward rounds (discussed below). It may be that participants did not recognize this as a learning experience.

Participants were asked about engaging with learning and professional development. The following figures illustrate these concerns at each competency level.

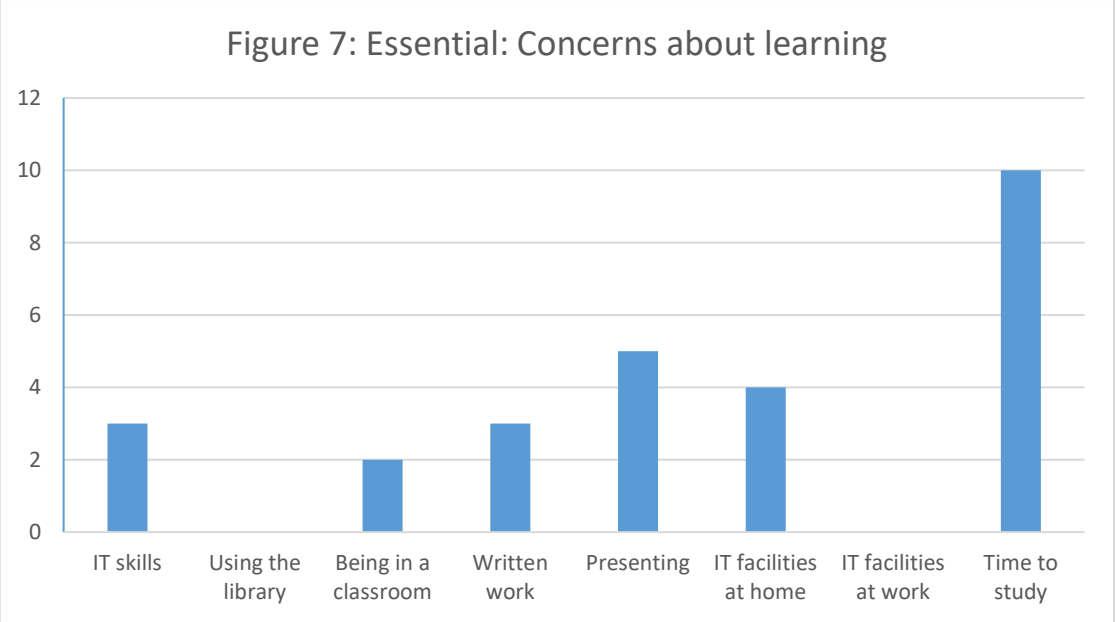


Figure 7: Essential: Concerns about learning
12
10
8
6
4
2
0
IT skills
Using the library
Being in a classroom
Written work
Presenting
IT facilities at home
IT facilities at work
Time to study

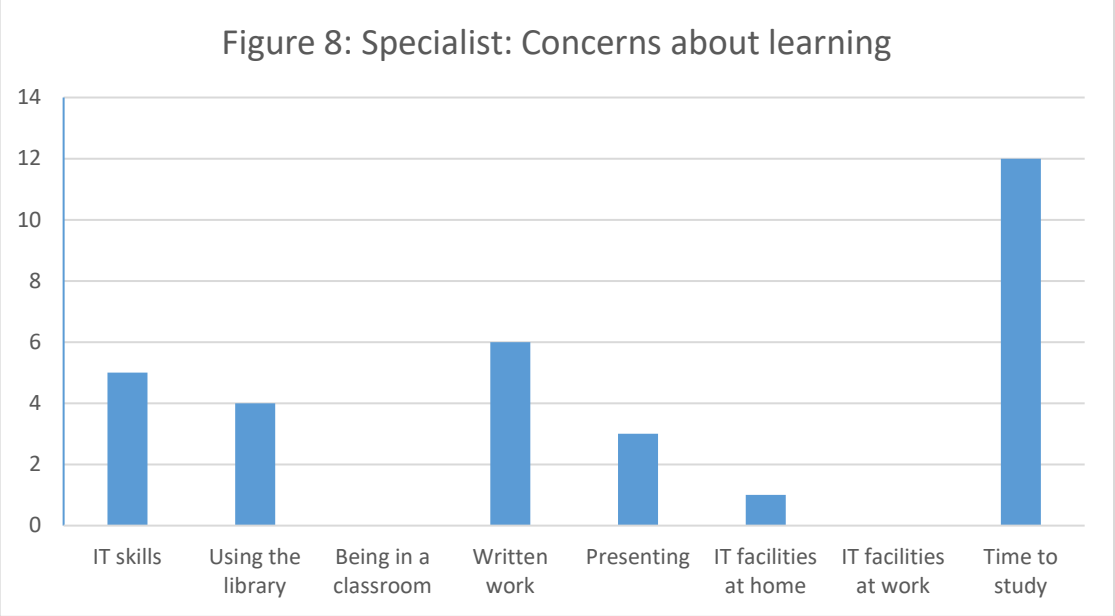
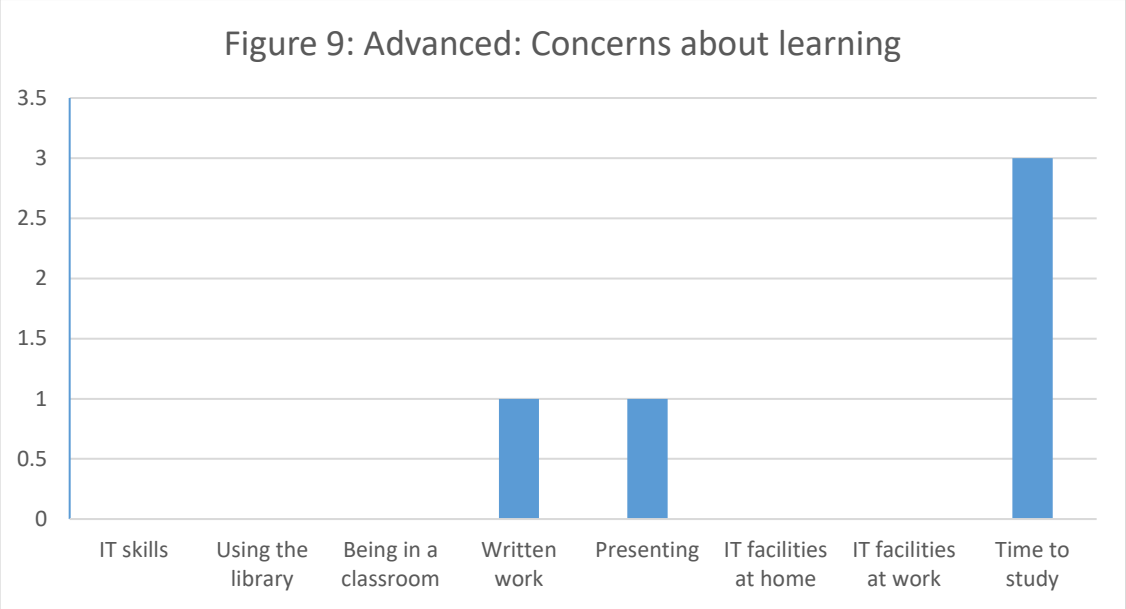


Figure 8: Specialist: Concerns about learning
14
12
10
8
6
4
2
0
IT skills
Using the library
Being in a classroom
Written work
Presenting
IT facilities at home
IT facilities at work
Time to study



Time to study was a major concern for all groups with between 83% and 100% of participants expressing concern. Although the advanced group were not concerned about IT skills or facilities, between 25% and 35% of essential and specialist groups were, and for 7% to 33% of essential and specialist participants, accessing IT facilities at home was a problem. 17% of essential level participants expressed concern about being in a classroom; between 25% and 43% of all groups were concerned about written work, and between 21% and 42% of all groups were concerned about presenting.

These results suggest that concerns about using IT/accessing IT at home (essential; specialist) may contribute to why e-learning is unpopular. Also, concerns about time to study and written work/presenting even at specialist and advanced levels may contribute to why work-based and blended learning are popular options (ie practical learning/assessment, aspects of which could be integrated within the working day).

Participants were asked whether a recognised qualification in the care of older people with complex needs was important. The following figures show the responses at each competency level:

Figure 10: Essential: Importance of a recognised qualification in care of older people with complex needs

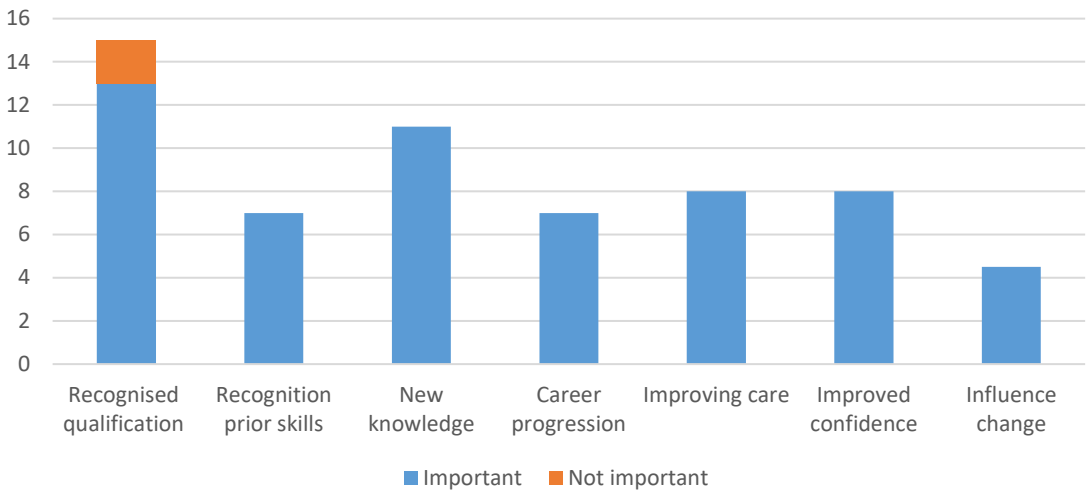
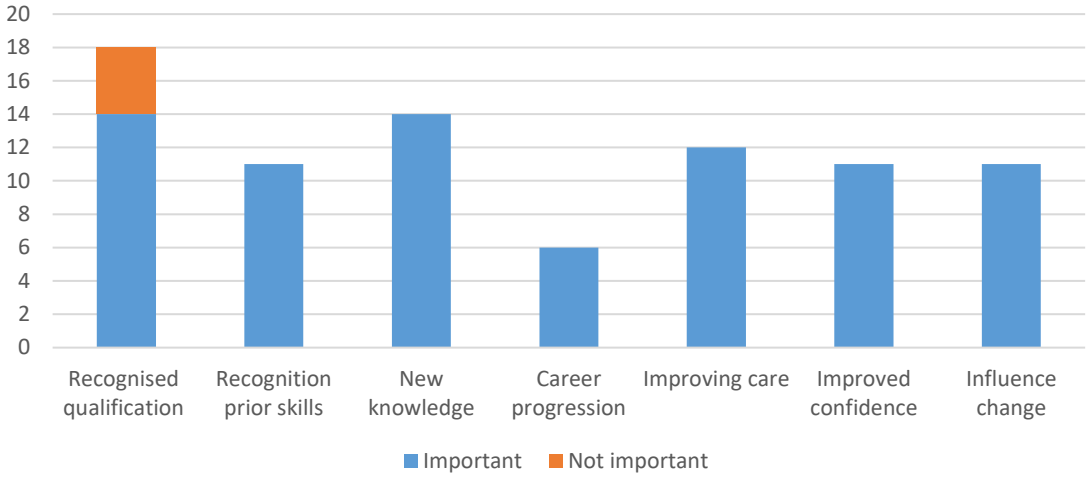
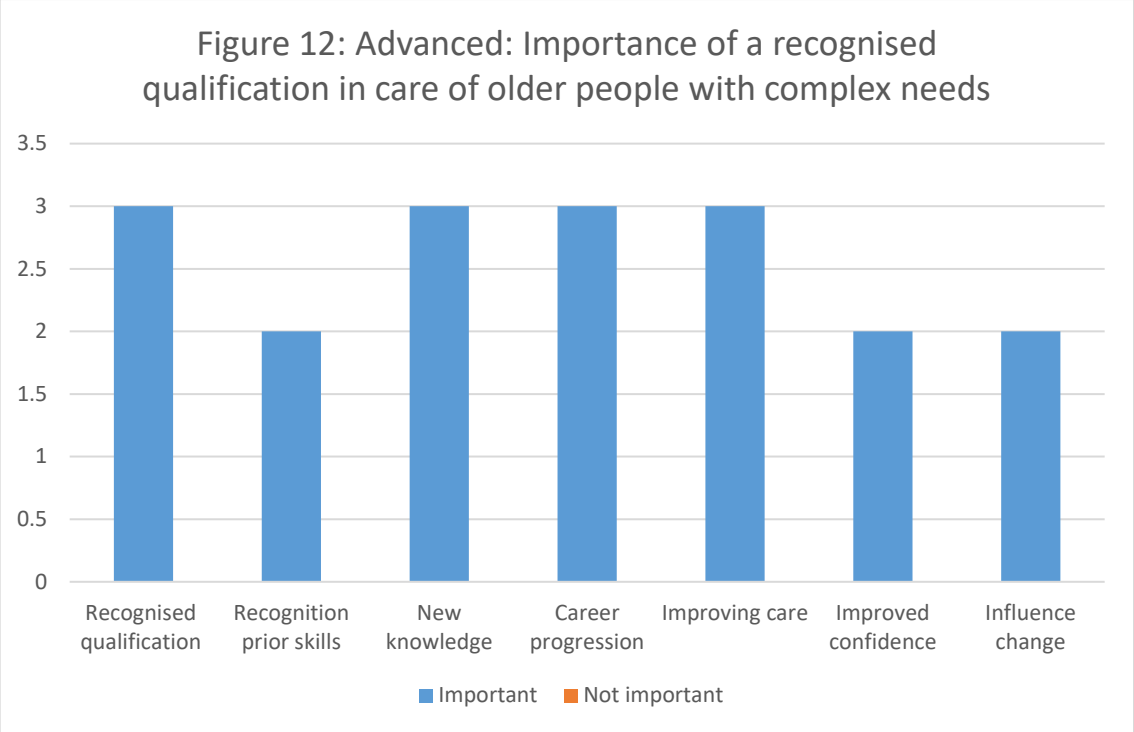


Figure 11: Specialist: Importance of a recognised qualification in care of older people with complex needs





87% essential level participants, 78% specialist level participants and 100% advanced level participants said having a recognised qualification in the care of older people with complex needs was important as a means of developing new knowledge, improving care, improving confidence, recognising prior skills, influencing change, and career progression.

Competency

Location and competency

Comparisons of location and competency domains/sub-domains showed that at the essential level, 'teaching, learning and support' (mean rank = 21.17) was found to score statistically significantly higher in location A (U = 43.5, p = 0.01) than location B, as did location A's 'leading, organizing and managing care' (mean rank 24.5, U = 80, p = 0.03). This may be due to the inclusion of nursing assistants in the location A sample only. The care home in location B did not employ nursing assistants.

Comparisons of location and competency domains/sub-domains showed that at the specialist level, 'collaborative working and communication' (mean rank = 23) was found to score statistically significantly higher in location A (U = 90, p = 0.005) than location B, as did location A's 'assessing, planning, implementing and evaluating care' (mean rank 22.1, U = 103, p = 0.027), and location A's 'management of mental health' (mean rank 17.09, U = 49.5, p = 0.025). This may be due to the influence of location A's virtual ward model, which promotes interprofessional working and facilitates the upskilling of OPSNs via maximizing

learning opportunities between consultants and nurses; the availability of OPSNs working at a higher competency level; and because RN staff working in the care home in location A includes some RNs with mental health expertise.

Comparisons of location and competency domains/sub-domains showed that at the advanced level (NB small sample), 'improving' (mean rank = 10.17) was found to score statistically significantly higher in location A (U = 4, p = 0.01) than location B, as did location A's 'communicating with patients and families' (mean rank 10.17, U = 4, p = 0.006), location A's 'pharmacology' (mean rank 8.4, U = 1, p = 0.009), and location A's 'promoting independence and autonomy' (mean rank 6.83, U = 1.5, p = 0.047).This may be due to the inclusion of consultants within the workforce model for location A.

Organisation and competency

All participants working at essential level were non-NHS employees.

Comparisons of organisation and competency domains/sub-domains showed that at the specialist level, NHS staff were found to score statistically significantly higher than non-NHS staff:

- Teaching learning and support – mean rank 19.23, U = 65.5, p = 0.025
- Improving care - mean rank 21.79, U = 42, p = 0.000
- Communication with patients/families - mean rank 20.48, U = 95, p = 0.032
- Assessing, planning, implementing and evaluating care - mean rank 22.11, U = 89.5, p = 0.013
- Promoting holistic health and well-being - mean rank 17.12, U = 66, p = 0.049
- Dementia – mean rank 16.94, U = 52, p = 0.029
- Frailty - mean rank 17.63, U = 26, p = 0.001

This may be due to NHS staff having access to a range of education and professional opportunities and having an infrastructure more able to support workforce competency development.

At advanced level, there was no significant differences between organisation and competency domains/sub-domains (NB small sample). Although results show NHS consultants work at a higher level than other staff, NHS GPs work at a lower level so that organisational differences in general are not apparent.

Highest academic level and competency

Although some essential level participants had 'A' levels, and some specialist level participants had Master/Bachelor level qualifications, there was no statistical significance between highest academic level and competency for essential and specialist level participants. There was a negative relationship between highest academic level and some competency domains/sub-domains at advanced level (NB small sample):

- Communication with patients/families - negative relationship (*rho*(3)=-1) and is statistically significant (*p*=0)
- Assessing, planning, implementing, evaluating care - negative relationship (*rho*(3)=-1) and is statistically significant (*p*=0)
- Promoting independence and autonomy - negative relationship (*rho*(3)=-1) and is statistically significant (*p*=0)
- Promoting holistic health and well negative relationship (*rho*(3)=-1) and is statistically significant (*p*=0)
- Mental health - negative relationship (*rho*(3)=-1) and is statistically significant (*p*=0)

In this case, staff with level 5 qualifications that focused on care home management had higher competency levels than staff with Masters' degree qualifications in subjects not specifically related to care homes or care of older people.

These results suggest that programmes of learning and development need to be relevant if they are to enhance competency in the care of older people.

Collaborative working and clinical competencies

Correlational comparisons between competency in collaborative working and clinical competencies showed positive relationships in all areas and these were statistically significant positive relationships as follows:

For essential level participants:

- Assessing, planning, implementing, evaluating care - *rho*(35)=0.696, *p*=0.000
- Pharmacology - *rho*(35)=0.533, *p*=0.023
- Promoting independence and autonomy - *rho*(35)=0.525, *p*=0.01
- Promoting holistic health and well being - *rho*(35)=0.552, *p*=0.001
- Dementia *rho*(35)=0.672 *p*=0.000
- Mental health *rho*(35)=0.652 *p*=0.005
- Frailty *rho*(35)=0.808 *p*=0.000

- End of life care *rho*(35)=0.721 *p*=0.001

For specialist level participants:

- Assessing, planning, implementing, evaluating care - *rho*(35)=0.718, *p*=0.000
- Promoting holistic health and well being - *rho*(35)=0.606, *p*=0.001
- End of life care *rho*(35)=0.477 *p*=0.021
- For advanced level participants:
- Assessing, planning, implementing, evaluating care - *rho*(16)=0.546, *p*=0.035

Teaching, learning and support and clinical competencies

Correlational comparisons between competency in teaching, learning and support and clinical competencies showed positive relationships in all areas and these were statistically significant positive relationships as follows:

For essential level participants:

- Assessing, planning, implementing, evaluating care - *rho*(28)=0.717, *p*=0.000
- Pharmacology - *rho*(28)=0.773, *p*=0.000
- Promoting independence and autonomy - *rho*(28)=0.513, *p*=0.004
- Promoting holistic health and well being - *rho*(28)=0.757, *p*=0.000
- Dementia *rho*(28)=0.745 *p*=0.000
- Mental health *rho*(28)=0.689 *p*=0.002
- Frailty *rho*(28)=0.756 *p*=0.001
- End of life care *rho*(28)=0.771 *p*=0.000

For specialist level participants:

- Assessing, planning, implementing, evaluating care - *rho*(28)=0.464, *p*=0.009
- Frailty *rho*(28)=0.606 *p*=0.001

For advanced level participants no domain is statistically significant.

Leadership, organisation and management and clinical competencies

Correlational comparisons between competency in *Leadership, organisation and management* and clinical competencies showed positive relationships in all areas and these were statistically significant positive relationships as follows:

For essential level participants:

- Assessing, planning, implementing, evaluating care - *rho*(35)=0.659, *p*=0.000

- Pharmacology - *rho*(35)=0.610, *p*=0.006
- Promoting independence and autonomy - *rho*(35)=0.449, *p*=0.007
- Promoting holistic health and well being - *rho*(35)=0.625, *p*=0.000
- Dementia *rho*(35)=0.593 *p*=0.002
- Mental health *rho*(35)=0.8 *p*=0.000
- Frailty *rho*(35)=0.668 *p*=0.003
- End of life care *rho*(35)=0.8591 *p*=0.000

For specialist level participants:

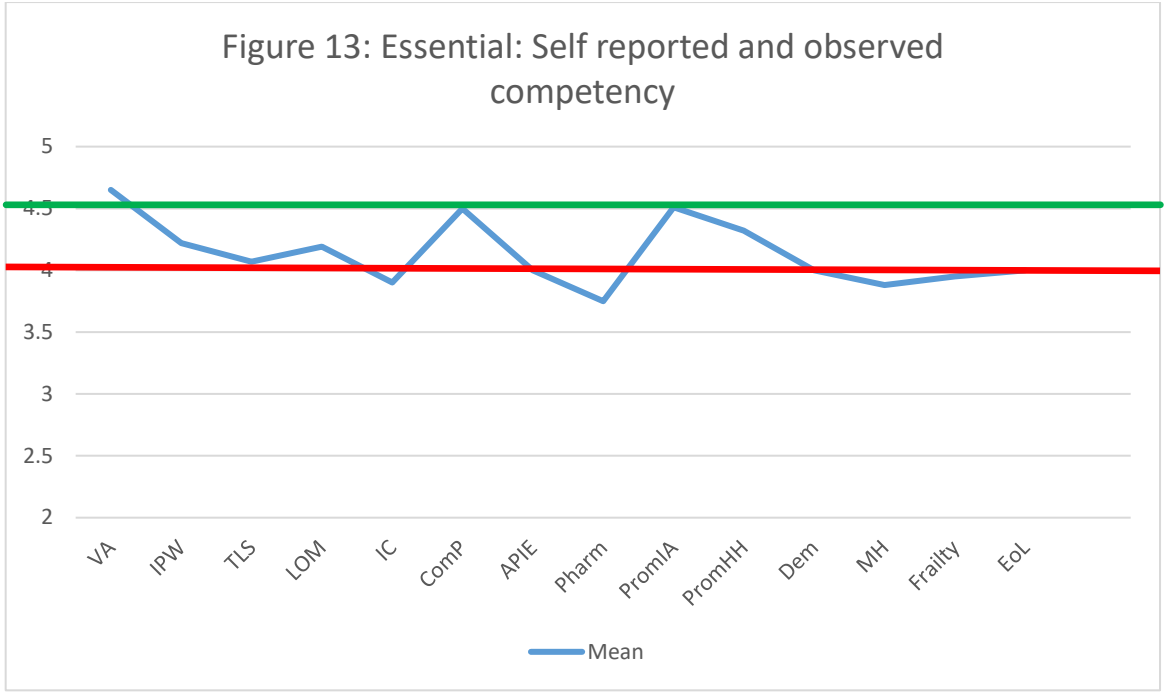
- Assessing, planning, implementing, evaluating care - *rho*(35)=0.431, *p*=0.011
- Pharmacology - *rho*(35)=0.369, *p*=0.049
- Promoting independence and autonomy - *rho*(35)=0.431, *p*=0.018
- Dementia *rho*(35)=0.535 *p*=0.003
- Mental health *rho*(35)=0.505 *p*=0.008
- Frailty *rho*(35)=0.586 *p*=0.002

For advanced level participants no domain is statistically significant.

These results suggest that higher levels of competency in collaborative working, teaching, learning and support and leading, organising and managing is associated with higher competency in clinical practice. This is particularly significant at essential and specialist levels.

Competency gap analysis and priority areas for development

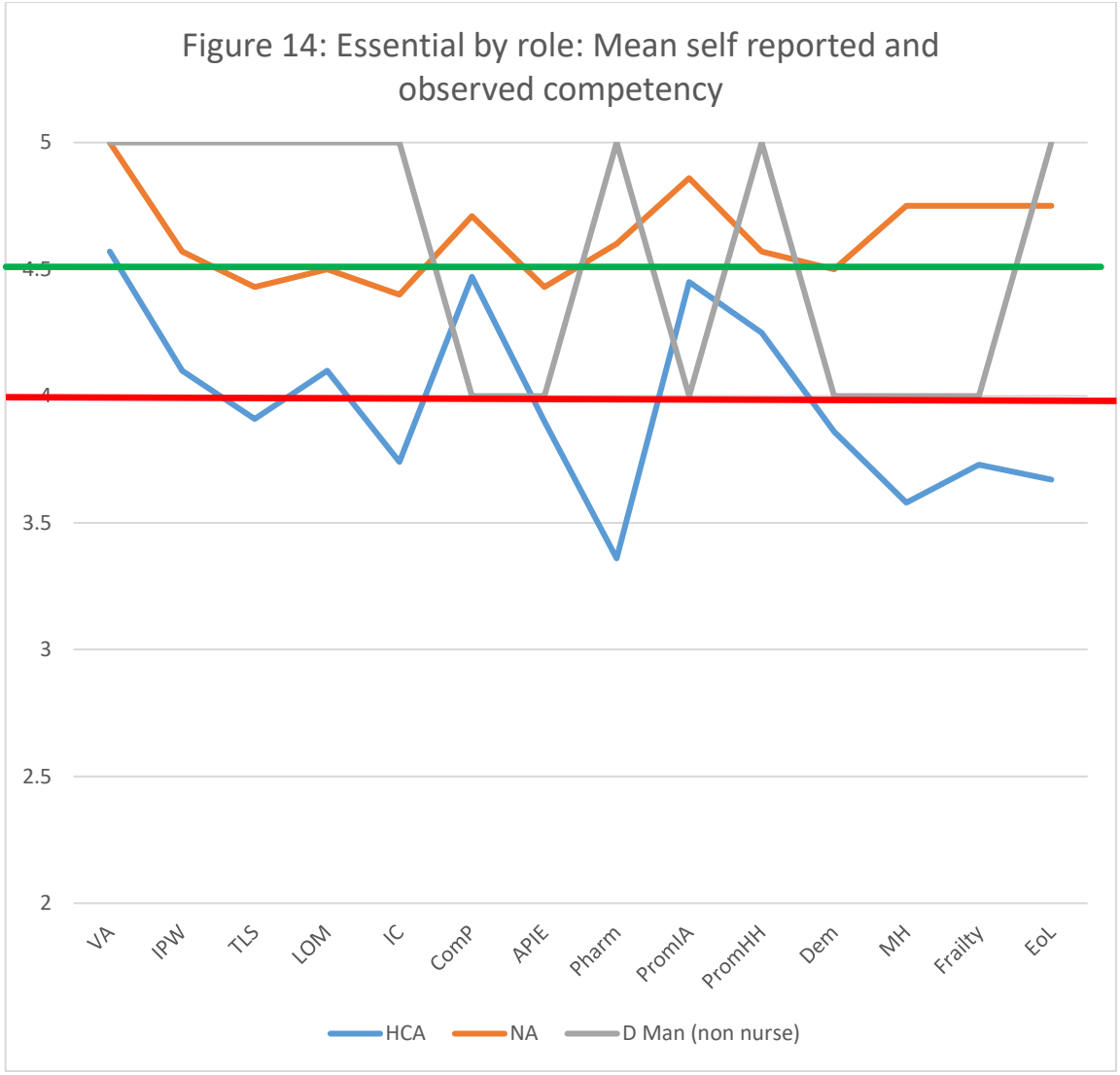
Essential: The mean combined self-reported and observed competency scores for all essential level participants are illustrated in figure 13:



Scores:
2=not at all; 3=not very; 4= somewhat; 5=very
= or > 4.5 strongest areas = or < 4 weakest areas

Strong areas were: values and attitudes; communication with patients and families; promoting and supporting independence and autonomy. Weak areas were: teaching, learning and support; improving care; assessing, planning, implementing and evaluating care; pharmacology; dementia; mental health; frailty; end of life care.

A review of the trends for occupational roles included in the essential level group reflected the combined group trend in that results for health care assistants and nursing assistants showed similar areas of strength and weakness.

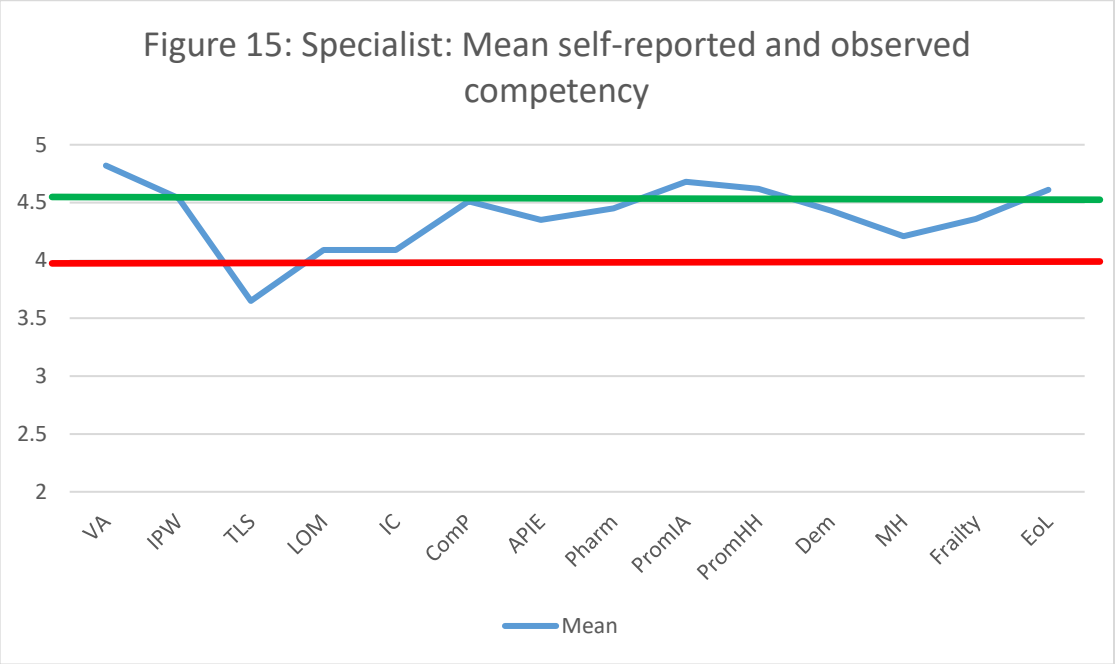


Scores:
2=not at all; 3=not very; 4= somewhat; 5=very
= or > 4.5 strongest areas = or < 4 weakest areas

However, results for nursing assistants consistently showed higher levels of competence in all areas. Only location A employs nursing assistants. These staff are recruited internally for this role from the health care assistant workforce. Candidates have to apply for, and are interviewed for, the role and once accepted, undertake an in house professional development programme, which includes some work-based learning and shadowing the management team and RNs (some RNMHs -mental health). The aim of the programme is to develop management skills, clinical skills and skills specific to the care of older people including dementia, mental health, frailty and end-of-life care. The non-nurse deputy manager has undertaken professional development via informal shadowing and working with

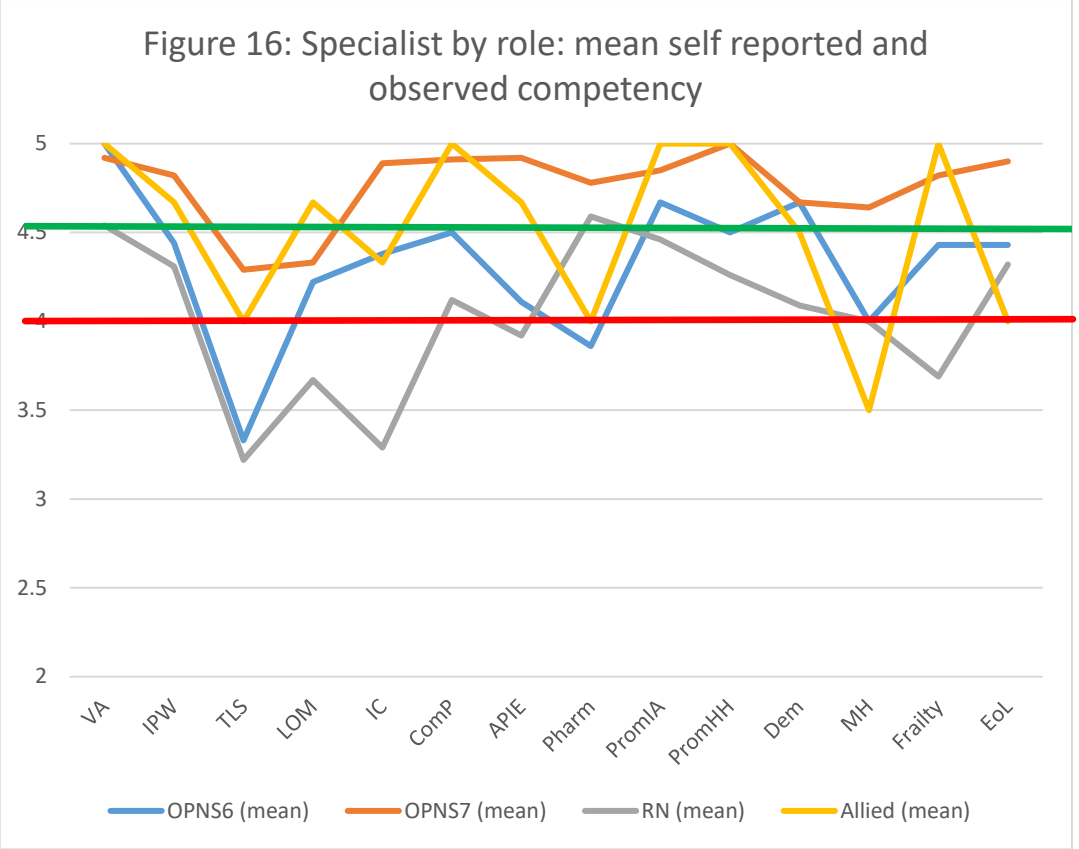
experienced RN managers. This staff member has a number of years' experience as a senior carer.

Specialist: The mean combined self-reported and observed competency scores for all specialist level participants are illustrated in figure 15:



Scores:
2=not at all; 3=not very; 4= somewhat; 5=very
= or > 4.5 strongest areas = or < 4 weakest areas

Strong areas were: values and attitudes; inter-professional and inter-organisational working and communication; communication with patients and families; pharmacology; promoting and supporting independence and autonomy; promoting holistic health and well being; end of life care. A particularly weak area was teaching, learning and support.



Scores:
2=not at all; 3=not very; 4= somewhat; 5=very
= or > 4.5 strongest areas = or < 4 weakest areas

A review of the trends for occupational roles included in the specialist level group reflected the combined group trend to an extent, although OPSN Band 6 nurses were also weak at pharmacology, assessment, and mental health management, and consistently practiced at a lower competency level than OPSN Band 7 nurses across all domain/sub-domains. Observations of OPSN Band 6 nurses highlighted that while they managed ward rounds and records GP assessment and plans, their input into assessment was limited. The group often practiced in isolation rather than using their rounds as opportunities to teach, support and assess learning for care home staff. There was a recognition of complex co-morbidities and frailty, but limited recognition of the implications for medicine management or for the resident in general. This group were strong collaborative workers in that they were effective brokers of information between care homes and the NHS. They also had good levels of competency in promoting independence and health and well-being, and managing dementia care.

Care home RNs required competency development in a number of areas, in particular teaching, learning and support, leading and managing care, improving care, assessment and

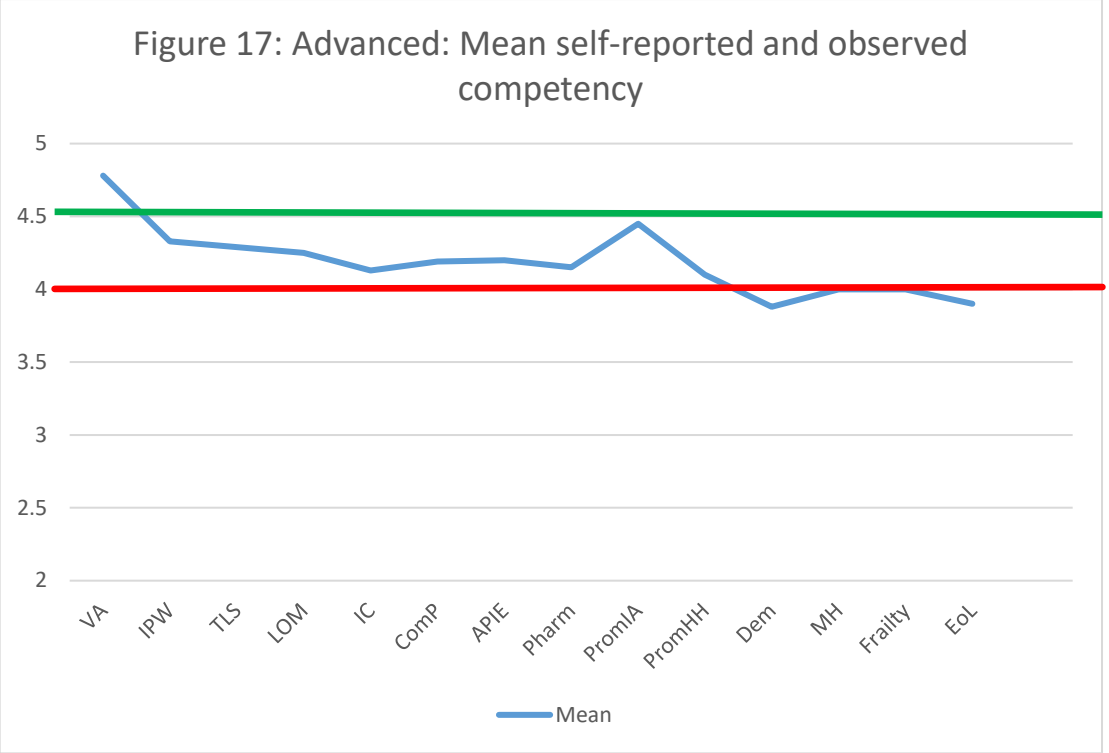
implementation of care, and frailty. Teaching and support was problematic for participants as most were not registered mentors. Previous work undertaken at a local level suggests being able to mentor student nurses contributes to practice development in care homes, as students introduce and reinforce current evidence-based practice, and act as catalysts for promoting closer working relationships and learning opportunities between sectors and organisations (Tiplady, Thompson and Proud, 2018). Also, a lack of opportunities for the RN participants' own competency development limited how they could support other staff. Care home RNs managed care on a day-to-day basis, but tended to rely on management teams, GPs and OPSNs to lead care. On occasions, RNs attempted to lead care processes and decisions but were 'overruled' by OPSN Band 7 nurses. In terms of improving care, some RNs reported that they did not really see this as part of their role. Rather this was seen as the remit of management teams and OPSNs. Care home RN participants were not generally familiar with the process of comprehensive geriatric assessment or their contribution to this. While they recognised and identified problems, care was at times reactive. Due to limited access to competency development, competency assessment, clinical skills updates, and some equipment and resources, these RNs were unable to undertake some interventions. With regard to frailty, the RNs recognised it on an informal, intuitive basis but were not familiar with frailty assessment or how frailty impacts on health. The care home RN participants demonstrated a good level of competency in pharmacology. For example, they questioned current medication regimes and initiated medication reviews, and identified changes in residents that could be attributed to medication.

Allied health care professional participants were very strong in promoting independence and autonomy and health and well-being, and management of frailty. Weaker areas were pharmacology, mental health and end of life care. Development in teaching and support competency may contribute to developing rehab skills within the healthcare assistant workforce and the wider MDT.

OPSN Band 7 nurse participants scored means of >4.5 in most domains/sub-domains, suggesting that they are working towards advanced level practice. This may be because they are working at a senior nurse level and because many have undertaken development programmes in prescribing and advanced clinical skills. This group of staff have regular access to learning sessions during/after the 'virtual ward rounds'. During these rounds, the OPSN Band 7 nurse team meet with consultant geriatricians and consultant psychiatrists to discuss patients on the round case-by-case and in detail. This not only enables collaborative care that meets the individual needs of patients, but it is also a forum for teaching and learning. In addition, during discussions barriers and challenges with regard to system

processes are identified and strategies implemented to address these. Evaluations of services and research studies are also initiated. After the rounds, presentations and learning sessions are provided that address issues suggested by, and therefore relevant to, attendees. As findings suggest that this experience is a valuable method of developing a range of competencies, it should perhaps be open to care home staff as well as NHS staff.

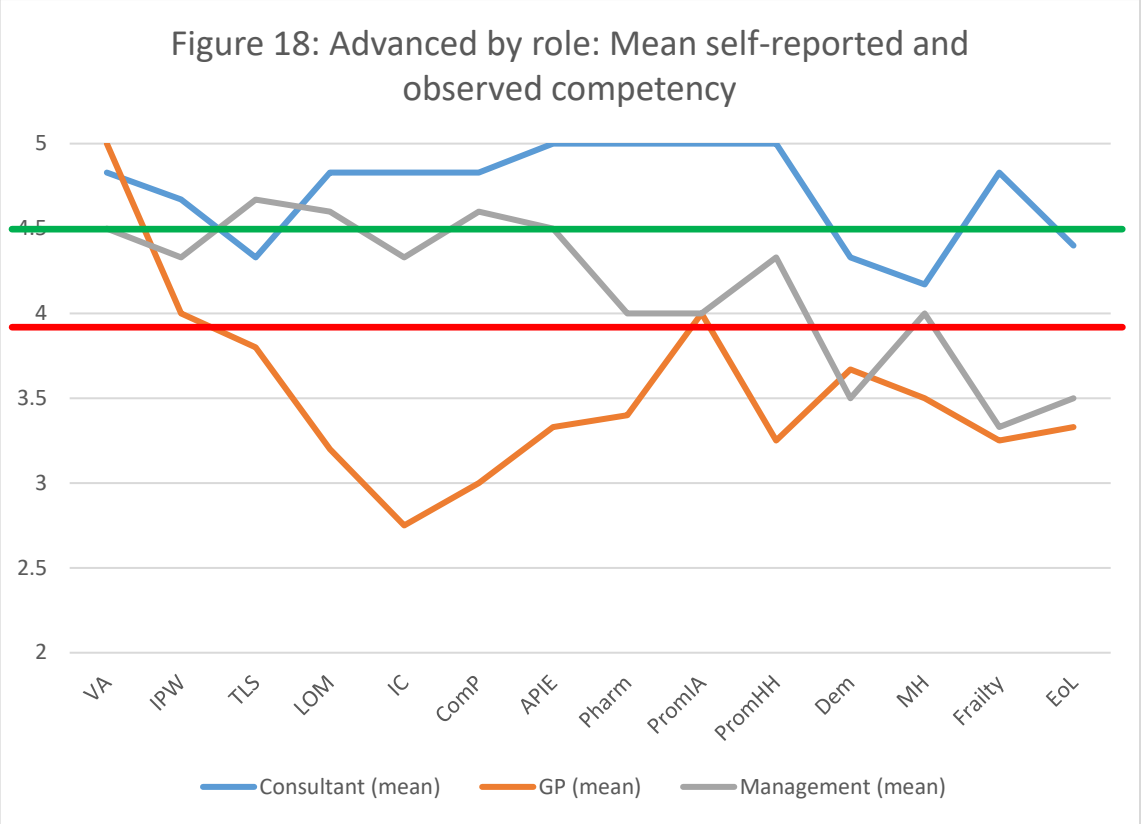
Advanced: The mean combined self-reported and observed competency scores for all specialist level participants are illustrated in figure 17:



Scores:
2=not at all; 3=not very; 4= somewhat; 5=very
= or > 4.5 strongest areas = or < 4 weakest areas

Strong areas were: values and attitudes, and promoting and supporting independence and autonomy. Weak areas were: management of dementia, management of mental health, management of frailty, and end of life care.

A review of the mean competencies for roles within the advanced level, however, showed a wide disparity in competence.



Scores:
2=not at all; 3=not very; 4= somewhat; 5=very
= or > 4.5 strongest areas = or < 4 weakest areas

Consultants operated as part of the care home team in location A only. They were strong in all competency areas. During observations, it was noted that consultants effectively used virtual ward rounds as opportunities to develop OPSN's skills and competency in clinical care. They were well organised and efficient, and were cost aware when considering care decisions. Consultants provided expert advice regarding complex clinical issues, but also complex family issues and ethical issues. They identified obstacles to care and initiated discussion about resolutions. They had extensive knowledge of contemporary/recent evidence, and used this to influence practice. They Identified areas where further research would be valuable and initiated research studies.

Management team members (RNs) were strong in teaching, learning and support; leading and managing, communicating with residents/families; assessing, planning, implementing and evaluating care. They were weaker in managing clinical aspects of care specific to the needs of older people, for example, dementia, mental health, frailty and end of life care. This may be because programmes of study and professional development they have undertaken focused on leadership and management rather than clinical practice. The management team

members were innovative in supporting learning. For example, in one instance, the management team facilitated all care staff, domestic staff and kitchen staff to complete NVQ 3 health and social care with the aims of developing a flexible workforce, allowing ancillary staff to understand how their roles can contribute to care, and supporting career development. Management teams also proactively engaged with education providers and university research teams to develop ways of improving and assessing competency. One care home management team also developed an in-house competency assessment system, a method of cascading training, and an in house professional development programme for nursing assistants.

A caveat regarding the findings about GP competency is that the sample size was small. This limited sample showed that GP participants were not working at advanced level. This may be because GPs are generalist rather than specialist practitioners, and within the care home team, the GP role is the only role that does not specifically relate to the care of older people with complex needs. Although these participants demonstrated leadership, collaborative working with OPSNs and care home staff, this did not meet the advanced level criteria. Ward rounds and encounters with OPSNs, RNs and HCAs provided opportunities for learning and collaborative work, but these opportunities were sometimes missed. In some instances, GP participants demonstrated limited knowledge of polypharmacy and the implications of polypharmacy and changes in medication for frail older people. In some instances, there appeared to be limited understanding of the care management of people with multi-morbidity. Some interventions were ‘trial and error’ based, and some participants strongly relied upon OPSNs to guide care decisions.

4.2 Phase 1, strand 2

This strand of the study aimed to gain insight into stakeholder perspectives of capacity, capability and agreement for cross system practice based learning and assessment through focus group, individual and dyad interviews; and identify and develop staff from different organisations within the pilot sites as mentors/practice based supervisors/ assessors of competence. A number of themes emerged from the data collected during this strand of the study. These were: the need for a workforce competent in the care of older people with complex needs; standardisation of competency levels across the care of older people’s workforce; competence development; assessment of competence to practice; mentorship and supervision.

The need for a workforce competent in the care of older people with complex needs

Participants' responses suggested that having competent staff improves the quality of care and reduces variation in the standard of care delivered, but also that having competent staff is important in achieving resident focused outcomes.

> Well obviously the benefits for the residents -it improves the quality of the service. It also standardises the service, and the fact you're not dependent on somebody being on shift to what approach you get (NHS)

> We need to be able to meet their needs and improve their outcomes. Because they're not here to die, they're here to live… So people have to be competent to care for residents from the day the residents comes into the home (Care home)

Participants proposed that caring for older people requires a broad knowledge–base and a range of competencies because of the complexity of caring for people with multi-morbidity and frailty:

> They are looking after people, who are living longer. They're frailer. They've got multiple, you know, co-morbidities. Complex care needs. And they're looking after, you know, a unit of 25 beds Whereas, you can have a 20-bedded orthopaedic unit, and the 20-bedded orthopaedic unit are all hips and knees and you know what that protocol is. The diversity of care needs within… Within the care homes is… Is enormous (NHS).

Participants identified that having a competent workforce had benefits for the wider health and social care system in that competent staff could assist in reducing pressure on other parts of the system, including the prevention of avoidable hospital attendances and admissions:

> If people are getting good, person-centred, holistic care from people with the right skills, they won't hit the rest of the system so much, inappropriately (NHS)

> I've done the PEG training. Why would you let somebody wait in A&E because their PEG has come out?... so I think the more competent we are the better. If we can change a PEG then it prevents a hospital admission (Care home).

It was also suggested that a competent workforce benefits service provider organisations by providing evidence for Care Quality Commission (CQC) inspections, which in turn improved CQC reports. Good CQC reports were associated with increasing resident occupancy and associated financial benefits.

> The company, at the end of the day, they are a business. And the better that they train their staff up, the better, you know, a business, lead... You know, at the end of the day, it's all finance. So, it gets their grades up better, so they're benefitting financially. And the homes fill up. Because, as we know, in this day and age, there is a lot of occupancy problems. And it's usually the homes with poor occupancies, because they haven't got a steady stream of nurses who are competent and carers who are competent (Care Home).

Achieving competence was also felt to be important to staff, in that this increased their self-esteem and pride in their work:

> Plus the staff, because they feel proud in themselves that they've learnt to upgrade their skills (Care home).

Standardisation of competency levels across the care of older people's workforce

Frail older people with complex health problems require care from a workforce that is proficient in personal care, enablement, management of complex multimorbidities, acute deterioration and interventions in emergency situations. No-one individual or individual service can manage this alone, hence input from multiple professionals occur. A number of participants indicated that in order to achieve quality multi-professional working, standardisation of competency across the whole workforce needs to occur:

> The benefits for the residents was that it improves the quality of the service. And then everybody gets a good quality service. It also standardises the service, and the fact you're not dependent on somebody being on shift to what approach you get. Because one of the things I thought I found is a lot of people have, like, a training programme. Not everybody had the same training. So, that knowledge was lost if you weren't on shift. So, that's why I try to standardise it across everybody. And for the person themselves, is, like, obviously, that they… They bring up that they're quality nurses. But also their self-worth as well. And they see the difference it can make with people in their care (Care home).

The participants suggested that effective multiprofessional working relies on an assumed understanding of the competence of professionals involved in patient care. This in turn relies on an inherent expectation that there is standardisation of competencies within professional groups. However, in the following example, it is clear that there is variation in what individuals within a profession are proficient to do:

> There should be some standards in the home as well…in terms of bloods, some nurses can't take bloods…I have been on a ward round and three patients have needed bloods. It's an agency staff member on duty who hasn't had ……blood taking training ticked off….so then you've got to get the district nurses in to do that. And then the district nurses will say – "Oh, well, that's a nursing patient, the home should be providing the service to take bloods". It is a minefield (NHS).

Another participant highlighted that core competencies are required by different care home resident populations:

> Different competencies are required in different services caring for different patient groups. In the unit upstairs they'll take ECG readings, which you wouldn't do downstairs. They do… They're like a hospital ward – so the girls up there have upgraded their skills, and they use their skills downstairs for us. But, you know, in an elderly setting – in a nursing home – you wouldn't be doing an ECG. But because the upstairs unit is an NHS unit that provides services for older people who are less stable, they do. So, yeah, they're able to keep their skills updated, more than the staff downstairs. But that's the difference (NHS).

Here there is the suggestion that there could be different sets of core competencies: a) generic across professional groups who are working at different levels of practice; and b) specific competencies within services. This, together with the fact that many different organisations are involved in the provision of care for older people with complex needs, has led to different facilities and different organisations taking different approaches to developing competency. In the following example, a care home with a rehabilitation unit focused on competencies that promote independence:

> Now, we ended up on 19 competencies. The biggest one, and it threaded through all the other ones, was communication. Because it's pertinent to all of them. There was also mobility. With or without aids. Assisted and unassisted transfers. Bed mobility. Exercise. Kitchen practice. Stair

> practice. And then, like, some chronic conditions. Like Parkinson's disease, mental health... Also arthritis is another common one (NHS).
>
> My competencies, that we've created, might be totally different to the care home down the road (Care home).

It was clear that different organisations are working to identify the required competencies of their workforce. This can lead to variation within the workforce, and when staff move from one organisation to another often their competency is reassessed because there is lack of a recognised standard or acceptance of previously assessed competence in another organisation.

Some participants proposed that professional, regulatory, or commissioning bodies could potentially have a role in determining competency standards:

> And different governing bodies want things different. So, until the NMC, kind of… Either steps up, or the commissioners step up, and this is their policies and procedures around PEG feeding, oral medication… Every other company is going to have completely different competencies. There's no baseline. There's no set standard (NHS).

Other participants, however, identified that regulatory and commissioning bodies do have requirements regarding workforce competency, but their requirements vary causing a problem in itself:

> In some places, the CQC don't require anything…then the CCG in partnership with the local authority who actually ask now, for those additional training sessions. For example, they've now put... In [place name], they've now asked for training on osteo and rheumatoid arthritis. That's very new. So, it tends to be external people who dictate what the skill should be (Care home).

Tensions exist in agreeing the requirements of the workforce that is caring for complex older people, particularly those living in long term care. The issue of lack of standardisation of workforce competencies surface in many of the above extracts. Yet there is also a consistent message that standardisation of competencies across the workforce would improve interprofessional working and importantly care of frail older people with complex health problems:

> It's about maintaining and improving the standards - that's to benefit the residents' care (Care home).

Competence development

Although there is no standardisation of competency levels across the workforce, the participants reported that their employing organisations have their own approaches to competence development across all levels of practice. These include:

- Introductory standard education
- Role specific induction programmes
- Role modelling and shadowing
- Formal education and training (often this was non-accredited)
- Personal development plans
- Refresher sessions and up-dates
- Ongoing experiential learning
- Skill development to meet a specific resident need
- Virtual ward – case management
- Ward rounds in care homes where learning focused on individual problems and management of complex conditions.

This range of learning opportunities could be broadly categorised as:

Initial development of competence to practice: This included introductory standard education; role specific induction programmes, role modelling and shadowing; formal education and training (often this was non-accredited).

An example of development of competence to practice was the introduction of nursing assistant posts. Some organisations provided opportunities for care staff to undertake further learning and development providing career progression to roles such as nursing assistants, care home assistant practitioners (CHAPs), or nurse assistant practitioner (NAPs). These roles have been developed within individual care home provider organisations, and are generally non-accredited. Participants suggested that this initiative enhances competency levels for the staff involved, and also has a positive effect on staff's self-esteem and self-worth:

> Seniors felt valued that they were having some dedicated development that would enhance their skills (Care home).

The difficultly with non- accredited learning is that it is often not standardised to support achievement of a given level of knowledge or competence. Whilst it may provide career progression within a specific organisation, the lack of transferability means it may not be recognised in other organisations, leading to repeated learning and assessment and lack of progression.

Ongoing personal development: This included: personal development plans; refresher sessions and up-dates; ongoing experiential learning. An example of ongoing personal development was the use of appraisal as a personal development tool. While there was variation across care home organisations in the learning and development opportunities that staff could access, in some cases, the use of staff appraisal was identified as an opportunity to assist staff development.

> And what we do - it's in two parts. The member of staff fills their own bit in, and then the appraiser fills the second bit in. And then you get together and you joint agree. And then, from the joint agreement, you sign up for the personal development plan for that forthcoming year (Care home).

Bespoke learning in response to resident/patient need: This included: skill development to meet a specific resident need; virtual ward – case management; ward rounds in care homes where learning focused on individual problems and management of complex conditions.

An example of bespoke learning in response to need was the learning and skills development that a particular care home team completed in preparation for a resident being discharged from hospital:

> We had a gentleman who was coming in with a trachy and we hadn't done one for a while so we requested the ward if we could go in and do a refresher session. So we all went up and did a refresher session (Care home).

Whilst the existence of this range of learning opportunities suggests that there is some infrastructure to support continual workforce development, there are problems. The majority of participants spoke of the difficulties that they experienced in accessing learning opportunities that would enable them to fulfil their role effectively. One of the major problems reported relates to difficulties accessing learning opportunities and competency development provided by the NHS. Some participants suggested this was a barrier to integrated care:

> I was told who to contact for some training at the hospital. I've emailed and had no response. So it's very sad that we are meant to be integrating, yet there is no integrated training for care home staff (Care home).

Another barrier reported by participants was the cost and funding of specialist courses:

> There is a lot of training that stipulate NHS only. A lot of university courses- the CPD ones you've got to fund yourself (Care home).

> So we've got three sets of clinical training coming up venepuncture, tracheostomy and catheterisation that we have to fund (Care home).

Accessing relevant learning opportunities was particularly problematic for agency and night staff. The shift patterns of these workers often prevents engagement with learning that is delivered during the day. Also, lack of cover for those wanting to attend training and updates was a barrier in many instances.

There were issues raised about the differences within and across organisations including the variation in the financial recognition that staff received. One participant noted that lack of financial recognition in their employment could pose a barrier to engaging staff in learning and competency development:

> We've just said that these people need really good skills, because these are the most complex, but we actually pay them the worst wages in the country. But now we're expecting them to sign up to a competency framework with equal skills. So, that could be a huge barrier (NHS).

A further financial difficulty arose for care workers who were paid for the extra hours worked to attend learning sessions. Some of these staff found that this could impact on their benefit and welfare payments, which discouraged engagement with competency development opportunities.

Assessment of competence to practice

Participants proposed that one of the most significant problems concerning the development of a competent workforce is demonstrating proficiency in specific competencies. A number of factors contribute to this problem. For example, some participants identified the requirement for assessors of clinical competencies to be occupationally competent as clinicians themselves. As many care homes employ non-nurse managers or do not have a stable RN staff base, access to competence assessment in house can be limited:

> In this home, yes. But across the company, it's not always easy. Because a lot of the managers are non-nurse managers. So, they're not able to sign them off. And a lot of the homes don't have a cohort of nurses, so they're relying on agency staff. So, there is an issue as to who's deemed them as

> competent. No. What's happened in the past is I've had phone calls, because I'm one of the very few nurse managers, being asked can I go along and assess their competency? Or, can my clinical leads that I have here go across and assess their competencies for them? (Care home).

Within this company this manager or her staff often assessed the competency of staff in other homes, which led to depletion of service in their own care home.

An alternative approach to assessment of competencies in the care home sector could be other professionals working in sectors such as the Local Authority or NHS fulfilling this function. One participant explained how this was working successfully in a local care home:

> The other thing you've got to think about is, like, who signs off the competency when you're talking about the sign off from a different organisation. We overcome that by involving the workforce development officer from the local authority. To be fair, he approached me first and then kind of was very willing and very helpful in the whole process. To try and standardise the observations, we had, like, standardised questions. So, it would be, like, a case of, like, what you would expect to see. And if you didn't see that, what questions you might ask to, like, reinforce it. So, you might see somebody walking along and prompting somebody to use the walking frame properly. But you wouldn't particularly... Like, see them checking the safety features in it. So, you would, like, ask, you know, what are the safety features? And it probably has been done, but you mightn't have observed it in that time. So, it's just, like, trying to standardise what you want to see to be signed by somebody as competent (NHS).

In this example, rather than relying solely on observations of practice, assessors built a series of questions into the assessment process to improve the validity of assessment and so their assessment could extend beyond the 'here and now' care episode. However, in most cases, participants said that cross-organisational competency assessment was problematic because assessors were concerned about implications concerning accountability arising from assessing staff from another organisation:

> Because they're employed from a different company to us. So, I have asked them to assist, but because they're employed by another company in the private sector, they don't assist, and can't assist (Care home).

> I don't see them on a regular basis, doing it. So, there is a bit of a… A dodgy… You know, like there are issues of accountability. I'm signing somebody off, but I'm not watching them in practice all the time. I'm just seeing that one-off session. And I know have to do… If it's venepuncture, I would have to observe them six times. But, I'm only seeing a snapshot. I'm not working with that physical person all the time to be monitoring their progress (NHS).

While this participant said that clinical activities had to be observed 6 times prior to competency sign-off, this was not consistent across all organisations. Some participants reported that 3 observations were sufficient for sign-off, and others suggested up to 10 observations. Defining the number of repeated observations required is an attempt to improve the validity of assessment to ensure the person is proficient in different contexts and situations, however reliance on numbers of observations reflects the lack of confidence and competence of assessors to make an accountable decision regarding proficiency.

Some participants suggested that education providers do not routinely offer competence assessment as part of their education programme. There was a range learning opportunities that could be accessed by care home staff, however much of this provision was predominately offering training focused on knowledge and skills development without always assessing that knowledge and skill development had occurred and could be applied in the practice setting. Determination of competence to practice was then left as a responsibility for the employing organisation:

> So, the nurses can go on a ten-day clinical course over three months. They'll do the theory. They'll do a practice session on that day. So, if it's… For example, doing a catheterisation, they'll use a model where you… You know, you insert the catheter and everything. They'll monitor you doing that, but then they give you a competency framework to take away, to be signed off by staff that are in your home, and they're competent enough to sign off your competencies (Care home).

Cross organisational assessment is not just problematic from the perspective of the assessor. Being assessed by individuals working for external agencies was also of concern due to perceived tensions in relations between health and social care organisations, but also because the assessed may have little knowledge about the assessors' own competency levels:

> It is interesting. Because, historically, the relationship between health and social care hasn't been the best. There's always been that hierarchical attitude in my view, of NHS staff coming in to care homes. And that Cinderella service - it's still not brushed off. And so, I think there would be a reluctance within the care homes to be assessed by those people. But, actually, we don't know what their competencies and skills are (Care home).

Other barriers to competency assessment reported by participants included the time required to assess competence and the need for this to be inherent in practice rather than an added extra in one-off pre-determined situations:

> I think that's the big thing about it. As I said before, it needs to be part of their daily practice, and not additional to their daily practice. Because nobody has got time to do anything extra (NHS).

Also, assessing competency for night shift staff was problematic due to reduced opportunity for working with those with appropriate proficiency to assess their performance.

During interviews, participants were asked to identify approaches that could be implemented as competency assessment methods. A number of suggestions were made including: continual observation of staff performance; self-assessment; reflective practice; audit of practice and practice outcomes; observation and sign off of competency requirements by senior staff; 1:1 supervision. Participants highlighted that there is a need for integrated assessment which encompasses knowledge, understanding and the values that underpin proficiency, not just observation of clinical activities. In order to facilitate this, and overcome the challenges and inconsistencies apparent in current competency assessment practices, there is a need for an integrated approach across the system. However, to increase validity and reliability of assessment this should be underpinned with; a standardised competency framework to enable objective assessment against agreed criteria rather than subjective decision making, and appropriate preparation of those assessing proficiency in the principles and practice of valid and reliable assessment (Cassidy 2009, Cowan et al 2005) with annual update (as required by the NMC 2008). To plan and manage this at scale requires the development of infrastructure to develop and assess the achievement of proficiency against the mentor standards. In addition, there is need for a cross organisational agreement to address governance issues of signing off competencies across organisational boundaries.

Mentorship and supervision

During the study, the following categories of individuals who were responsible for supervision and assessment of competence were identified within the pilot sites:

Location A:

- NHS RN mentors – 1 x OPSN
- Care home RN mentors – 0
- NHS assessors of competence – 0
- Individuals with responsibility to assess competence in care homes – 2 x management team (using an in house competency assessment framework)
- NHS practice based supervisors - 0 (consultants, GPs and allied healthcare professionals act as supervisors for NHS staff within their own professions, but not specifically with regard to the formalized development of competency in the care of older people with complex needs. These professionals do not act as supervisors for care home staff).
- Care home practice based supervisors – 2 x management team and all RNs and nursing assistants supervise staff.

Location B:

- NHS RN mentors – 1 x OPSN
- Care home RN mentors – 0
- NHS assessors of competence – 0
- Care home assessors of competence – 0
- NHS practice based supervisors - 0 (consultants, GPs and allied healthcare professionals act as supervisors for NHS staff within their own professions, but not specifically with regard to the formalized development of competency in the care of older people with complex needs. These professionals do not act as supervisors for care home staff).
- Care home practice based supervisors – 2 x management team and all RNs supervise staff.

In order to attain a clearer picture of mentorship and supervision beyond the 2 pilot sites, phase 1, strand 2 interview participants were asked about their experiences within the care home setting of these activities. It was noted that during the interviews, participants holding a nursing qualification used the term ‘mentorship’ when discussing the support of student nurses, but ‘supervision’ when discussing the support of staff. Other groups used the term

‘supervision’ in relation to both students and staff. There was also awareness that to assess the practice of student healthcare professionals, assessors usually have to be a registered assessor (for example, an NMC registered mentor), although this is not the case with regard to assessment of competency for staff.

All participants identified that mentorship/supervision was part of their role. However, there were variances in how prepared participants were for this aspect of their role, particularly with regard to care home staff. A few care home staff felt very well prepared:

> I have completed my mentorship module with [university name] and also completed an internal supervision training course with a previous employer. Recently, the company has developed a mentorship induction program that I have received training on. This includes both face-to-face sessions and an e learning module. The training I have received regarding mentorship has prepared me well to support colleagues and students (Care home).

For this participant, their current employing organisation provides a development programme for mentorship/supervision. However, many care home provider organisations neither provide such programmes, nor engage with education providers who do provide them. Participants suggested that this may be because until recently, care homes did not host student nurses in this region, so as NMC registered mentors were not much required in these settings, formal mentorship/supervision development programmes have not been deemed necessary. For care home staff, this has resulted in either there being no opportunity for development in this area of practice, or in staff having to rely on mentorship/supervision skills they developed in previous roles (without required annual update), or via informal experiential learning which does not necessarily lead to achievement of the NMC mentor/assessor standards (2008) :

> I am a registered NMC teacher and mentor, but if I had not had all my previous experience of working as a senior lecturer in university and practice within clinical settings then the role would have been harder as I have had no support to do this from the company (Care home).

> With regards supervision, this is something I believe I had an awareness of, due to personally receiving supervision over the years, however I think this is something I have learnt and developed through experience rather than a formal supportive structure (Care home).

Despite the lack of opportunities to develop mentorship/supervision skills within care home settings, the participants were mindful that regulatory and professional bodies have expectations that formal supervision takes place:

> Supervision is a national… It's through CQC guidelines as well that we have to all have a supervision every eight weeks. That is six supervisions a year, and an appraisal once a year as well. They're CQC requirements under the' well-led' section (Care home).

However, although CQC have determined regulations regarding minimum numbers of supervision sessions, different organisations and even different care homes within the same organisation, had their own methods of carrying out supervision. Some participants stated that supervision was little more than a 'tick box' exercise, others worked in care homes that held more sessions than the CQC recommendations, others used formal appraisal-like supervision sessions, while others used the sessions as a means of reflecting and developing practice skills.

A number of participants did acknowledge the benefits of supervision, viewing it as a valuable method of improving care practices. Some suggested that supervision provides an opportunity to reflect on what is working well, and to explore areas where improvements could be made. Supervision could provide a learning opportunity to discuss required standards of practice:

> We have just had a supervision between the two of us, about how best to deal with comments from professionals that would improve the care on a day-to-day basis. So following supervision that becomes the manager's responsibility, in terms of leadership within his home, my responsibility to support him to do that. Informal supervisions don't tend to happen for negative things. These can be about improving the care (Care home).

> The home manager actually chooses a policy a month and do that within supervisions (Care home).

Some participants suggested that group supervision sessions provided opportunities to review practice against national and professional standards with a view to ensuring best evidence-based practice, and instilling professional values:

> It's about being able to set up professional supervision groups with the nurses to look at trends that are happening in the home. To look at new developments from either the NMC or the NICE guidelines. To make sure

> that we're actually doing best practice. It's also about, importantly, talking to carers. And when I'm in the homes, making a point of hopefully getting a group of carers together to talk about those core professional values of the need for respect, kindness, compassion when caring (care home).

Supervision was also highly valued by participants as a means of supporting individuals' clinical skills practice. Participants proposed that if skills are not practiced regularly, staff can lose confidence and proficiency. In these situations, participants said peer support and clinical supervision are welcomed:

> We kind of continuously assess each other and support one another. For example, at the weekend, I had to erect a syringe driver. And, yes, it's been maybe a couple of months since I did one. You know, I still read it, but I had the support of another colleague who supervised me initially. I was quite confident - it was just that added backup. You know, support for each other is important. So, I think we do continuously support each other with every task that goes on in the home (Care home).

The interview findings clearly reinforced the need to develop mentors/supervisors/ assessors of competence who are readily available in organisations, work in a standardised way to: eliminate variation in competency development; capitalise on good competency develop practices already utilised; and ensure capacity for developing competence in the care of older people with complex needs in both the current and future workforce. Within the pilot sites, the research team aimed to achieve this via provision of appropriate preparation (delivered in the practice setting, with backfill for care home staff) to enable evidence based supervision, coaching and assessment of competence that is valid and reliable using the EnCOP competency framework. For staff at specialist and advanced practice level, this was to be via enrolling on a nationally recognised credit bearing module (facilitating learning and assessment in practice offered at level 6 or 7), or accreditation of prior learning (APEL) against the module learning outcomes. For senior support workers this was to be a bespoke course (non-credit bearing) at the appropriate level to enable evidence based supervision, coaching and assessment of competence that is valid and reliable using the EnCOP competency framework. Undertaking these modules would enable staff to be registered as an assessor on the Northumbria University mentor data base (wherever they are employed) and offered annual updating. It would also enable staff with professional registration to use this learning and development as evidence for revalidation purposes.

Due to contractual delays, the study did not commence until mid December 2017. This meant that in order to achieve the deadline, the study had to be completed within 2.5 months. Time was reduced further due to the Christmas and New Year period, during which research staff were unavailable due to statutory leave, and commencing programmes of study was not a priority for either NHS or care home staff. As a result, it was not possible to deliver a bespoke course for senior carers before the submission deadline for the report. However, the course is planned for delivery in the 2 pilot sites in March 2018.

With regard to modules for advanced and specialist practitioners, staff working in the pilot sites who were not registered mentors were invited to enrol onto Northumbria University's mentorship course for professional practice with a view to either undertaking the mentorship module, or obtaining accreditation for their prior experiential learning (APEL). However, enrolment onto widely available modules was delayed due to difficulties in accessing funding from Health Education England North East (HEENE). HEENE's (2017) 'widening access policy' for continuing workforce development states:

> This policy requires individual organisations to register with HEE as approved to access CWD provision. This will involve providing details of their organisation, a key contact and to state they acknowledge and accept the conditions of accessing continuing workforce development via the application form for non-NHS staff to access the HEE funded post-registration education provision. Once the application form has been returned and approved, this will allow non-NHS employees to apply for HEE funded CWD provision. Once organisations have registered, they will appear on an approved list of widening access organisations. When universities receive applications from non-NHS employees, universities will verify that applicants' employers have signed up to the policy before processing applications… Organisations that choose not to register with HEE will not be able to access post-registration education and training or any provision commissioned by HEE (HEENE, 2017).

The process required to register with HEE proved difficult to achieve for the pilot care home sites. This was because managers were unsure who from their organisations was responsible for registering and acting as the key contact. Regional and operational managers of the pilot site organisations were not aware of this requirement, and requested more information and time to consider how best to meet these requirements prior to registering. The research team liaised with teaching and support staff from Northumbria University's 'Mentor/Education Preparation' programme and found that this situation was

not unique to the 2 pilot sites. A number of care home staff had recently attempted to enrol onto the mentorship programme (since the recent introduction of student placements in care homes), and had faced similar challenges in accessing HEENE funding.

Once the registration process was recognised as a barrier to enrolment on mentorship programmes in the North East of England, HEENE rescinded this requirement. Hence, from late January 2018, to gain access to funded mentor courses there is no requirement to apply to HEENE for funding by non-NHS organisations or individuals. Individuals now directly apply to a North East university of their choice, and once the application is received by the university's programme support team, it is checked to ensure that the individual's employing organisation offers placements on pre-registration health programmes. If this is the case, the university can offer a place on the module under their HEENE contract. Since the registration requirement was rescinded, staff from the pilot care home sites have applied for mentorship modules, and will commence their study or APEL process in March 2018.

Preparation of care home staff to enable them to provide evidence based supervision, coaching and assessment of competence was also facilitated by means of mentor updates. The research team identified individuals who had been mentors in previous roles, but whose mentor registration had lapsed once they were employed by care home provider organisations. There were no such staff in the pilot site care homes, but a number of staff in this situation were identified across the region. These staff were offered mentor update sessions so that they could re-enter the mentor register. To-date, 8 staff have received updates, and a further 14 are planned for March/April 2018.

In January 2018, Northumbria University employed 2 practice education facilitators who work in private, independent and voluntary sector organisations (PIVO). These staff are responsible for developing a register of mentors in the care home sector, contribute to recruiting care home staff to the mentorship programme which can be completed by formal study or APEL of prior experience against the module outcome and support academic staff with module delivery or APEL for this sector. They also support staff to maintain mentor registration by offering annual mentor updates required by the NMC, and for a range of staff working in, and into, care homes.

4.3 Phase 2

The post-it note and flip chart data were initially transcribed and entered into an internet application to create a Wordle. Wordles, or word clouds, produce a visual

representation of the text, giving greater prominence to the most frequently used words in records of the discussion that took place during the workshops. This provided a basic understanding of the data. ‘Need’ featured prominently in this visual representation, reflecting the participants’ overwhelming view that the status quo cannot be maintained; and that there is a pressing need for a strategy to develop an integrated approach to workforce development for enhanced care for older people. This included significant discussion of approaches to learning, assessment of practice, and determination of competency and proficiency. These issues were frequently discussed across all levels of practice including direct care, specialist levels within the whole system (see figure 19, stakeholder workshop Wordle).

Figure 19: Stakeholder workshop Wordle

The Wordle highlights the diversity of topics that were explored in the workshops. These discussions were rich, with participants offering different perspectives on complex issues. There was also learning within these discussions when participants shared current initiatives for competence development of their staff, barriers to accessing accredited education, and funding. These discussions are captured in the following sections – challenges, solutions and funding options.

Challenges

The workforce required to care for older people with complex health problems sit across multiple statutory and independent sector organisations. This is a large and diverse workforce that will increase with the ageing society. There is now an increase in the oldest old, and there is a direct relationship between advanced older age, multimorbidity, frailty and end-of-life. This population requires a workforce that is integrated across health and social care and across sectors, yet there is a lack of a collaborative approach to workforce development across all services caring for older people. Also, there are not enough people who are proficient in in the delivery of essential, specialist and advanced levels of practice within the EnCOP framework to provide care for older people with complex needs. There is an urgent need to upskill across and within the workforce, with particular attention to care home nurses, health care assistants and GPs to manage complex older people who are living in care home settings and other types of supported housing. Whilst clinical supervision provides good opportunities for learning, there is a short fall in supervision for care home managers. This is a national problem that requires solutions that work within localities.

Workshop participants stressed their concern that the majority of resources for developing professional competency are available to NHS professionals, but not to the non-NHS workforce. While participants acknowledged that there is funding available for non-NHS staff education (for example HEENE ring-fence 10% of their funding for non-NHS education), there remains significant competition within the independent sector for access to commissioned CWD. It was also highlighted that many organisations are unaware of this funding, and those that are aware are unsure of how to access it, or they find the process of applying for it complicated, and therefore a barrier to access.

There were many illustrations of care home staff not being able to access relevant education. They acknowledged that learning opportunities do exist, but the challenge rests in the limitation of learning options that are accredited, result in competency development and proficiency and are provided in a way that is accessible, eg practice based. In the main, education provider companies focus on knowledge development rather than competence development. For an integrated approach to workforce development, there needs to be a shift towards competence development.

The complexity of the care home sector adds to the challenge of adopting a whole system integrated approach to workforce development. The size of care homes and diversity of care home organisations impact on education provision – with some offering an extensive in-house suite of learning opportunities and others accessing courses provided by a range of

external education providers. This diversity of education offered contributes to a lack of standardisation, not only of the education provision but the quality of learning opportunities. The following issues were highlighted by participants:

- Competence to practice is not agreed across the older people's workforce
- Assessment of competency is not standardised, leading to concerns about validity of the assessment where this does occur
- There is no standardised approach for agreeing when staff are proficient.
- There are no agreed processes to ensure the reliability of assessment of both competence and proficiency.
- There is no standardised approach to ensure staff maintain their proficiency through regular updating and supervision.

There are gaps in the current learning opportunities offered and there is an opportunity with the availability of new funding streams to address gaps. Participants agreed that this should be through a system based approach with an agreed method determining proficiency against the EnCOP competency framework for the older people's workforce. This is not easy and will require new ways of working and cultural change across large complex sectors. There are barriers, including different organisational priorities, varying governance arrangements, lack of clarity of use of the available funding steams such as the apprenticeship levy and barriers accessing CWD funding.

Solutions

When discussing the challenges that are currently faced regarding workforce development, workshop participants readily identified solutions. Some of these would require system-wide change to support integrated working across sectors. Other solutions concerned the learning offered. There was general agreement that there should be a move away from the existing model of training, to approaches that support competency development and proficiency maintenance. These ideas were captured in the notes made by the facilitators. The following present's key points that were recorded during these discussions and these are explored in the discussion and recommendation sections of this report.

<u>Whole system approach to integrated workforce development</u>

- A standardised whole system approach to workforce development should be adopted within localities and region-wide.
- Make recommendations to regional commissioning groups and commissioners, STP neighbourhoods and communities group, Closer to home and Frailty leads for an integrated whole-system workforce development approach.
- Services and organisations should work together across operational boundaries to

define workforce development requirements through assessment of community profiles.

- Establish a 'community of practice' to develop a joined up learning offer for all levels of practice.
- Appoint a designated body or workforce development lead with a remit of co-ordinating workforce development across providers.
- Explore options for a transactional approach to commissioning that is based on outcomes, adds value, and commissions for capacity (this may optimise the role of contracts in supporting the development of the workforce).
- A system-wide framework for workforce development for the care of older people with complex needs should be integrated into commissioning and regulatory processes.
- Build on successful models such as OPSN working in nursing homes to other sectors such as OPSN working in residential care homes.

<u>Sign up to EnCOP across organisations and boundaries</u>

- Adoption of the EnCOP competency framework across health and social care systems to support staff to develop competence at different levels of practice.
- Transform job descriptions and align to the EnCOP framework.
- Develop an infrastructure for delivery and competence development and proficiency maintenance that is aligned with the requirements of regulatory and professional bodies.
- Benchmarking and standardise specialist practice across all localities.
- Identify carer learning requirements, and provide opportunities to develop and recognise their knowledge and skills.
- Agree a policy for the assessment of proficiency and 'sign-off' of competencies that is recognised across organisational boundaries.

<u>Provision of an enhanced learning offer that is accessible to the older people's whole workforce</u>

- Learning should be based within a locality to optimise the fit with local workforce requirements.
- An integrated learning portfolio should be established and available across a locality.
- Reduce variance in current education provision and standardize to match the EnCOP framework.
- Adopt a strategic approach to apprenticeships at all levels of practice of the EnCOP framework including:
    - Consideration of using or adapting the current Associate Nurse apprenticeship in the care home sector
    - Development of a trailblazer group to explore potential for new apprenticeship standard for Specialist Practitioner in the care of older people with complex needs.
    - Explore potential of Advanced Clinical Practitioner apprenticeship
    - Shared learning across organisations that taps into existing expertise, enhances understanding of everyone's role and increases learning.
- Enhance the interprofessional learning offered in all localities.

- Opportunities for regular updates to support proficiency maintenance that reflects and integrates new advances in practice.
- Specialist learning programmes to enhance competencies of care home nursing staff, managers and GPs for managing the care of complex older people.
- Certificates of attending training need to be backed up by assurance of competence.

Recognition of competence and proficiency across older people's services

- Explore the feasibility of adopting 'Passports of competency,' or 'Passports to practice' within the workforce.
- Investigate if these passports would be welcomed by employers.
- A 'Brief profile' or 'WFD one page profile' could be used by health and social care staff working into care homes to evidence their knowledge, skills and competencies.

Assessment of competence and clinical supervision

- A system-wide framework for assessment of competence and proficiency should be agreed
- In-house education providers should assess competency and proficiency provided consideration is given to addressing validity and reliability
- Appointment of practice educators who work across sectors and services
- NHS organisational staff could provide support to registered nurses across providers for clinical supervision and vice versa
- Build competence development into coaching and appraisal of roles
- Standardise assessment of competence across professions for all competency levels

Approaches for the delivery of the learning offer

- Practice-based approaches to learning and competence development should be adopted.
- Practice-based learning should replace off-site education wherever possible unless the education would be enhanced (for example by access to simulation facilities) .
- Integrate routines practices as opportunities for learning:
    - Ward rounds in care homes are effective in the development of competence.
    - Making every contact count as a learning opportunity.
    - Virtual ward rounds as learning opportunities across all levels of practice.
- Blended learning should be considered to optimise the benefits of face-to-face and e-learning for those working in care homes.
- Practice based learning could be supported by teams of practice educators. enabled to work across organisational boundaries within the geographical locality

Access to the learning portfolio

- Ensure that care home staff understand what specialist care courses are provided by HEI.
- Information should be made available to care homes about processes for registration for access to funded education provided by HEIs.

Funding options: opportunity and issues

There was much discussion about the types of revenue streams to support workforce development, what the funding could support and how to access funding. Hence there is clearly a need for information to enable employers and commissioners to make decisions about workforce requirements. Key issues that were highlighted were:

- There is a need to understand how employers are spending their apprenticeship levy, what success has been achieved regarding levy spending, and what competency gaps exist after spending the levy (some employers are spending their levy on practice levels 2 and 3; up-skilling deputy and care home managers; creating a skills academy).
- There is a need to explore other sources of funding to support workforce development including the European Social Fund; Better Care Fund (if it could be demonstrated that this would improve outcomes); HEE commissioned CWD provision under widening access policy
- Influencing the commissioning of CWD that is aligned with the development of a proficient workforce rather than the provision of training.

Reach and significance

The workshop participants argued that an integrated approach to development of the older people's workforce is urgently required. Local solutions can be developed, however there is a real need to share what works within localities in order to impact on the quality of care for older people nationally. A career framework that works across sectors and service provision could be explored by both employers and professional bodies. Workshop participants highlighted that workforce development is a national issue that requires effective locality based solutions.

5: Discussion

Competency gap analysis

Findings from the study in two care home sites identified areas for competency development for all 3 competency levels:

Essential level: All competency domains/sub domains require development, although participants did demonstrate strengths in values and attitudes, communication with residents/families, and promoting independence, health and well-being. Priority areas for development are:

- Teaching, learning and support
- Improving care
- Assessment, planning, implementation and evaluation of care
- Pharmacology
- Management of dementia
- Management of mental health
- Management of frailty
- End of life care.

Specialist level: The primary priority area for development is teaching, learning and support. Specialist level practitioners need to develop and practice mentorship, teaching, and assessment of competency skills if the competency of the workforce at large is to be developed and maintained, not only for the present, but for the future.

OPSN Band 7 nurses demonstrate high levels of competency across most specialist level domains/sub domains. To enhance competency to advanced level, an advanced professional development programme is required.

OPSN Band 6 nurses and care home RNs require development in all areas to ensure their skills and competencies address the needs of older population with complex co-morbidities and frailty. Priority areas for OPSN Band 6 nurses are:

- Teaching, learning and support
- Assessment, planning, implementation and evaluation of care
- Pharmacology
- Management of mental health.

Priority areas for RNs are:

- Teaching, learning and support
- Leading, organizing and managing care
- Improving care
- Assessment, planning, implementation and evaluation of care
- Management of mental health
- Management of frailty.

Care home RNs require competency development in leadership and improving care to enhance their ability to address issues around resourcing and equipment acquisition, and improving care systems, as well as care management. However, NHS staff need to recognize and value their input i.e. allow and enable care home RNs to lead care.

Advanced level: The sample size for advanced level competency was small, which compromises validity of the findings. However, within the small sample, consultants demonstrated advanced competency in most domains/sub domains. Partnership working between consultant geriatricians and consultant psychiatrists maximized provision of a comprehensive advanced service. During the virtual ward rounds, consultants were able to support competency development of OPSN Band 7 nurses. GPs and care home staff were not in attendance during these observations. Similar events attended by consultants, GPs and care home staff may be useful.

Management team participants demonstrated competency in the care domains of values and attitudes; collaborative working; teaching, learning and support; leading, organizing and managing, and improving care. They demonstrated competency in assessment. Clinically based skills required further development. This may be because current professional development programmes for managers focus strongly on leadership and management. An advanced practice programme, which includes clinical care specifically to address the needs of older people may therefore be beneficial. Priority areas for management team members are:

- Pharmacology
- Promoting independence and autonomy
- Management of dementia
- Management of mental health
- Management of frailty
- End of life care.

GPs who participated in this study were not working at advanced level practice in any domain/sub domain. They require development in all areas. This may because they are generalist practitioners rather than having specialist/advanced knowledge in caring for older people with complex needs. The RCGPs and RPS have developed an accredited 'GPs with a Special Interest (GPwSI) framework for developing competency in the care of older people, which could be used to enhance skills in this practice area (RCGP, 2018). This programme was developed independently of EnCOP, and as workforce development progresses in the future there is the potential to align GpwSI and EnCOP. Alternatively, new professional development programmes could be developed based on the EnCOP framework to standardise competency in the care of older people across roles and sectors irrespective of role.

Learning

The findings suggest that preferred methods of learning and professional development were not reflected in available programmes of learning or support. E-learning was used widely, but was the least popular learning method. Externally provided and in house programmes of study were often used, and fairly well received. However, the most preferred methods of professional development were practice-based learning, blended learning and shadowing – methods which participants said, are used infrequently. Observations, however, showed that these methods are used, but are not necessarily recognized as learning experiences as they occur informally. An important factor in the quality of learning when using practice based learning or shadowing is the quality of the practice of the person/people modelling or supporting the learning process. The practice based facilitators of learning must be both occupationally competent /proficient and proficient in facilitating and assessing practice proficiency in others. At present there is limited availability of such support.

The primary concern for participants regarding learning was finding time to study. This was a particular problem for night shift staff, as this group struggled to access daytime education sessions. There were also concerns about written work/presenting, even at specialist and advanced levels, and essential level participants were concerned that paid hours for education sessions outside their usual working hours would impact on employment benefits. These concerns may contribute to why work-based and blended learning were popular options i.e. they involve practical learning and assessment methods, aspects of which could be integrated into work time, so that concerns about time, night shift working, written work and benefit payments could be reduced. Essential and specialist level participants were also concerned about using IT/accessing IT at home, which may contribute to why e-learning was so unpopular.

The findings suggest that practice-based and blended learning methods are not just preferred, but may enhance competency. The nursing assistants in location A consistently worked at a higher competency level than health care assistants. Nursing assistants undertake an in-house professional development programme, which includes some work-based learning, and shadowing the management team and RNs. This may contribute to their higher competency levels. OPSN Band 7 nurses consistently worked at higher competency levels than other nurses. A number of factors may contribute to this, for example, their seniority as nurses, and their advanced clinical and prescribing skills. However, their exposure to, and participation in, virtual ward rounds facilitates their upskilling as these events act as forums for teaching and learning between consultants and nurses. An additional factor affecting these learning experiences is the relevance of learning to all individuals irrespective of their role and level of practice. Many of the cases discussed during virtual wards rounds are complex cases that require clinical management from the multi-professional team. No single professional knowledge base is adequate on its own for effective care, thus learning occurs across the multidisciplinary team when professionals involved in the case share their understanding of the problem and potential interventions and solutions. After the rounds, presentations and learning sessions addressing issues that are relevant to attendees further enhance these learning experiences.

Accommodating the preferred learning methods identified in this study on a more formal basis would require a shift in the way learning and professional development programmes are commissioned, provided and delivered. There would need to be less emphasis on training, e-learning and ‘classroom’ type teaching, and much more emphasis on learning, and developing skills and competency using practice based, shadowing and blended learning methods.

The vast majority of participants said having a recognised qualification in the care of older people with complex needs was important as a means of developing new knowledge, improving care, improving confidence, recognising prior skills, influencing change, and career progression. Having a recognised qualification would also enable a more standardised approach to competency development. This would reduce variation in competency across sectors and organisations, and facilitate more effective multi-professional working that can rely on an expectation that there is standardisation of competencies within professional groups. A standardised and recognised qualification would also be more acceptable to professional, regulatory and commissioning bodies. However, findings suggest that achieving a knowledge based qualifications is not enough in itself to develop competency/proficiency. Programmes of learning and development need to be

directly relevant to enable achievement of the specified competencies within the EnCOP framework, through the development and assessment of BOTH knowledge and understanding AND competency in practice, if they are to enhance competency in the care of older people.

Competency

Findings demonstrated that nurse participants working in the NHS have higher competency levels than nurses working in care homes. A contributory factor may be that NHS nurses can access a range of learning opportunities not open to care home nurses. This includes updates and assessments to maintain competency in a range of clinical skills and interventions. This suggests a need to for an infrastructure that facilitates learning and competency development across sectors, so that the workforce is able to respond to patient need seamlessly and efficiently.

Location A employed nursing assistants who had undertaken an in-house programme of professional development that develops management skills, clinical skills and skills specific to the care of older people including dementia, mental health, frailty and end-of-life care. The rationale behind developing nursing assistants is to enhance the competency of the non-professional care workforce. This group works at a higher level of competency than health care assistants. Location B did not employ nursing assistants but were keen to explore ways of introducing this role into their organisation as they were aware that other companies were successfully developing the role. The current nursing associate apprenticeship (Institute for Apprenticeships, 2016) could be utilised and adapted to develop a role specific to care homes.

Both pilot care homes were sited in locations that align OPSNs and GPs with care homes, which allows care homes to access multi-disciplinary ward rounds, and wider health and social care services. Comparisons of location and competency domains/sub-domains showed that in many areas, specialist and advanced level competency scored significantly higher in location A than in location B. This may be due to the influence of location A's virtual ward model, which: uses the input of consultants with specific expertise in the care of older people with complex needs; promotes inter-professional working and facilitates the upskilling of OPSNs via maximizing learning opportunities between consultants and nurses, and the availability of senior OPSNs working at a higher competency level. Rolling out this model may enhance competency in other localities.

The EnCOP framework is based on the premise that having knowledge and skills in care delivery is not enough on its own. Practitioners need to have the right values, be able to

work together, and lead and improve care if the care delivered is going to be effective – hence the A B C D structure of the framework. This premise was borne out in this study as findings showed a positive relationship between collaborative working competency and clinical skill competency; teaching, learning and support competency and clinical competency; and leading, organising and managing competency and clinical competency. Any professional development or learning programme should therefore embed within it these competency development areas. A particular area requiring development within the teaching, learning and support sub-domain was supervision processes and competency assessment. In terms of supervision, standard, valid and robust practices are required that meet the needs of professional, regulatory and commissioning bodies, and that aim to improve and ensure safe practice. In terms of competency assessment, it was very clear in the findings that the number of individuals proficient in competency assessment needs to expand. These individuals need to be able to demonstrate competency in their own clinical area, and strategies are required to facilitate these individuals to work across sectors. In order to meet the competencies required for a standardised qualification, methods of assessment need to be standardised, integrated with, and encompass the knowledge, understanding and values of a standard competency framework such as EnCOP.

Throughout all stages of the study, it was found that difficulties in accessing funding to support competency development was a significant barrier to upskilling and developing the workforce caring for older people with complex needs. It is essential that current available funding streams are identified, publicised and made easily accessible to all organisations and sectors. Also, plans and solutions at a strategic level are required to ensure maximisation of efficiency and effectiveness of funding streams.

Accreditation and recognised qualifications

The vast majority of participants said having a recognised qualification in the care of older people with complex needs was important as a means of developing new knowledge, improving care, improving confidence, recognising prior skills, influencing change, and career progression. However, the findings suggest that achieving a knowledge based qualifications is not enough in itself to develop competency/proficiency. Programmes of learning and development need to be directly relevant to enable achievement of the specified competencies within the EnCOP framework, through the development and assessment of competence in practice underpinned by knowledge and understanding at the appropriate level in the care of older people with complex needs. Some relevant national frameworks exist for recognised qualifications with accreditation, however there are some gaps which can be addressed by actions as identified below.

Advanced Clinical Practice (ACP)

Health Education England has recently published the Multi-professional framework for advanced clinical practice in England (ACP). This framework, which builds upon previous work, guides the preparation of the ACP workforce in a consistent way to ensure safety, quality, and effectiveness. The framework has been developed for use across all settings including primary care, community care, acute, mental health and learning disabilities and is multidisciplinary in its approach. It sets out the required core capabilities for health and care professionals if they are to be considered and recognised at working at the level of advanced clinical practice. The framework sets out the educational requirements and key principles and governance expectations to guide the planning and development of the ACP workforce including the generic knowledge and competencies of advanced clinical practice (around 80% of the curriculum), however there is recognition that the application of advanced clinical practice requires specific knowledge and competencies relevant to the client group. As such, ACP programmes, which are commissioned by HEE enable them to be aligned to particular contexts of practice through specific content and competencies. For example, in a local pilot, HEE have commissioned the development of an ACP programme with defined pathways including one specific to the care of older people with complex needs. This will result in an academically accredited qualification, a Post Graduate Diploma in Advanced Clinical Practice, which is at the required level 7 and maps to all required capabilities and pillars of Advanced Clinical practice and the EnCOP framework. Whilst there are a limited number of HEE funded places in the pilot phase, there is potential to commission further places, provided capacity is built to enable assessment of proficiency specific to the context.

In recognition of the importance of the ACP role in many contexts of practice, an apprenticeship standard is currently in development. https://www.instituteforapprenticeships.org/apprenticeship-standards/advanced-clinical-practitioner-degree/

Once finalised, employers can use their apprenticeship levy to fund new or existing employees who meet the entry criteria (must be registered health professionals who are at graduate level) to undertake the apprenticeship with 80% of time in practice based learning and 20% in formal learning. The funding band has not yet been published, which will indicate the maximum amount employers can draw down from the levy pot to enable them to commission a local provider. Education providers who are on the apprenticeship provider

framework can provide such programmes, and can align their ACP provision with the EnCOP framework.

Specialist Practice

The nature of specialist practice encompassed in the EnCOP framework is not reflective of the knowledge and competencies of either the Registered Nurse Adult (Level 6 Degree in Adult Nursing, although previously Advanced Diploma, Diploma or Certificate level) or Registered Manager award (Level 5 Diploma in Leadership for Health and Social Care – adult care, previously Level 4 Certificate). Both awards are of relevance and provide background knowledge and competence, however, as indicated in the EnCOP competency framework, Specialist Practice includes additional knowledge and competence relating to all domains of the EnCOP framework, but specifically Domain D, knowledge and skills for practice required when caring for older people with complex needs. An additional period of learning, building on the initial qualification could enable achievement of the required competencies at the level of specialist practice. Specialist practice is located at level 6 (degree level) on the regulated qualification framework.

A multi-disciplinary programme of learning and assessment could be developed and provided at level 6 (degree level) to enable nurses, AHPs or care home managers to develop proficiency at the specialist level of the EnCOP framework. HEE currently commission continuing workforce development (CWD) and this study should inform future commissioning decisions. Consideration would be needed of the current restrictions on access to HEE funded CWD highlighted in this report to make this an accessible and equitable provision for all relevant staff whether employed in independent or NHS sector.

In order to provide a longer term sustainable funding solution, there is the option of developing a new apprenticeship standard via the trailblazer route. Apprenticeship standards can be developed in relation to a defined job role (Specialist Practitioner in Care of Older People with Complex Needs). It must be employer led to meet an identified workforce development gap, and involve at least 10 employers. The trailblazer process is outlined via the link but does take around 18 moths to develop and reach approval for delivery

https://www.gov.uk/government/publications/how-to-develop-an-apprenticeship-standard-guide-for-trailblazers

Essential practice

Those providing the essential level of care described in the EnCOP framework are mainly support workers/senor support workers employed in the independent sector adult social care. Funding for adult social care WFD is from Skills for Care via their WFD fund (£12m) now mainly provided via apprenticeships which develop occupational competence rather than short training courses.

Apprenticeship standards approved for delivery include;

- Healthcare support worker (level 2)
- Adult care worker (level 2)
- Lead adult care worker (level 3)
- Nursing Associate (level 5)
- Healthcare assistant practitioner (level 5)

Other apprenticeship routes are in development

- Lead practitioner in adult care (level 4)
- Leader/manager in adult care (level 5)

The findings from the study support recent strategic intent to join up the system to commission, provide more effective WFD and evaluate the impact.

"*HEE currently spends over £350 million each year supporting workforce development. Alongside this there is investment by other national bodies on specific service areas (such as NHS England's investment in IAPT training), the investment of employers, and of staff members themselves on CPD. However, there is a growing recognition that we need to seek to align all this investment from across the system to better develop the workforce to deliver improvements in patient care."* HEE (2017: 46)

However, as identified by HEE

"There are no standard training requirements across large parts of the adult social care sector with too many staff not receiving training or professional development, despite providing direct care for vulnerable adults whose dignity and quality of life is dependent on the quality of their work. The Care Certificate, developed by HEE, Skills for Care and Skills

for Health, provides a standard induction framework across social care and health. There is no mandated …development across employers. " (HEE 2017: 69)

Whilst the Green paper on adult social care is due to be published summer 2018, this report provides evidence to inform the need for appropriate workforce development to support integrated models of care:

https://www.gov.uk/government/news/government-to-set-out-proposals-to-reform-care-and-support

6: Recommendations

Recommendations for workforce development

The research highlighted the lack of an integrated system based approach to workforce development and the problems and barriers inherent in the use of a training approach. At the stakeholder event, participants considered the options available, and indicated support for the adoption of a workforce development approach, which focuses on both individual learning and the system wide changes needed to enable the development and assessment of proficiency across the workforce aligned to the EnCOP framework. The study identified a lack of capacity and capability across the system to support practice based learning. It also highlighted that we do not have a clear picture of the potential funding available via the apprenticeship levy or other sources to support future workforce development in the older person's workforce.

Recommendation 1: Adopt a whole system approach to integrated older people's workforce development

An ageing society, with an associated increase in people with complex health and social care needs, requires a workforce, now and in the future, that is competent in the management of complex care as well as capable of working in pathways within and across organisations. Shunting service users across service boundaries and across sectors for specialist care should be a thing of the past, and service delivery can be wrapped around the older person and their family in integrated health and care systems. This transformation requires a whole system approach to workforce development. Appointment of a designated body or workforce development lead within the STP footprint, and localised practice educators who are both occupationally competent to specialist / advanced level of the EnCOP framework and proficient at facilitating learning and assessing proficiency in others who have responsibility for, and agreement to work across organisational boundaries would ensure that WFD strategy and solutions are based upon evidence and offer standardization of approach and economy of scale. The appointed workforce development lead could work with commissioners of services to develop service specifications providing leverage for the recommendations to be embedded within employing organisations.

Recommendation 2: Gain agreement across all sectors for adoption of a competency framework for all levels of practice to deliver enhanced care for older people with complex needs

The older people's workforce is diverse and for effective care and service delivery there is a need for standardisation of competency across organisations and sectors. This can be achieved through agreement of competency to practice rather than on role requirements. The EnCOP framework offers elucidation of competencies required at essential, specialist and advanced levels of practice across the whole workforce. Consideration should be given to aligning job descriptions, professional and regulatory requirements against the EnCOP framework within public and independent sector organisations across the region. At present there is variation in the competence of professionals working at specialist and advanced levels of practice, with a greater degree of standardisation in essential practice. The evidence from this study suggests that the variation in specialist and advanced practice is not widely acknowledged, and that there is potential to upskill groups within the older people's workforce in the management of complex healthcare. This situation contributes to some of the challenges of inter-professional practice and working across organisational boundaries. With the adoption of a competency framework, such as EnCOP it would be possible to adopt a 'Passport of competence' or 'Passport to practice' by the workforce. This would support working across organisational boundaries and enhance inter-professional working through recognition of personal competence to practice.

Recommendation 3: Develop infrastructure for practice based learning and assessment

Develop necessary strategic infrastructure, via funded practice educator roles as described above, covering a specific geographical location eg a CCG area, to lead, develop and support a network of practice based mentor/assessors to facilitate practice based learning and assessment. Practice educator roles provide an effective link between practice and education and have been used effectively in a range of contexts to support a workforce development approach. The roles should span organisational boundaries and have the necessary strategic agreement in place to support workforce development across a sector, and able to work across NHS, private, independent and voluntary sector providers. The practice educator role requires the post holder to be proficient in the practice context (able to demonstrate proficiency at advanced practice level of the EnCOP) and proficient at facilitating learning and workforce development with responsibility for:

- Strategic leadership of WFD for the older people's workforce across organisational boundaries within a given geographical locality.
- Development of capacity for practice based learning and assessment through the identification and facilitation of staff from care homes and community settings to achieve the NMC mentor standards (or alternative, as the standards are currently being reviewed) through access to the taught mentor/assessor module which is HEE funded, or through the accreditation of prior experiential learning route for those with experience but without a relevant qualification.
- Partnership working with education providers to develop and deliver accredited programmes relevant to each level of the EnCOP framework which are delivered in the practice setting using a blended learning approach. Such programmes may be aligned to the appropriate apprenticeship standards (employer funded via the levy payment) or specifically commissioned using HEE or other funding sources.
- Facilitate the development of necessary policies, procedures, and memoranda of understandings as required to enable cross system acceptance and agreement of practice based assessment of proficiency. Cross organisational competency sign off is urgently needed to enable professionals to work across health and care sectors, which is increasingly becoming common place as new models of care are being embedded across older people's services.

Recommendation 4: Equality of access to practice-based learning for development of proficiency at all levels of practice

Cross organisational and professional learning and development is important in increasing the workforce's ability to manage complex care and this has a positive impact on the individual's confidence and skills in fulfilling their role. Traditionally there has been a lack of parity for all sections of the older people's workforce to access learning opportunities and this has contributed to variation in competency across the workforce. The move to an integrated approach to workforce development requires all learning and development opportunities for all member of the workforce irrespective of the employing organization.

Commission the development and delivery of accredited programmes of study which lead to the development of proficiency at each level of the competency framework (essential, specialist, advanced) which are:

- Practice based.
- Integrated with routine practices as opportunities for learning (ward rounds in care homes; virtual ward).

- Interprofessional, and facilitate opportunities for shared learning with experts in a locality.
- Provided via a blended learning model
- Where technology enhanced learning/e learning is used it should be of high quality and underpinned by pedagogy of effective TEL (DH 2011)
- Academically accredited at the relevant level
- Enable 'Recognition and Accreditation of Prior Learning' (RPL).
- Assessed in theory and practice (enable achievement of proficiency)
- Provide a 'learning passport' which is recognized across the system.

Consideration should be given to developing, or further development of, accredited programmes of learning where gaps exist in the workforce. These include:

- Development of a trailblazer in multiprofessional/multi-skilled specialist practice for older people with complex needs.
- Using or adapting the current nursing associate apprenticeship (Institute for Apprenticeships, 2016) in the care home sector.
- Having student nurses on placement in care homes increases the future workforce competence in managing the complex needs of residents. This this model should be encouraged and consideration given to rolling this out across other professional groups.

Recommendation 5: Develop understanding of funding sources, options and related issues

There is a need for employers to explore sources of funding to support workforce development including the apprenticeship levy; European Social Fund; Better Care Fund (if it could be demonstrated that this would improve outcomes); and HEE commissioned CWD provision under the widening access policy. Through collaborative working it is feasible that employers will be able to access funding for workforce development that has not been previously available.

Identify and engage employers in the sector to explore potential funding available to support WFD via the apprenticeship levy. Employers with a pay bill of over £3 million per year have been subject to the levy since April 2017, which means 0.5% of their pay bill is paid into the apprenticeship fund via PAYE. Employers receive a 10% top up into their digital account. They may draw down this funding to use for approved apprenticeships for their own staff. Each apprenticeship standard has a maximum amount of funding that can be drawn down

(for example £3,000 for a support worker, £27,000 for a nursing apprenticeship) and used to commission an education provider who is on the approved provider list of apprenticeships.. Apprenticeships are provided via a partnership model, where the education provider is responsible for the learning and assessment of the apprentice, and the employer is involved in the assessment of the apprentice in their work role. Employers who do not use the levy money they have paid in, lose it. Smaller employers not subject to the levy can use the levy fund to pay 90% of the cost of an approved apprenticeship for their staff, with the employer responsible for the remaining 10% of the cost.

Exploration of the use of levy funding should involve key people within provider organisations (NHS, private and independent providers) who have information and influence on their organisational intent and use of the apprenticeship levy and the amount available to them. Agreement for the strategic use of levy funding should be sought to benefit the whole sector.

Recommendation 6: Commission an evaluation of outcomes which incorporates effectiveness of WFD

Given the investment in WFD, it is important that any strategic WFD programmes are properly evaluated (HEE 2017). Evaluation should provide evidence of impact on the participants and those they support (residents/patients). Kirkpatrick's (1994) four stage model of evaluation focuses on reaction, learning, behaviour, results.

- Reaction: Did individual learners enjoy and benefit from the learning experience?
- Learning: Was there an improvement in knowledge, skills and values?
- Behaviour: Have learners changed the way they practice as a result of learning?
- Results: What are the outcomes of WFD on patient/resident outcomes?

7: Appendices

7.1: Links to the phase 1, strand 1 surveys:


essential.html


specialist.html


advanced.html

Appendix 7.2

Observation Survey Tool – Phase 1, strand 1

Each attendee at the virtual ward round who is a study participant is to be observed. Oberved competence and confidence should be mapped against the following EHC framework domains and sub-domains (refer to the full EHC competency framework to assist with mapping if necessary).

Values, attitudes and behaviours

Participant N/A	Role	EHC framework level (essential, specialist, advanced)	Not at all	Not very	Somewhat	Very
P1	-------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	-------	--------
P3	-------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	-------	--------

(add further participants if necessary)

B: Workforce collaboration, co-operation, communication and support

B1: Inter-professional and inter-organisational working and communication

Participant N/A	Role	EHC framework level (essential, specialist, advanced)	Not at all	Not very	Somewhat	Very
P1	-------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	-------	--------

P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

B2: Teaching, learning, and supporting competence development

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------
P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

C: Leading, organising, managing and improving care

C1: Leading, organising and managing care

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------

P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

C2: Improving care

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------
P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

D: Knowledge and skills for care delivery

D1: Communication with older people, families and friends

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------

P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

D2: Care process

D2.1: Assessing, planning, implementing and evaluating care

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------
P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

D2.2: Pharmacology and management of medicines

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------

P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

D3: Promoting health, wellbeing and independence

D3.1: Promoting and supporting independence and autonomy

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------
P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

D3.2: Promoting and supporting holistic health and wellbeing

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------

P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

D4: Management of dementia

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------
P3	-------	----------	----------	----------	----------	-------	--------
P4	-------	----------	----------	----------	----------	-------	--------
P5	-------	----------	----------	----------	----------	-------	--------

(add further participants if necessary)

D5: Management of mental health

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	-------	----------	----------	----------	----------	-------	--------
P2	-------	----------	----------	----------	----------	-------	--------
P3	-------	----------	----------	----------	----------	-------	--------

P4	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**
P5	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**

(add further participants if necessary)

D6: Management of frailty

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**
P2	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**
P3	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**
P4	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**
P5	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**

(add further participants if necessary)

D7: End of life care

Participant	**Role**	**EHC framework level**	**Not at all**	**Not very**	**Somewhat**	**Very**	**N/A**
		(essential, specialist, advanced)					
P1	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**
P2	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**
P3	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**
P4	**-------**	**----------**	**----------**	**----------**	**----------**	**-------**	**--------**

P5	**-------**	**----------**	**----------**	**----------**	**-------**	**--------**

(add further participants if necessary)

Appendix 7.3: Information sources concerning apprenticeships and funding

Apprenticeship standards can be found here:
https://www.gov.uk/guidance/search-for-apprenticeship-standards

Standards in development here:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/641042/Copy_of_CURRENT_STANDARDS_IN_DEVELOPMENT.pdf

If no standard exists that meets employer specific need employers can group together (needs at least ten employers) to form a trailblazer:
https://www.gov.uk/government/publications/how-to-develop-an-apprenticeship-standard-guide-for-trailblazers
Frameworks .gov.uk/government/publications/how-to-develop-an-apprenticeship-standard-guide-for-trailblazerstrailblazers"
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/601512/Apps_Framesworks_Standards_A_to_Z.pdf

If you as an employer and know which apprenticeship standard you require for your employees you can find a provider here by doing a postcode search:
https://findapprenticeshiptraining.sfa.bis.gov.uk/

You can keep up to date with new standards being approved and proposed nationally here and there is an opportunity to log and comment on proposals every month:
https://consult.education.gov.uk/

Funding bands for standards and frameworks can be found here:
https://www.gov.uk/government/publications/apprenticeship-funding-bands

Funding guidance for levy payers can be found here:
https://www.gov.uk/government/publications/apprenticeship-levy-how-it-will-work/apprenticeship-levy-how-it-will-work#non-levy-paying-employers

Funding guidance for non-levy payers can be found here:
https://www.gov.uk/government/publications/apprenticeship-levy-how-it-will-work/apprenticeship-levy-how-it-will-work#non-levy-paying-employers

All training providers (including employers wishing to deliver training to their own staff) must be on the Register of Approved Training Providers. See here:
https://roatp.apprenticeships.sfa.bis.gov.uk/download

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