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**Why you should read this article:**

- To read about a replicable skills-led learning programme to equip multidisciplinary adult community teams with the knowledge, skills and competencies required to meet the complex needs of older people at home
- To recognise the benefits of a versatile, multiskilled workforce for individual practitioners and for the wider healthcare system
- To understand the need for organisations to invest in their current workforce's abilities and skills to support the move towards community-based care

# Equipping the healthcare workforce to meet the complex health needs of older people in the community: a skills-led approach

**Marie Prior, Susan Blake and Helen Lyndon**

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## Abstract

The shift towards delivering more clinical care in the community not only supports the healthcare system by avoiding unnecessary hospital admissions, but can also improve outcomes, particularly for older people with complex healthcare needs. Therefore, healthcare organisations need to consider how to ensure their workforce has the capabilities required to provide care in accordance with this new model. This article details a project that involved the design and development of a replicable Ageing Well programme of learning to increase knowledge, skills and confidence among registered and unregistered practitioners, underpinned by a 'skills not roles' strategy. Although evaluation of the programme is ongoing, the authors encourage its wider adoption by outlining its benefits, how the challenges encountered during this project were overcome and the learning points gained from the experience.

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## Keywords

**community, community care, competence, healthy ageing, older people, professional, professional development, professional issues, workforce**

In the UK, people are living longer now than at any other time in history, but this does not necessarily mean that they are in better health as they age (GBD 2019 Demographics Collaborators 2019). There is evidence that the gap is widening between longevity and health span (the length of time that a person is generally in good health) (All Party Parliamentary Group for Longevity 2021). This means that a greater number of people are living with several long-term conditions and are therefore at increased risk of clinical deterioration and hospital admissions (National Institute for Health and Care Research 2021).

The NHS (2019) Long Term Plan outlined the long-term goals to move from reactive care towards proactive models centred on early intervention and to transfer more hospital-based care to community-based care. This includes the implementation of services that focus on avoiding hospital admissions, such as urgent community response (UCR) services (NHS England 2023a) and virtual wards (NHS England 2023b). UCR services provide a rapid response within two hours to assess, treat and support individuals in health crisis in their usual place of residence, with the aim of preventing an acute admission to hospital. Examples of typical presentations which may

require a UCR include frailty symptoms, urgent catheter care, acute delirium with unknown cause and new or deteriorating mobility issues.

A literature review into the clinical effects of moving care closer to home found that community-based care carries less risk and is of greater benefit for individuals compared with hospital-based care (Monitor 2015). A later study found that outcomes for a group of older patients with frailty could be enhanced at home through an admission avoidance hospital at home intervention (Shepperd et al 2021). With larger caseloads becoming the norm for community practitioners, the changes in how clinical care is delivered – together with the growing clinical complexity of patients – have implications for the scope of community practice. As a result, the health and social care workforce may feel underequipped and unprepared to manage the clinical demands placed on them. The implementation of new services with a focus on avoiding hospital admissions might not always consider the skills and capabilities of existing staff to provide these services. The term 'capabilities' is used here to refer to a level of competence that includes the ability to perform successfully in situations that may be complex and necessitate adaptability and creativity (Skills for Health 2022).

This article presents a project from a community NHS trust in south west England, describing how the trust has responded to the shift in healthcare services by enhancing the knowledge and confidence of the workforce with a focus on 'skills not roles'. Although this may be a challenging cultural and professional transition, it is necessary for moving towards integrated care systems detailed in the NHS (2019) Long Term Plan. While the emphasis is frequently on the integration of the health and social care sectors, it is crucial to acknowledge that there is still work to be done in organisations to avoid silo working.

This project highlights how the development of a versatile and multiskilled workforce can be a driver of integration at all levels, with benefits to the wider healthcare system and workforce in terms of flexibility, morale and career progression. The project fits within a 'bottom up' rather than 'top down' approach, which is a critical element in the effective deployment of integrated care systems (Wodchis et al 2015). The development of an integrated system that prioritises what is essential to older people requires input at clinical, service and system levels (Lawless et al 2020).

## Background

Historically, in addition to traditional community nursing teams, new services were commissioned to support specialist care in the community, such as heart failure services, respiratory teams and intermediate care services. Contrary to the structural changes brought about by the Health and Care Act 2022, which were characterised by collaboration and integration, these new services evolved based on contracted commissioning specifications and had an underlying transactional relationship. In the authors' professional experience, this contributed to the development of a culture where teams were detached from each other, only delivering activities contained in service specifications. As a result, skills such as venepuncture and catheterisation were perceived to be procedures for the community nursing service and no longer recognised as requiring specialist services and intermediate care. Additionally, the growth of specialist services has led to greater depth of knowledge in specific clinical areas, for example Parkinson's disease or diabetes mellitus, but with a narrower scope in skills and confidence in general community care.

The authors observed that there was a tolerance of task-oriented care in community nursing, with practitioners identifying that they were not allocated sufficient time to undertake comprehensive assessments for complex individuals, for example those with multiple long-term conditions or frailty. This local trend was reflected nationally in research that revealed an increasingly task-oriented care model, practitioners who were hurried and abrupt with patients, a decline in preventive care and a loss of continuity of care (Malbin et al 2016). In 2019, an analysis of what makes an outstanding community nursing service by The Queen's Nursing Institute and the Royal College of Nursing (2019) found that district nurses were 'compelled' to work in a task-oriented way due to a lack of investment in community nursing.

As part of its role as one of ten accelerator sites for delivering a UCR service, the trust committed to investing in the expansion of its current workforce and skills rather than setting up a standalone service. The development of a UCR service as an integral part of a wider community offer was aligned with the move towards an integrated care model. It aimed to provide seamless access to a multidisciplinary team of professionals, optimising the efficiency and effectiveness of the workforce. This approach also reflected the emphasis in national guidance for a two-hour UCR service to use practitioners in an interdisciplinary way,

whereby people from other disciplines agree to take on elements of others' roles to best use their skills and knowledge as a team (NHS England 2022). This was particularly important for older people with frailty, many of whom had complex needs and/or multimorbidity, who would meet the clinical criteria for the UCR service and would be at high risk of hospital admission if they were experiencing a health crisis.

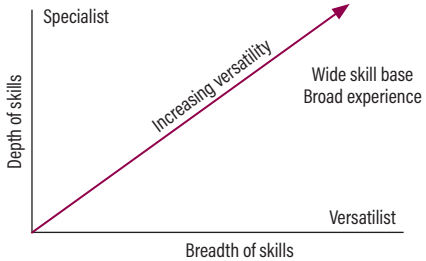
Rather than concentrating on specific roles, a 'skills first' strategy was used. The purpose of this was to identify the multifaceted abilities that all practitioners require to function efficiently and flexibly, not to formally redesign roles. The NHS England (2020) People Plan encouraged this shift towards versatility by emphasising the value of developing capabilities and adaptable skills rather than traditionally defined roles. It describes the importance of staff working and learning together in multi-professional teams as critical to keeping patients and staff safe. Figure 1 shows the theory used for developing a versatile workforce.

While the focus of the project at this stage was on skills and not structures or pathways, some of the challenges centred on out-of-date working practices and patterns that did not reflect the requirements of the current healthcare landscape. The project's focus on skills acknowledged the workforce as the most important resource in the organisation. It was also a response to the widening gap between service demand and delivery that could not be filled by simply recruiting more staff.

## Aim and initial steps

The aim of the project was to develop versatile and confident practitioners whose practice was evidence-based and who had the clinical competence to meet the complex needs of older people at home. The starting point was to gain an understanding of the skill mix required to achieve this aim and the current competencies of practitioners working in the community. A peer consultation involving community practitioners enabled the development of a skills matrix that identified the skills required to meet the complex needs of older people with multimorbidity and/or frailty. Between October 2021 and July 2022, practitioners were asked to complete the matrix and assess themselves as competent or not competent and to specify the reason if they were not competent or not using the skill.

**Figure 1. Developing a versatile workforce**




The findings of this skills review, along with anecdotal observations in practice, were captured on a spreadsheet. A subsequent analysis of these data provided insight into trends relating to the competence and confidence levels of practitioners and these teams' attitudes and cultural norms. The analysis produced some rich information on practitioners' skills and capabilities and valuable insights into why they were not always using some of the skills they deemed themselves competent in. Reasons staff gave for not using their skills included:

- 'We don't do that in our service.'
- 'It's not on my job description.'
- 'I always refer to a specialist service for that.'
- 'I'm not allowed to do that because I'm not registered.'
- 'I haven't done it for so long, I don't know how to do it now.'

The main issues identified from the skills review were:

- Existing interventions were task-oriented or disease-specific and were not routinely reflecting the changing complexity of clinical needs being met in the community rather than in a hospital setting.
- Lack of knowledge regarding the management of long-term conditions and assessment of people with frailty, evidenced by the frequent use of a task-oriented rather a person-centred approach.
- Subsequent overreliance on referrals to specialists rather than first considering 'What can I do?'.
- Overreliance on GPs for clinical decision-making and subsequent loss of clinical autonomy.
- Silo working, resulting in some practitioners' loss of capability to perform clinical skills regularly used in the community setting, for example venepuncture and catheter care.
- A lack of confidence in responding to and managing complex older people, including those in health crisis.
- A process of reactive care that addressed the patient's presenting signs and symptoms but did not explore the additional underlying issues that may have led to a health crisis or that could become a health crisis in the future if not identified proactively.

## Development of the Ageing Well programme

The findings from the skills review prompted the development of an education and coaching programme that emphasised clinical curiosity and learning throughout the entire clinical team, with an aim of empowering practitioners to optimise and value their skills. A core feature was registered and unregistered practitioners from nursing and allied health professions learning together, embracing Health Education England's (2017) philosophy of lifelong, flexible, adaptive and interdisciplinary learning. Registered practitioners included nurses (community, ward, specialist and digital health nurses), nursing associates, occupational therapists, physiotherapists and dietitians. Unregistered practitioners included community support workers, generic therapy assistants, healthcare assistants, assistant practitioners and falls technicians.

Developing a curriculum where unregistered and registered practitioners from different professions would be learning together in a classroom setting required careful planning. To support this, two sets of learning objectives and competencies were developed that were informed by relevant capability frameworks, for example the frailty framework (Health Education England et al 2018), virtual ward and urgent community response (Skills for Health 2022) and the Nursing and Midwifery Council (2018) standards of proficiency for registered nurses.

While it was uncertain how effective this joint learning approach would be, interprofessional and multilevel learning was an important element that would encourage new ways of thinking and challenge norms and working practices in the context of a supportive learning environment.

## Structure and content of the programme

The programme consisted of five face-to-face taught classroom days focused on increasing knowledge and skills in a range of subjects relevant to the healthcare of adults with complex needs in the community. All the sessions included the identification and interpretation of symptoms and clinical signs, underpinned by a structured model of clinical enquiry and strategies to promote clinical reasoning and decision-making. There was also an emphasis on skills to support the proactive management of long-term conditions, all with a focus on older people and how to support individuals to age well.

A holistic approach ensured that physical and mental health dimensions were included. Box 1 outlines the content of the Ageing Well programme.

The content took into account the needs of registered and unregistered practitioners and the differing levels of practice and proficiency they required. During the sessions, a clear distinction was made between the actions, behaviours and responsibilities that were within the scope of practice of all practitioners and those specifically relating to registered practitioners.

Following the taught days, participants received place-based one-to-one coaching to reinforce the transfer of knowledge into practice. The trust invested in three clinical facilitators, a new band 7 role that would work with practitioners in the workplace. The ethos was one of 'being alongside', characterised by an emphasis on coaching that also provided an opportunity for modelling professional behaviours and standards and challenging cultural norms.

Learning and competence were demonstrated by the completion of an online portfolio comprising ten sections (Box 1). Each section contained a list of learning objectives and competencies, along with content and a range of resources to develop and demonstrate competence. The portfolio was developed not simply as a record of competence, but as a comprehensive resource of learning materials. The online platform used for the competency portfolio enabled real-time editing and facilitated the sharing of further resources and support. Participants could continue to access their portfolio after programme completion, as a record of their competence and to encourage ongoing learning and professional development.

**Box 1. Content of the Ageing Well programme**

Five taught classroom days focusing on:
- 'Top-to-toe' screening and assessment
- Clinical enquiry and reasoning
- The biology of ageing
- Long-term conditions
- Dementia, delirium and depression
- Nutrition
- Medicines reviews
- Identifying patients who are approaching the end of life
- Falls and reablement
- Health promotion and prevention

Followed by:
- Place-based coaching in practice to support completion of a competency-based portfolio

## Key points

- A move away from reactive care towards proactive models centred on early intervention requires services that focus on avoiding hospital admissions
- The implementation of new services that focus on avoiding hospital admissions might not always consider the skills and capabilities of existing staff to provide these services
- Adopting a 'skills first' strategy identifies the multifaceted abilities all practitioners require to function efficiently and flexibly to meet patients' complex needs
- Workforce development strategies where the focus is 'skills not roles' are necessary, practical and achievable

## Evaluation of the programme

At the time of writing, 102 practitioners across three cohorts had completed the programme. Evaluation has focused on its effect on the clinical practice of individual practitioners who have completed the training, with interviews conducted with each participant from the first cohort (*n*=30). For subsequent cohorts, baseline data were also captured at the start of the programme via the questionnaire, which asked practitioners to self-report their levels of knowledge and confidence in relation to the programme's aims and objectives. The same questionnaire was administered at the beginning of the programme and after the follow-up coaching to assess improvement in participants' knowledge and confidence. All 102 practitioners completed these baseline and post-programme evaluation questionnaires. During the place-based coaching, further insights into the effect of the programme were gained from the clinical facilitators, who received informal feedback from managers, team leads and the wider teams in which participants worked.

Consistent feedback was received that, following completion of the programme, participants were less task-oriented when they visited patients, using new knowledge and skills that enabled them to identify subtle changes in patients' conditions and provide timely preventive care and advice. One allied health professional who completed the programme said:

*'The programme gave me the knowledge and confidence to be able to support my patients to age well, regardless of their age. It has brought forward in me a different way of thinking, treating and assessing older people.'*

The clinical facilitators who were accompanying practitioners on their visits identified that, after completing the programme, the practitioners were able to 'do more' for the patients they visited and were more confidently able to draw from a wider skills base. They also observed that a shift in mindset towards a more proactive and holistic response had taken place among those who had completed the programme. This was demonstrated primarily by their more thorough 'top-to-toe' assessment skills, which enabled practitioners to explore potential underlying causes for patients' presenting signs and symptoms and to integrate elements of preventive healthcare.

When comparing baseline and post-programme evaluation questionnaires, registered practitioners demonstrated improvements in their levels of knowledge, skills and confidence, which enabled them to do more for patients and increased their job satisfaction:

*'I now have a better understanding of how medications can impact older people and always check whether a medication review would be beneficial to see if deprescribing may be an option.'* (Cardiac specialist nurse)

*'It has had a fantastic impact on my role. My assessments have improved tenfold. I provide more in-depth holistic care and have been sharing this within my team to ensure we are making the most of our visits and stopping the scattergun approach to referrals.'* (Community nurse)

Unregistered practitioners also demonstrated improvements in the questionnaires, with one community support worker stating:

*'It's completely opened up how I work and how I look at things. Doing a top-to-toe assessment during each visit is really important. I'm now more aware of what to look for, picking up subtle changes in the patient's condition and providing preventative care and advice.'*

However, there were some differences in relation to specific components, for example malnutrition and falls assessments. Interviews with the participants identified that these differences were mainly due to inconsistencies regarding the skills that unregistered practitioners were permitted to undertake in different teams, rather than a lack of knowledge and confidence. One issue highlighted by the programme was discrepancies in the scope of roles, particularly for unregistered practitioners.

Many unregistered and registered practitioners expressed how the programme had reinvigorated their desire for learning. Observations by clinical facilitators in practice found that unregistered practitioners wanted to develop their skills and be able to do more for patients. Furthermore, team leads and managers said they had noticed a difference in members of their team who had completed the programme, specifically in relation to their holistic approach to patients and the move away from a task-oriented model.

Beyond the teams directly involved, other teams reported improvements in the quality of referrals they received. For example, practitioners described making fewer referrals to GPs and specialist teams, recognising an increase in their clinical autonomy. Post-programme interviews with participants identified that, overall, it had created 'curious' practitioners who wanted to enhance their learning and understanding. This was notable

among the unregistered practitioners, many of whom reported feeling more valued as part of the team following the programme. Furthermore, it was identified that both registered and unregistered practitioners were sharing their learning and influencing the working practices and culture of the individuals and teams they worked with:

*'I am now more confidently able to apply evidence-based strategies in my practice. As part of the programme, we learned about the importance of nutrition. I used this knowledge to generate an evidence-based resource pack for patients, to promote the importance of protein in wound healing.'* (Nursing associate)

## Costs and other resources

The initial start-up costs for this project were measured more in time than in direct financial input, as the design and development of the skills matrix and the curriculum were undertaken alongside existing roles. While it is challenging to determine exactly how much time this took, the overall timescale of this phase was approximately 12 months. The skills matrix and curriculum are now available as resources and may be adapted for any local context.

Three clinical facilitators were employed to provide place-based coaching as part of a wider role in facilitating learning and quality improvement in practice. The expertise of the programme clinical lead (MP) and trust-employed specialist practitioners was used together with the clinical facilitators to support the five taught classroom days. While new roles such as that of the clinical facilitator required investment, one of the main strengths of the 'skills first' approach is its focus on maximising the skills and potential of the existing workforce rather than recruitment of additional staff.

Finally, an emphasis on place-based learning minimises the number of days that practitioners need to be released from their duties to attend classroom-based learning.

## Challenges during the project

The initial work of gathering baseline skills data via the skills matrix and review was time-consuming and took significantly longer than expected, primarily due to service pressures. In addition, it was challenging to engage some of the practitioners in a process that some approached with suspicion.

Accessing the online competency portfolio and resources was a challenge for some practitioners who were less familiar with the platform used and/or had limited information technology (IT) skills. Some practitioners had not undertaken any classroom-based learning for some time and needed support to complete the online competency portfolio. The importance of effective design, development and IT support should be recognised, and the success of the project was due in large part to the commitment and tenacity of the programme support manager (SB).

It is important to recognise that the challenges in using a 'skills not roles' strategy often related to the systems, cultures and practices in which the skills and capabilities were used. Therefore, it is not possible to undertake any meaningful skills and capability-based work without exploring these systems, cultures and practices.

The challenges that occurred during the project offered some insightful information for individuals and the organisation. Some practitioners were initially concerned about being expected to perform tasks they felt were outside of their scope of practice. Examples of this included nurses carrying out reablement, which they perceived to be a therapist's role, or therapists undertaking clinical skills that they perceived to be nursing tasks. Other practitioners expressed concern that, due to their high workloads, they were learning new skills that they would not have time to use. As the curriculum progressed from the teaching days to the completion of the portfolio in practice, these anxieties lessened. Practitioners could see the advantages of learning new skills for their patients, and they reported an increase in job satisfaction because of their improved ability to take the initiative and act with more self-assurance. At an organisational level, areas were identified where the efficiency and effectiveness of teams could be improved, for example by ensuring consistency in the scope of skills in the same roles.

The clinical facilitators provided support in overcoming challenges that the individual or team encountered, whether these were practical issues, such as accessing the portfolio, or role-specific concerns. They were also able to support participants to apply and embed new knowledge and skills into their practice.

## Next steps, sustainability and scaling

At the time of writing, the programme has been developed and tested in adult community services, in line with organisational priorities. This has demonstrated its potential and scalability. Future aspirations include extending the programme to primary care, social care and private providers of nursing and residential care.

An important next step will be to evaluate the effects of the programme from the patient perspective, ensuring that the measures used reflect what older people consider important. To do this, an evaluation will be conducted using a qualitative and appreciative enquiry approach, drawing on the findings from a report commissioned during the UCR accelerator phase (Healthwatch Cornwall 2023). Interviews with 20 older people who had received a UCR visit were conducted, in which they identified their healthcare priorities as (Healthwatch Cornwall 2023):

- A service that enables people to be cared for in their own homes, avoiding hospital admission whenever possible. This is particularly important in rural areas since the nearest hospital may be some distance away.
- One practitioner being able to assess, treat and deliver support needs rather than involving several people over several visits.
- Skilled, knowledgeable and compassionate healthcare practitioners who can organise tests and follow-up results without the person having to leave their home.
- Practitioners who can signpost people to other services and help them 'navigate the system'.

## Learning points from the project

The primary aim of this article is to share knowledge with organisations who want to replicate the Ageing Well programme, or elements of it, in their services. The main learning points from the project are shown in Box 2 and may serve as a guide when considering its implementation. For further information about this project, please email: cft.ageingwelldevelopmentteam@nhs.net

## Conclusion

The establishment of a community UCR service prompted the creation of the Ageing Well programme of learning. The programme was designed to equip multidisciplinary teams in adult community services with the knowledge, abilities and self-assurance they needed to maximise the health, happiness and independence of older people with a variety of complex needs. To meet this need, organisations should invest in the abilities and skills of their current workforce to reflect contemporary patient profiles and the move towards more community-based care. Workforce development strategies where the focus is 'skills not roles' are a necessary, practical and achievable response to this need.

**Box 2. Main learning points from the project**

- Undertake a skills review before introducing the Ageing Well programme as this will provide a rich source of information
- Consider the resources needed for developing the competency portfolio and keeping it up to date. It should be reviewed annually to ensure it reflects contemporary evidence and best practice. The original version is available for sharing, but it will need to be tailored to local areas as some content is geographically specific
- Practitioners need to be able to see the value of taking part in the Ageing Well programme, for themselves and for the people they care for, so explain its purpose clearly
- The aim of the programme is not to redesign roles; however, it may challenge perceptions of professional boundaries since participants are encouraged to 'think differently'. As the emphasis is shifted to skills and not roles, rather than asking 'Is this part of my role?' participants should ask 'Do I have the skills needed to meet this person's needs?'. It is about giving practitioners 'permission to act' rather than imposing changes on the scope of their roles
- Operational managers will be acutely aware that it can be challenging to release staff for education and training. The role of clinical facilitator and a place-based approach to learning ensured the programme had minimal effects on service delivery. Teaching and facilitation skills are necessary to ensure the effectiveness of the classroom-based taught days. If in-house practitioners are asked to facilitate and teach on these days, the support they may need to develop these skills must be considered
- Communicate the aim and content of the programme to the whole team to ensure that participants' practice development is not limited by traditional expectations of their roles
- Be aware that some participants will require support with basic information technology skills, for example to be able to save and upload evidence to their online competency portfolios
- The quality of the learning experience and credibility of the programme were enhanced by achieving accreditation from the Continuing Professional Development Certification Service
- The project highlighted the need to undertake further skills-related work, including the development of a list of fundamental skills which all practitioners will be expected to undertake regardless of their role or banding. This will support the shift towards versatility, providing clarity and consistency in relation to the scope of skills required
- Be prepared to experience challenges. It will not always be comfortable to talk about issues related to skills, capabilities and culture, but the outcome will be more effective and efficient practitioners and ultimately a better experience of care for patients

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