Healthcare Workforce Skills and Competencies for an Ageing Society
Age UK

15 September 2010
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Age UK

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Executive summary

Summary of the research

Older people are the largest users of health services. Their health needs are often more complex than younger service users, with mental health and other long-term conditions also more prevalent. Life expectancy in the UK continues to rise: nearly one-quarter of the population will be over 65 by 2034. As well as having specific clinical needs, older people also have a number of aspirations for the way in which this care is delivered. These aspirations are listed in the text box below.

This study was carried out in the context of the recently passed Equalities Act, which has strengthened law around age discrimination (which is a protected characteristic within the Act). The values it protects are those of the healthcare workforce already. Therefore, the new law could act as a catalyst for the sector going further than merely non-discrimination and base service improvement around the aspirations of older people.

The study assesses the extent to which these aspirations are being met, looking at the key workforce groups and skills for delivering them. Where the aspirations are not being met, it aims to understand why. It also looks at the interplay between these barriers and the aspirations themselves; due to their differing nature, each aspiration has different barriers and enabling factors. The study aims to understand why these gaps continue to exist, particularly as many in the sector believe the aspirations to be perfectly reasonable and achievable, and the actions which are most likely to lead to change.

The study involved a literature review to assess the direction of policy at the national level and a workforce mapping task which broke the NHS workforce down into its constituent career groups and roles. We then tried to understand the aspirations in more detail, specifically, the extent to which workforce factors can influence them, and how they break down into skills and competencies. From here, we mapped the aspirations against the NHS workforce to assess how well the key documents which shape the health sector’s workforce (such as professional requirements and job descriptions) reflect the aspirations.

The main fieldwork in the study was with workforce managers in healthcare providers and commissioning organisations, supplemented by interviews with senior stakeholders representing government and workforce groups across the sector. With these groups, we tested our findings from the scoping phase, discussed skills gaps and which parts of the workforce they affected, the barriers to meeting the aspirations and actions which may help the sector to better meet the aspirations, with a particular focus on where Age UK can influence the agenda.

Key findings

A review of the major health policy documents of recent years reveals that there has been a top-down policy focus on meeting the needs of older people for some time. The National Service Framework for Older People, published in 2001, presented a ten year plan for meeting these needs. The goals of this framework closely reflected the content of the aspirations which indicates that the particular aspirations of older people are well understood at the national level. Other major policy developments over the period, such as policies around person-centred care, increasing choice of provider and services, and a focus on moving services into community settings, can be interpreted as attempting to move the health sector in the direction of meeting the aspirations of older people.

Moving on to understand other key drivers influencing current practice, a review of guidance published by some of the major workforce groups (such as regulators and Royal Colleges) reveals that these bodies understand and encourage their professionals to practice in a way that would meet the majority of the aspirations; the aspirations, therefore, are tied into regulation. A review of the tools used for
recruitment, such as job descriptions revealed only a schematic recognition of the aspirations. This is, perhaps, understandable given that they are produced at the employer level. The variation in meeting the aspirations is also related to the fact that their workforce dimension differs widely. There is also variation in how specific to older people each of the aspirations is. Finally, there is a degree of overlap between different aspirations.

Despite the fact that we have identified that government policy has been, broadly speaking, moving towards the aspirations, and that they are recognised and included in professional guidance (albeit, with variation across organisations and occupations), very few of our interviewees felt that the health sector was entirely meeting the aspirations of older people. There are three areas where gaps exist. Firstly, skills relating to joined-up team working, supporting service users’ transitions between services and providing clear communication about their treatment. Secondly, there is a gap in relation to empathy, listening and relationship building; these competencies underpin a number of the aspirations. Thirdly, outside specific geriatric roles, there is a knowledge gap in relation to the likely healthcare needs and aspirations of older people.

Interviewees provided more focussed feedback on the workforce areas they considered to be of most importance for the care of older people. Nursing, medicine and the allied health professions were highlighted. Nurses in both community and acute settings, are seen as having a vital coordination role. General practitioners have a vital role, too, particularly as they are the first point of contact for older people on most occasions. A number of the allied health professions, such as physiotherapy, occupational therapy and podiatry, provide services which link closely to older people’s needs.

Despite these skills gaps, most people working in the sector enter it in order to provide the sort of person-centred empathic care that meets the aspirations. Therefore, it is important to outline the barriers to the aspirations being met. Government policy is seen as an impediment. Despite the direction of policy being one that is broadly supportive of meeting the aspirations, NHS managers spoke of difficulties in providing a consistent service in the face of constant reform and initiatives from the Department of Health. Targets to improve service provision, while generally considered to have had positive effects, are also seen as impediments to health sector workers being able to focus on the quality of the care provided, rather than merely outcomes.

At the service level, there is a barrier in service users moving between acute and community care, and between the health and social care sectors. Difficulties are related to service users being discharged from hospital too early in their recovery (often driven by targets) and unsuitable rehabilitation services being available in the community (often related to poor communication between services).

The scarcity of resources was highlighted on a number of occasions; many NHS Trusts we engaged with are planning budget reductions over the next few years and given that staff costs constitute a large part of the NHS’s budget, some of these reductions are likely to be witnessed on the frontline.

At the workforce level, some interviewees argued that the increasing specialisation of the clinical professions was an impediment to truly person-centred care; specialisation is viewed by some as being at the expense of clinicians (particularly doctors) treating service users holistically, and this contributes to many of the aspirations. Conversely, specialisation in gerontology is seen as being a vital workforce area; however a lack of popularity (particularly among younger clinicians) and difficulties associated with gaining specialised experience of this sort in the acute sector means this specialist experience is in low supply.

Both pre and post-registration training were seen as clear barriers to meeting the aspirations. Interviewees thought the extent to which curricula (particularly for doctors) focussed on the care of older people was insufficient. Related to the scarcity of resources, there is some evidence to suggest that continuous professional development for both professional and non-professional staff is subject to competing demands. Older people’s care appears to lose out here, as well. Recruitment practices are also viewed as a barrier to meeting these aspirations. The standard tools such as the knowledge and skills framework do not focus sufficiently on the types of behaviour required.

Despite these barriers there are a number of potential levers for change. Leadership is vital in changing the culture of organisations and workforces. Recognition of the importance of patient complaints in improving services needs to be used as a way of promoting high quality care; this focus needs to come from the top of organisations.
At the workforce level, there are strategies for ensuring that people with suitable skills and competencies are recruited; effective CPD within the sector is also seen as a way of improving the workforce. In both of these areas, using patient stories and testimony to illustrate good and poor practice are ways of changing mindsets. There are numerous examples of healthcare organisations around the country redesigning roles so as to provide greater flexibility in the workforce and meet the complex needs which many older people have. There are numerous examples from which Age UK can learn and contribute to.

**Recommendations**

1. **Internal structures of NHS Trusts:** When engaging with NHS commissioning and provider Trusts, Age UK should focus efforts on the clinical leaders rather than the non-clinical workforce and HR Managers. The former group are more knowledgeable about the skills and competencies required to meet the needs of older people as well as being more influential over the practice of the clinical staff in the sector.

2. **The new equalities legislation:** Age UK should look for opportunities to promote defining messages from the aspiration gaps (joined up care; empathy; knowledge of views and preferences of older people) to NHS organisations with a view to those organisations being able to show that they are meeting the requirements of the legislation.

3. **Highlight older people’s care experience with the key workforce development organisations:** Age UK should produce a bank of case studies on older people’s experiences of health care (both good and poor practice) drawn from its own networks. Age UK should act to persuade the leads on the care of older people, within the key Royal Colleges, regulatory bodies and unions, to use these resources in their workforce development activities.

4. **Focus attention on the lower workforce bands:** Age UK should work with Unison to lobby the sector to ensure that service user-facing staff are receiving appropriate and sufficient training in areas that would improve the experience of older people. A particularly important role in the coming years is that of Healthcare Assistant working in the area of nursing. As nursing moves to an all-graduate career, healthcare assistants will take on further low-level clinical duties. For the standard of care not to be risked, this group of employees requires further development. Clinical support workers represent a vital workforce group who are not as well regulated as the clinical workforce.

5. **‘Sense check’ future regulation and guidance:** Age UK should actively contribute to the development of workforce regulation and guidance (where opportunities exist to do so). It should, wherever possible, work with regulators and Royal Colleges to inform and ‘sense check’ materials being produced to ensure that they sufficiently capture the older person perspective. The General Medical Council will be leading on the new requirement for doctors to revalidate their fitness to practice every five years from 2012. Age UK should use this as an opportunity to work with the GMC to ensure that the care of older people is properly represented in this new policy.

6. **Work with the Royal College of General Practitioners**
   Age UK should actively seek to contribute to the Royal College of General Practitioners’ campaign to increase GPs’ consultation time to fifteen minutes (from ten) as this will contribute to meeting a number of the aspirations.

7. **Work with the British Geriatrics Society**
   Age UK should work with the British Geriatrics Society to assess the demand for specialist geriatric clinical skills in the medical, nursing and psychiatry workforces. They should also work together to address the barriers to clinicians specialising in this area.
1 Introduction

This is the draft final report for the research study undertaken by GHK Consulting on behalf of Age UK looking at the skills and competencies required by the healthcare workforce to meet the needs and aspirations of older people.

1.1 Background and context to the research

1.1.1 Research aims and objectives

The aim of the project was to gather evidence to ensure that the ongoing debate relating to healthcare professionals’ competencies, skills and training has due regard to the needs and aspirations of older people.

A key objective was to provide a picture of current workforce development practice (and potential gaps) across a range of healthcare settings in England in order that Age UK can develop a clear voice for influencing the workforce debate in the context of an ageing population and to deliver the kind of care that older people want.

1.1.2 The Equality Act

An important catalyst for addressing these issues is the Equality Act. The Act received royal assent on the 8th April 2010. It updates and clarifies previous anti-discrimination legislation in requiring equal treatment for specific groups of people in access to public services and employment.

A significant element of the Act is that it includes age as a protected characteristic. It therefore introduces a requirement for public bodies to promote age equality and, in the context of access to public services, supports equitability of healthcare provision for older people.

It could be argued that the requirements of the new legislation are in tune with the broad aspirations and values of health professionals – in terms of providing high-quality care that meets the needs of individual patients and service users. Our research shows, perhaps unsurprisingly, that the reality of healthcare delivery is much more complex.

1.1.3 The healthcare workforce role

There is an interplay between planning, commissioning and resources, as well as organisational culture and structure, which influences healthcare delivery in practice and shapes the experiences of service users (in this case older people). Workforce development is an important part of the story, but it is only one part of the story – and has to be considered in conjunction the various other drivers and constraints on healthcare organisations.

Furthermore, this interplay may vary across healthcare organisations and service areas that are facing quite specific challenges. Nevertheless, the role of the healthcare professional is a constant, and one of the aims of this study has therefore been to try to identify and isolate the specific workforce dimension to meeting the needs of older people. In order to do this, our research builds on a study previously undertaken for Age UK to encapsulate the needs and aspirations of older people from healthcare.

1.1.4 The aspirations of older people

In 2009, Age Concern and Help the Aged published a report based on research undertaken by Ipsos Mori1, which asked older people directly about their aspirations for the health services they receive. Nine aspirations were articulated which were felt to include a workforce component – listed below. These aspirations provided the basis for our research.

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1 Age Concern and Help the Aged (2009), Waiting for Change: How the NHS is responding to the needs of older people
They formed a template against which the degree of alignment of workforce skills and competencies across the health sector could be ‘assessed’. This required a degree of interpretation, though. Part of this study has looked, for example, at how to translate what are quite broad aspirations into specific skills and competencies from a workforce perspective.

The nine aspirations, as articulated in the 2009 study, are as follows:

1. **Face-to-face, personalised, flexible appointments:**
   - “Older people value continuity and want to see the health professional that they know and trust. However, mobility difficulties and lack of transport can prevent them from getting to a GP surgery.”
   - The research noted that GP consultations undertaken as home visits have dropped from 9% in 1995 to 4% in 2008. Having a face-to-face appointment is important for care tailored to the individual, and sometimes this will need to be in the form of a home visit.

2. **To retain control in their home:**
   - “Many older people receive care in the home. This should complement rather than smother older people’s capacity to help themselves, in order that they retain their independence and a feeling of control.”
   - This aspiration links to the major health policy initiatives in recent years (articulated, chiefly, in the National Service Framework for Older People, the white paper *Our Health, Our Care, Our Say*, and the NHS Constitution), which promote person-centred care.

3. **Respect for preferences and belongings:**
   - “Any health worker entering a service user’s home must respect the way they like things to be done, including the use of their belongings”.
   - A potential barrier to this aspiration is that as the market for community health services fragments, it will be difficult to oversee the implementation of a common set of standards to hold providers to account, based on the actual experiences of patients – including the extent to which they treat patients and their belongings with respect.

4. **Company and the opportunity to be listened to:**
   - “Older people can feel lonely or isolated. Contact with health and care workers can offer a much-needed form of interaction, and friendly conversation is often welcome.”
   - The 2009 research identified that health services are “not set up to deal with problems associated with social detachment.”

5. **Proactive healthcare and support:**
   - “Older individuals are often unaware of what is available to them and may need help and support to understand and access what is on offer. Information, advice and outreach are key to making this work.”
   - Healthcare professionals must signpost older people on to centres of expertise where they can get the information and support they need: “Every interaction with a healthcare professional is an opportunity to link people into wider support networks”.

6. **Choice and control over daily routines:**
   - “An unfamiliar and busy acute care environment can make patients feel lost and uncomfortable, impeding recovery. Older people should be able to preserve familiar aspects of their daily routine such as when they take medications or the kind of food they like to eat”.
   - The research identified a policy facilitator for the aspiration. “NHS policy now recognises that it is no longer satisfactory to treat people as numbers and that a good patient experience is intrinsic to the success of an overall care package.”

7. **A ‘connected’ relationship between staff and patients:**
“Communication based on mutual respect and understanding engenders trust and supports good decision making. Taking the time to understand the person behind the patient will further enhance the therapeutic partnership between patient and practitioner”. 

This aspiration requires clinicians to involve patients (and where appropriate, their families) in decisions about care.

8. Maintenance of privacy in hospital:

“Older people should never feel embarrassed or humiliated in hospital. Staff can do a great deal to reassure them that personal or intimate care is not a burden. In addition, the environment should support privacy but not at the expense of interaction. Older people often prefer the company of others on a ward rather than the isolation of a single room. However this is only the case when sharing accommodation with people of the same sex”.

Government has been making commitments in the area of mixed sex wards for a number of years. As yet, these commitments have not been met, despite a £100 million privacy and dignity fund to help hospital trusts make the required changes, and introducing financial penalties for hospitals that fail to tackle the problem.

9. Joined-up care:

“Older people’s health and care needs should be assessed holistically. Professionals should work together both to ensure that the appropriate package of services is created and that the patient is informed of every stage of the care process.”

Joined-up care is particularly important for those with co-morbidities, which may require the intervention of a number of clinicians. Training barriers may exist. The career structure (as highlighted in Modernising Medical Careers) obliges doctors to specialise after two years. The danger is that this can encourage a blinkered approach to an individual’s overall health, with a tendency to treat individual symptoms or conditions separately rather than collaborating to provide a holistic service. Potential technological barriers also exist, as having the requisite IT systems available may be necessary.

1.2 Research Method

The research methodology employed for this study involved literature / policy review, a workforce mapping exercise and interviews with stakeholders and practitioners responsible for workforce development in the health sector. The research was undertaken from April to August 2010.

1.2.1 The analytical framework

We developed an over-arching analytical framework (included in Annex 4) to make sense of what is a complex research question. In addition to being framed around each of the aspirations of older people, the analytical framework was structured in terms of a series of key questions (or ‘levels of analysis’):

- **What is shaping current practice?** – Understanding the key drivers influencing current practice, in particular assessing how national health policy is either supporting or acting as a barrier to the achievement of the aspirations.

- **What is the current position regarding the extent to which the aspirations are being met?** – Understanding how the health workforce, across a multitude of roles, ‘performs’ in relation to the various aspirations as a way of identifying where the gaps and areas of need are greatest (both in terms of specific aspirations and specific job roles / occupational groups).

- **What is likely to influence achievement of the aspirations in future?** – Looking at the various levers for change in relation to how health organisations operate in practice and, in particular, distinguishing and understanding the interplay between various workforce
levers (regulation; initial training and CPD; career pathways; recruitment and appraisal etc) and other levers (organisational and cultural influence).

Each of our main research tasks linked into one or more of the levels of analysis. There were also a number of important cross-cutting research questions outlined in the framework (translating the aspirations into skills and competencies; understanding the specific workforce dimension to each aspiration; defining how specific each aspiration was to older people as opposed to all service users) that helped us to make the link between the levels of analysis and the aspirations themselves.

1.2.2 Literature & policy review

We began the study with a review of the main literature relating to health provision for older people (government policy papers, research on the care of older people, regional policy documents and workforce strategies).

The aim was to understand the various drivers influencing healthcare practice with regard to older people and to provide an initial, sector-wider overview of the current state of play (key issues identified and good practice already articulated).

We reviewed 78 documents as part of this task, the full list of which is included in the bibliography to this report (Annex 5).

1.2.3 Workforce mapping

The next stage involved us ‘mapping’ the health sector’s workforce. At the highest level, this involved understanding how the workforce is spread across the public, independent and third sectors. We focused on the public sector as the predominant employer and used the NHS Career structure to disaggregate the workforce by career grouping and then role. Where available, we incorporated data on the size of each job role (i.e. the number of staff per role) in order to begin to prioritise different parts of the workforce.

Using the work conducted by the NHS Workforce Review team and our own understanding of the NHS workforce, we also prioritised each role by its importance for the care experience of older people, and meeting the aspirations.

We then focused our attention on the roles considered more important to the experience of older people in order to investigate whether, and the extent to which, the underpinning workforce ‘frameworks’ and standards for key roles aligned with the aspirations of older people.

We looked at a selection of job descriptions, person specifications, occupational proficiency standards and professional requirements for the most relevant healthcare roles (reviewing 154 documents relating to 107 separate roles). We developed a template in order to assess each document (and role) systematically in terms of coverage and quality of link to the aspirations. The completed spreadsheet is available separately to this report.

1.2.4 Practitioner fieldwork

In order to both verify the picture of the current landscape (emerging from documentary evidence) and understand the levers for change, we undertook interviews with a series of stakeholders (described below) and practitioners. The practitioner sample included individuals in senior workforce management positions in NHS Trusts and other health organisations around England (e.g. HR Directors, Workforce Development Managers etc). Within the practitioner group we also engaged with a number of senior clinicians with responsibility for workforce management (Medical Directors, Chief Nurses etc).

The topic guides used for both the practitioner and stakeholder interviews is included in Annex 3 to this report.

In total, we interviewed with 41 practitioners in 40 healthcare organisations. The breakdown of the interviews by type of organisation is displayed in Table 1.1 below.
Table 1.1 Breakdown of practitioner interviews

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<th>Type of organisation</th>
<th>Number of interviews</th>
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<tr>
<td>Acute Trust</td>
<td>15</td>
</tr>
<tr>
<td>Primary Care Trust</td>
<td>13</td>
</tr>
<tr>
<td>Mental Health Trust</td>
<td>5</td>
</tr>
<tr>
<td>Community Providers</td>
<td>4</td>
</tr>
<tr>
<td>Independent provider</td>
<td>2</td>
</tr>
<tr>
<td>Care Trust</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
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1.2.5 Stakeholder fieldwork

Running alongside the practitioner consultation, we also engaged with senior stakeholders in organisations across the health sector. All stakeholder interviewees were senior policy leads, dealing with either older people’s or workforce issues depending on the organisation we spoke to. In total we conducted 19 interviews with 22 individuals from the following organisations:

**Strategic Health Authorities:**
- NHS East Midlands;
- NHS East of England;
- NHS North West;
- NHS Yorkshire and Humber.

**Sector Skills Councils:**
- Skills for Health;
- Skills for Care.

**Royal Colleges:**
- Royal College of Nursing;
- Royal College of General Practitioners;
- Royal College of Physicians;

**Regulatory organisations**
- Care Quality Commission;
- General Medical Council;
- Nursing and Midwifery Council;
- Health Professions Council

In addition, we undertook interviews with senior figures within Unison, the National Mental Health Development Unit, Alzheimer’s Society, NHS Institute for Improvement and Development and interviews with individuals from Age UK.

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2 Of these 40 organisations, 14 had achieved Foundation status; the majority of these were acute providers.
1.3 This report

The remainder of this report is divided into the following chapters:

- **Chapter 2 - Healthcare policy context:** This chapter sets out the key policy drivers influencing workforce development in the context of meeting the aspirations of older people.
- **Chapter 3 - Mapping the healthcare workforce against older people’s aspirations:** This chapter sets out the key roles and occupations across the healthcare workforce for meeting the aspirations for older people and provides an assessment of the current state of play in terms of appropriate / relevant skills and competencies.
- **Chapter 4 – Meeting the aspirations in practice:** This chapter summarises how health organisations reflect on the aspirations for older people, what the current landscape looks like ‘on the ground’ and what are the main priorities for action.
- **Chapter 5 – Barriers to meeting the aspirations:** This chapter looks at the levers for change and some of the key challenges in achieving the aspirations.
- **Chapter 6 – Conclusions and recommendations:** The final chapter presents our overarching conclusions and recommendations to Age UK for targeting further action / influencing activities.

The report also includes a series of annexes. Annex 1 provides a summary of each of the practitioner interviews undertaken as part of the research. Annex 2 presents our mapping of the workforce disaggregated into roles most relevant for older people. Annex 3 is our topic guides for the practitioner and stakeholder interviews. Annex 4 presents the analytical framework. Finally, Annex 5 contains the bibliography of documents used for the policy review and throughout the study.

As noted above, a further output (the analysis of sample job roles, person specifications, professional standards and requirements) fed into the analysis in Chapter 3 and is available as a separate spreadsheet.
2 Healthcare policy context

This chapter presents our analysis of the major public policy drivers in relation to older people and the healthcare sector during the past decade. In addition to major Government-led changes (relevant White Papers etc), we also look at the strategies published, periodically, by strategic health authorities (SHAs) and the guidance from the key clinical workforce groups (covering nursing, medicine and the allied health professions).

We also review and analyse the body of research on the healthcare needs of older people, assessing how well they are being met. The aim is to understand the nature of the challenge facing the sector, as well as the key ‘top down’ factors influencing workforce practice. The chapter begins by setting the demographic and healthcare context.

2.1 Healthcare and older people

2.1.1 The demographic position

Older people represent a significant and growing section of the UK’s population. They also represent the largest user group of the NHS. Recent figures show that older people in the UK use three and a half times the amount of hospital care of those aged under-65, and almost two-thirds of general and acute hospital beds are in use by people over 65. Furthermore, 65% of NHS spend is on those aged over 65.

Improvements in life expectancy, driven to a large extent by improvements in healthcare, mean that over the past 25 years the number of people aged 65 and over has increased from 15% to 16% (an increase of 1.7 million people). This proportion is expected to increase to 23% of the population by 2034.

Furthermore, the rate of increase has been fastest among those aged 85 and over. In 1984, there were 660,000 people in this age range. By 2009, the number had grown to 1.5 million people; and is expected to reach 3.5 million people by 2034 (a figure accounting for 5% of the population).

The combination of the healthcare resources older people use and the long-term demographic trends mean that it is projected that, by 2022, public expenditure on long-term care alone will rise by 94%, to £15.9 billion. This presents a strong case for the health sector looking at the specific needs of older people, and how best to manage what will in the future inevitably be a quite different model of care in a way that stays as true as possible to what patients fundamentally want and expect from health services.

2.1.2 The diversity of the cohort

One of the key challenges for the health sector in responding to the specific needs and aspirations of any group of service users is that groups can be hard to define. This is certainly the case when thinking about ‘older people’. The label can be so broad and all-encompassing that it is difficult for health organisations – even with the best of intentions – to develop a coherent, targeted response.

Furthermore, a common theme from our practitioner and stakeholder interviews was that definitions of what is considered ‘old’ vary and shift over time. This relates to the underlying demographic trends set out above: people are living longer and are healthier for longer.

To what extent, therefore, can age be considered as a defining characteristic for health service providers? The strong consensus from our interviews was that it can be, and this is reinforced by evidence indicating that there are specific health needs associated with age. For example:

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3 Department of Health (2010), Improving Care and Saving Money
5 Department of Health (2010), Increasing the Health and Wellbeing of People with Long-term Conditions, p.4.
Nearly half of people with disabilities are aged 65 or older\(^6\).

Older people are three times more likely than younger people to be admitted to hospital following attendance at an emergency department\(^7\).

Fewer than half of older people with dementia ever receive a diagnosis\(^8\).

The risk of suffering a stroke increases with age.

Falls are a major issue and are the leading cause of mortality due to injury in older people aged 75 and over.\(^9\)

Additionally, older people often have multiple health problems (co-morbidities) and long-term conditions.\(^10\)

There is also an argument that the needs of service users associated with older age have specific consequences for treatment and for the health service workforce. The British Geriatrics Society suggests that there are specific workforce needs in effectively caring for older people:

*Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills.*\(^11\)

This viewpoint was fairly uncontested in our research and, as such, it appeared to be a fairly moot point how specifically the target group (of what constitutes an older person) is defined.

Arguably the most useful delineation regarding age is terms of ‘phases’ of older life. For example, the National Service Framework for Older People identified three sub-groups that may require different types of and approaches to healthcare:

- **Entering old age**: This group is characterised as active and independent and may include people as young as 50. The goals for policy for this group, according to the National Service Framework for Older People, are to promote and extend healthy lives.

- **Transitional phase**: These people are in the transition between an active life and frailty. This transition usually occurs in the seventh and eight decades of life. Care providers should be aiming to identify emerging problems and effective responses.

- **Frail older people**: This group of people are vulnerable, as a result of problems such as stroke or dementia, and may have social care needs. The goals of health and social care providers are to anticipate and respond to problems and recognise the complex interactions of physical, mental and social care factors.

This kind of categorisation remains a fairly broad generalisation, but it does at least begin to reflect the heterogeneity of the cohort. Using age as a categorisation in isolation is likely to be unhelpful; but ignoring it as an explicit consideration is equally problematic given the evidence of specific needs.

### 2.1.3 The workforce dimension to meeting the aspirations of older people

The demands placed on the health sector by the aspirations of older people are multi-dimensional. The workforce dimension is integral to this, as the aspirations can be met, at least in part, through the skills and competencies of workers. While we will take this as the focus of the next section (*Chapter 3*), it is important to note other dimensions acting as barriers or facilitators to the aspirations.

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\(^6\) Department of Health (2001), *National Service Framework for Older People*, p.4  
\(^7\) Department of Health (2007), *A Recipe for Care – Not a Single Ingredient*, p.1  
\(^8\) Age Concern (2007), *Improving services and support for older people with mental health problems*, p. 5  
\(^9\) Department of Health (2001), *National Service Framework for Older People*, p.76  
\(^10\) Department of Health (2007), *A Recipe for Care – Not a Single Ingredient*, p.1  
\(^11\) Department of Health (2001), *National Service Framework for Older People*, p.76  
There is a systems and organisational element to meeting some of the aspirations. An example here would be ‘joined up care’ which is aided by integration of service providers (for example, stronger links between health and social care providers). Other aspirations are only achieved through a combination of workforce and organisational development. An example of this is the role of commissioners. An improved knowledge of the care of older people may contribute to the commissioning of more suitable services. However, such services may be provided by social care providers. Joint commissioning arrangements between local authorities and primary care trusts (within the current, but perhaps not the future, landscape) may be a prerequisite for meeting the aspirations.

The implication is that achieving change requires coordinated action at a number of levels. Even when there is apparent synergy in strategic policy from government nationally and sub-national delivery structures (with spending following the policy), backed up by guidance from key workforce leaders such as professional organisations, meeting the aspirations remains challenging. It is, though, important to understand how, and the extent to which, national policy is influencing the delivery of services in line with the aspirations of older people – as national policy provides a key underpinning role in relation to the priorities and basic organisation of the (public) health sector.

2.2 Alignment between national policy and the aspirations of older people

2.2.1 Governmental recognition of the gaps in older people's services

There has been a longstanding focus on the needs of older people in national health policy. The National Service Framework for Older People (NSFOP), published in 2001, articulated the need for improvement in this area, and it is therefore striking that unmet aspirations remain such an issue. The context for the 2001 framework was a situation where:

"Too often the financial commitment to older people in [social care and health care] has not been translated into a cultural and institutional focus on the needs of older people ... too often they have had to work against the systems, and across organisational boundaries, to try to get the best for the patients and service users”\(^\text{12}\)

This quotation, which is the rationale for the NSFOP, recognises the complex nature of meeting the needs and aspirations of older people. It requires a financial commitment, which then needs to be transformed into cultural and institutional change.

There is significant overlap between the eight standards of the NSFOP and the nine aspirations recognised by Age UK. In particular:

- ‘Standard 2: Person-centred care’, aims to ensure that older people are treated as individuals and enabled to make choices about their own care.
- ‘Standard 3: Intermediate care’, commits to older people having access to a range of intermediate care services at home or in designated care settings, to promote independence.
- ‘Standard 4: General hospital care’ has a strong workforce dimension. It states a commitment to appropriate specialist care for older people and ensuring hospital staff have the right skills to meet older people’s needs.
- ‘Standard 8: The promotion of health and active life in older age’, supports health promotion activities, through a co-ordinated programme of action between the NHS and local authorities. This standard closely reflects the aspirations for proactive healthcare and support and joined-up care.

The fact that the NSFOP was released nearly a decade ago shows that many of the specific aspirations defined by Age UK’s earlier research are long-standing concerns for the sector. That the issue has multiple dimensions is also not new. The framework acknowledges that there are cultural barriers ("The NSF focuses on: rooting out age discrimination"), factors

\(^{12}\) Department of Health (2001), National Service Framework – for Older People, p.2
related to the skills and competencies of the workforce (”The NSF focuses on: providing person-centred care promoting older people’s health and independence”) and systemic / organisational barriers (”The NSF focuses on: fitting services around people’s needs”).

The NSFOP also highlighted areas of focus in the care of older people which were highlighted in our own research. These include the standards expected for the care of someone who has had a stroke. Similarly, the care standards for older people with mental health issues and means of reducing and treating falls among older people were highlighted.

Progress against the National Service Framework’s standards was monitored with regular updates. One of these, A New Ambition for Old Age: Next Steps in Implementing the National Service Framework for Older People, published in 2006, presents ten programmes of activity, several of which, again, dovetail with the aspirations. These programmes were presented under three thematic headings: dignity in care, joined-up care and healthy ageing.

The programmes, too, had aims closely related to the aspirations, such as the promotion of independence using assistive technologies and better coordination of care for people with complex needs. This shows that what is contained in Age UK’s aspirations reflects not only long-standing needs, but needs that have been reinforced and repeated over time.

A midpoint review of progress against the NSFOP\(^\text{13}\) recognised both significant progress and need for improvement. Significant improvement was noted in the following areas:

- Explicit age discrimination had declined since the NSF was published, as a result of NHS Trusts auditing policies on access to services, and social services reviewing eligibility criteria;
- Services for stroke sufferers had improved, there had been an increase in flu vaccinations for older people, and the number of older people who had stopped smoking had increased;
- More people were being supported to live at home.

The Centre for Policy on Ageing argues that one of the main impacts of the NSFOP was in increasing awareness of the care of older people which means that "explicit policy based age discrimination is likely to be rare."\(^\text{14}\) Where the aspirations are not met, it is more likely to be the result of "conscious or subconscious ageist attitudes on the part of medical staff". This tallies in part with what we found when talking to practitioners – although practitioners themselves tended not to label the issue as ‘ageism’.

Despite these gains, research into older people’s views of the impact of the National Service Framework was inconclusive: "if asked, older people do not perceive improvements as the result of NSFOP, but nonetheless they do perceive improvements in systems. It is difficult to attribute any of the changes in experiences that we identified to the NSFOP itself\(^\text{15}\)."

These evaluations reveal that patient experience suggests a significant gap that could not be addressed through the NSFOP. A key response is to ensure that "the training and education of healthcare professionals needs to change to reflect the fact that their day-to-day role will increasingly centre on the care of older people with long-term conditions rather than younger patients with curable single conditions."\(^\text{16}\)

Such a focus is not fully advocated in the NSFOP or its updates, exemplified by ‘A new ambition for old age’, which outlines a number of work programmes on specific health areas,

\(^{13}\) Audit Commission, Healthcare Commission and Commission for Social Care Inspection (2006), Living Well in Later Life: A review of progress against the NSFOP.

\(^{14}\) Centre for Policy on Ageing (2009), Ageism and Age Discrimination in Secondary Healthcare in the United Kingdom


\(^{16}\) Oliver D (2007) ‘How do you stand working with all these old people?’, Health Service Journal 117 (6083, 22 November 2007) : 20-21
such as strokes or mental health. While there is much to commend about the focus on single health issues (and, as noted, there have been significant successes such as stroke care), the NSFOP has arguably not led to a significant improvement in care for those with long-term or multiple conditions. It provided a framework for thinking about older people’s needs but could not, in itself, be catalyst for some of the broader systemic issues that underpin many of the aspirations of older people.

2.2.2 Moving towards greater personalisation of services

A more systemic approach to meeting the needs of service users (and older people, in particular) was seen in the subsequent policy shift towards increasing the personalisation of services. In its simplest interpretation, this describes a healthcare system in which services and healthcare workers respond flexibly to service user choice and need. It aims to promote independence of service users, choice of services, as well as how they are delivered. Many of the aspirations are related to this policy theme.

Our Health, Our Care, Our Say, which was published in 2006, was the White Paper that introduced this agenda to the health sector. It was described as a “fundamental shift” towards integrated services provided in local communities. The aims of the White Paper, which was written after considerable consultation with service users (over 140,000 respondents were involved), including older people, show synergy with the aspirations:

- Better prevention and earlier intervention;
- Improved access to local services, encouraging primary care services’ opening times to respond flexibly to patient need;
- Improved access to community services, and to do more on tackling inequalities. This includes strengthening joint commissioning between PCTs and local authorities;
- Increased support for people with long-term conditions. This includes increased provision of assistive technologies to allow self-management of the condition within the home.

Furthermore, the White Paper made several commitments that reflect the aspirations. It committed to ensuring patients could see their preferred practitioner and provided an array of incentives for providers to offer more convenient opening hours.

These commitments were timely. Surveys conducted by the Picker Institute between 2002 and 2007 reveal a poor perception of the extent of person-centred care in the NHS among patients. For instance, the findings showed that:

- 25% of primary care patients said they had been put off going to their GP because practice opening times were inconvenient;
- Privacy is a significant issue: 30% of patients in 2006 who had undergone an emergency admission said they had to share a sleeping area with a member of the opposite sex. This figure is 11% for those admitted for elective or planned care;
- In 2006, 32% of primary care patients and 48% of hospital patients said they had not been sufficiently involved in decisions about their care.

There were commitments in the White Paper to lead the integration of health and social care systems, through joint commissioning arrangements. There was also a commitment to mainstream some of the good practice taking place around the country in providing more care services in community locations.

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18 Department of Health (2006) Our Health, Our Care, Our Say - Our Say: A new direction for community services, p. 69
19 Picker Institute (2007), Is the NHS Becoming More Patient-centred?
20 Department of Health (2006) Our Health, Our Care, Our Say - Our Say: A new direction for community services, p. 90
21 Department of Health (2006) Our Health, Our Care, Our Say - Our Say: A new direction for community services, p. 132
It is clear from looking at key Royal College of Nursing guidance, published two years before Our Health, Our Care, Our Say, that many of these commitments were already understood by the professions. Nurses were instructed on the following:

- “Providing effective nursing care for older people necessitates working in partnership with older people;”
- “Nurses also have an important health promotion role by making it possible for older people to understand better how to maintain their own health and fitness levels.”
- “Effective, person-centred care requires consideration of the person behind the illness … older people require the time and opportunity to express their views and to have their needs dealt with in an holistic way.”

Similarly, the Royal College of General Practitioners (RCGP) also displayed awareness of the workforce issues which can provide for the care needs of older people. Guidance published for RCGP members refers to systemic barriers to meeting the aspirations of older people. For the RCGP, one of the main barriers is time:

“The ageing population means that more patients will have long-term and increasingly complex conditions. They will need more time with their GP to discuss their care and treatment options.”

Other facilitators include improving access to talking therapies and improved round the clock care. However there are also skills and training implications with GPs requiring longer training to reflect an extending of their roles to manage more patients and their complex problems closer to home.

The RCGP also argues that a better skill mix in primary care, including working with elderly-care physicians is required: “Enhanced primary care teams … will include nurses, health visitors, midwives, community physiotherapists and pharmacists. Specialists including elderly-care physicians … should also be encouraged to work as part of the team providing more integrated care in the community, focused on the needs of the patients.” In addition to these profession-specific groups, the British Geriatrics Society (BGS) – the professional association of doctors practising geriatric medicine, old age psychiatrists, general practitioners, nurses and others with a particular interest in the care of older people – echoed the themes of control, dignity and proactive care for older people. Its 2007 publication, Standards of Medical Care for Older People: Expectations and Recommendations, outlines a set of principles of good medical and social care for older people. It includes:

- Involvement of older people in the management choices of their illness and decisions on future care;
- To promote good health in late life;
- To support older people in their own homes; and
- Preservation of dignity, autonomy and respect.

While the BGS’s work is non-binding on health professionals, it does represent the best practice in the area. The fact that this guidance from experts in gerontological care maps closely to the guidance from one of the largest professional groups (nursing) as well as

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22 Royal College of Nursing (2004), Caring in partnership: older people and nursing staff working towards the future.
23 Royal College of Nursing (2004), Caring in partnership: older people and nursing staff working towards the future, p. 6.
24 Royal College of Nursing (2004), Caring in partnership: older people and nursing staff working towards the future, p. 4.
25 Royal College of Nursing (2004), Caring in partnership: older people and nursing staff working towards the future, p. 6.
26 Royal College of General Practitioners (2010), Leading the Way: High-Quality Care for All Through General Practice.
27 Royal College of General Practitioners (2010), Leading the Way: High-Quality Care for All Through General Practice.
elements of what the RCGP has argued, suggests that workforce leaders understand the gap in meeting the aspirations of older people. The issue is not in terms of recognition, but in terms of addressing the problem.

A further reiteration of the same themes was evident in Lord Darzi’s report, *High Quality Care for All*[^28], which was the result of a major review set up by the then new Prime Minister Gordon Brown. It built upon the commitments articulated in *Our Health*, and person-centred care is at the heart of the report:

“All the visions emphasised the need to organise care around the individual, meeting their needs not just clinically, but also in terms of dignity and respect... personal care also considers the needs of the patient within the context of their support network, including carers, family and employers.”[^30]

Research has shown that an emphasis on person-centred care, articulated by the government in the aftermath of *Our Health* is vital to achieving age equality. A study of age discrimination commissioned by the Department of Health made the key recommendation that “Pressing ahead with a number of existing commitments (including the personalisation agenda [and] *High Quality Care for All*) will do a great deal to advance age equality and tackle discrimination.”[^30]

*High Quality Care for All* is also clear about allowing care to take place in the home: “There will be more use of assistive technology and remote monitoring to help patients lead independent lives.”[^31]

This commitment was borne out by subsequent Government spending:

“In its desire to promote individual independence among older people, the UK Government has committed a high level of funding to the provision of [assistive technology]. A total of £80 million was allocated to local authorities and their partner organisations between 2006 and 2008 using the Preventative Technology Grant and a further £80 million is planned between 2008 and 2010 under the banner of Extracare Housing.”[^32]

The major development in *High Quality Care for All* was that it went beyond re-packaging the same broad aims to including a much stronger workforce dimension. The associated report, *A High Quality Workforce*[^33], set out the workforce implications of *High Quality Care for All* and went beyond the previous White Papers to provide detail of how this should be implemented by the workforce. For example, the workforce implications of person-centred care are clearly articulated:

“The skills for listening, understanding and responding to the needs of individual patients and supporting them to manage their health in a manner that is respectful of diversity and difference must, wherever possible, be incorporated into education and training programmes and clinical practice.”[^34]

The policy commitment to primary and community care services is also reflected in workforce planning:

“In the light of the increasing demand for primary and community care services, SHAs will be expected to expand GP training programmes in 2009 ... in future at least half of doctors

[^28]: Department of Health (2008), *High Quality Care for All – NHS Next Stage Review*
[^33]: Department of Health (2008), *A High Quality Workforce – NHS Next Stage Review*
going into specialty training will be training as GPs. The expansion of general practice underlines our commitment to supporting and improving primary care." 

Allied Health Professionals are cast as "clinicians who can and should be able to lead" three agendas important to realising the aspirations:

- health promotion,
- providing care closer to home
- and the management of long-term conditions.

The Next Stage Review sought to ensure that the range of knowledge, skills and competence of this key professional group is properly understood, so that "their potential to be responsive, to ensure flexible, patient-centred care and to take on new and varied roles is... maximised." 

The nursing role is given a shift in emphasis congruent with the policies of prevention and provision of care closer to the home. The paper states that "there will be new education and development opportunities for specialist community and public health nurses." 

A year on, a number of significant quality improvements were recorded:

- More flexible access. Over 75% of GP practices are now open in the evenings and weekends, an increase of 25% from 2008.
- More personal care plans. 9.3 million people have an individual care plan, saving the NHS around £1 billion year on year due to fewer emergencies and outpatient appointments. The target is for every one of the 15 million with long-term conditions to be offered the choice.
- A future commitment to safeguard privacy and dignity, through the eradication of same-sex accommodation in the NHS by 2010. However, this commitment was not met. As at May 2010, hospitals in England provide same-sex accommodation for 90% of patients whose stay in hospital is planned, and for 71% of those admitted in an emergency.

Finally, evidence from the five year workforce strategies published by the Strategic Health Authorities suggests that the broad direction of policy has filtered down to the regional level. NHS South Central represents a typical case. Its most recent workforce strategy diagnoses particular skills needed for caring for people with long term conditions. These comments are closely related to national level policy.

"It is clear that we need more people with skills in preventative health care, more people who understand the complexities of treating and caring for people with long term conditions and more people who can provide care closer to home."

NHS London has committed to increase the proportion of GPs and doctors in community settings from 25% to 47%. Their workforce strategy also recognises that broader sets of skills to enable flexible working across care pathways, and broader public health knowledge to encourage health promotion are required.

NHS North West's Workforce, Education Commissioning and Education and Learning Strategy (2008) represents the drive for workforce flexibility as nationwide, stating that:

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35 Ibid. p.15.  
36 Ibid. p.23.  
37 Ibid. p.23.  
38 Ibid. p.20.  
39 Department of Health (2009), High Quality Care for All: Our journey so far  
“NHS organisations’ workforce plans show they expect a fundamental shift in roles from traditionally qualified, multi-professional specialists to practitioners working differently and flexibly in different care settings, undertaking a variety of new and different skills within a mixed team.”

In terms of pro-active health support, NHS North East made a similar commitment:

“We will require all of the NHS workforce to receive basic public health education so every contact is a health improving contact.”

The documents also highlight potential barriers to realising the aspirations. NHS North East report that while assistive technology is extensively used in parts of the region, access varies significantly depending on the awareness and role of the key professionals supporting the individual. This suggests a strong workforce dimension to the effectiveness of allowing care to take place in the home. NHS East Midlands’s From Evidence to Excellence: our clinical vision for patient care (2008) identifies three regional challenges relevant to our national concerns:

- A perceived power imbalance between the clinician and patient, particularly in the cases of vulnerable older people, which might impede patient-centred care;
- Providing care closer to home will require retraining of health professionals, as skills traditionally concentrated in the secondary care sector will need to be more readily available in primary and intermediate care settings;
- The lack of a real-time system of information, easily accessed and understood by all professionals working with a patient, impedes joined-up working.

The majority of SHA workforce strategies demonstrate a commitment to person-centred care, a greater focus on prevention and moving care closer to the home, through community services. There is a lesser, though still fairly widespread, commitment to increased flexibility of provision and allowing care to take place in the home. Nonetheless, the regional documents show an alignment with several of the aspirations, as well as highlighting challenges to be aware of.

The documents show little variation in terms of their broad themes covered. This is perhaps unsurprising as they closely follow the national policy direction. While there are differences in the demographic make-up of each SHA’s population, they are not significant enough to drastically affect the broad direction of the strategies; these differences become clearer at the local PCT level. The policy direction of recent years has been matched with spending in strategically important areas, including a number of clinical issues that disproportionately affect older people (such as strokes), as well as initiatives targeted at important parts of the workforce. These developments have been coupled with recognition and guidance produced by key workforce stakeholders such as the RCN. The overall direction of policy has filtered down to the regional level too. Meeting the aspirations of older people is clearly a multi-layered issue. As highlighted in the analytical framework, there are a number of areas where action is required, including, but certainly not limited to, the areas outlined here.

**2.2.3 Policy focus moving on to choice**

The broad policy direction of shaping services around the individual service user’s needs continued after the publication of the Darzi report. Building on these reforms, policy shifted to viewing the personalisation of services primarily through the prism of increasing patient choice in the healthcare market.

The DH-published guidance document, Transforming Community Services outlined that patient choice and personalisation would be provided by enabling choice: of provider, setting and treatment for people with long-term conditions.

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44 Department of Health (2009), Transforming Community Services: Enabling New Patterns of Provision
The patient’s choice of which hospital to be treated in was enshrined in the NHS Constitution. The command paper NHS 2010-2015: From Good to Great: preventative, people-centred, productive published in 2009, sets out mechanisms for ensuring that this form of patient choice drives service provision. These mechanisms include expansion of the patient satisfaction survey, clear and widespread dissemination of this information to inform patient decisions, and an enforced link between provider income and patient satisfaction.

Evidence from the King’s Fund suggests that while choice of provider is particularly welcomed by older people, who were also more likely as a group to be aware of having this choice, this mechanism alone cannot be relied on to drive up the quality of patient care. A number of barriers exist:

- Patients are often not being offered a choice in practice. “Although GPs maintained that they always offered their patients a choice, we found that just under half of patients recalled being offered a choice.”

- Choice is not offered to patients regardless of their circumstances. “GPs appeared to be more willing to let patients choose when the referral was fairly routine but were more directive when more specialist treatment was required.” This suggests a strong workforce training issue to facilitate a culture shift in the GP role from prescription to advocacy.

- When a choice is offered, most patients do not choose to travel further for treatment. “In our study, most patients chose their local provider (69% of those offered choice), and providers and GPs described their patients as loyal to their local trust.”

Where patients do choose a non-local hospital, this is normally because of a bad previous experience. The King’s Fund research also reveals that patients make little use of available performance data to inform their choices, relying mainly on their own experiences. Furthermore, the ability of organisations to provide choice (and this is true of a number of the specific aspirations of older people) may be constrained or diluted by competing priorities. The same research found that, on the other side of the choice mechanism, providers are not responding to ‘consumer’ signals.

“Our research suggests that choice did not act as a lever to improve quality in this way; providers were driven more by pressure from a range of other external factors such as waiting time targets.”

Taken together with Transforming Community Services, we can see that the policy direction in recent years has evolved from driving up standards in person-centred care (exemplified in Our Health), to the facilitation of an open market in healthcare provision with patients making informed choices on the basis of standardised and quality-assured surveys. Evidence suggests that the impact of this shift in policy on the experience of older people is mixed, at best. Much of it is framed in terms that are well-aligned to the aspirations of older people, but which do not necessarily translate into a radically different patient experience.

There is clearly a limit to the influence that government policy can play on the micro engagement between practitioners and patients. Yet it can also be argued that while there has been a relatively long-term focus on the concerns of older people, there has over the same period been a degree of constant change that may not support the realisation of some of these over-arching ambitions.

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46 King’s Fund (2010), Summary – Patient Choice: How patients choose and how providers respond, p. 3.
47 Ibid.
48 Ibid.
49 Ibid, p. 5.
Continuity from the new government?

While the first major health policy announcement of the new government, *Equity and Excellence: Liberating the NHS*, demonstrates considerable alignment with some aspects of the previous policy direction, the significant changes advocated, particularly to commissioning structures in the NHS, suggest that the influence of national policy will continue to be one of significant reform and change.

Key changes include a call for greater transparency over patient satisfaction and health outcomes, which, along with increased patient choice of services – extended to include, most significantly, choice in care for long-term conditions – is still seen as a means of driving service responsiveness to service-user need. This will be further promoted by the devolution of commissioning arrangements from PCTs and SHAs to consortia of GP practices. This is a further step down an established policy route; in this case, that of practice-based commissioning.

*Equity and Excellence* also explicitly recalls the *Next Stage Reviews*: “the debate on health should no longer be about structures and processes, but about priorities and progress in health improvement for all.” One such priority is a commitment to patient-centred care, encapsulated in the dictum: “*no decision about me without me*”\(^50\), which could be read as quite a powerful commitment in the context of the aspirations. This commitment goes beyond the issue of patient choice. Rather than open competition between providers being left to ensure responsiveness to patient need, all clinicians are obliged to involve patients fully in their care:

“*The Government’s ambition is to achieve healthcare outcomes that are among the best in the world. This can only be realised by involving patients fully in their own care, with decisions made in partnership with clinicians, rather than by clinicians alone. [...] We want the principle of “shared decision-making” to become the norm.*”\(^51\)

The mechanisms by which this will be ensured are not clear, with the document suggesting that the agenda is a work in progress:

“*The new NHS Commissioning Board will champion patient and carer involvement, and the Secretary of State will hold it to account for progress. In the meantime, the Department will work with patients, carers and professional groups, to bring forward proposals about transforming care through shared decision-making.*”\(^52\)

 Nonetheless, this national commitment provides a useful foundation for several of the aspirations, particularly those concerning connected relationships between staff and patients, personalised and flexible appointments, respect for preferences, and choice and control over daily routines.

In addition to the focus on quality of care, the white paper proposes a new NHS Outcomes framework which will span three domains: effectiveness of an intervention (measured by clinical outcomes); the safety of the treatment; and the broader patient experience. The framework will allow easier international comparison in morbidity rates of different conditions. It is seen as a means of driving up quality for particularly vulnerable patient groups, including older people.

The devolution of the majority of the commissioning budget to consortia of GP practices, with local authorities to be given control of local health improvement budgets, will have significant implications for the healthcare workforce and older people’s services. While there may already be personal health budgets in continuing care, most services are to be explicitly rationed by general practitioners, threatening the neutrality of clinician-patient relationships in deciding care. There are other risks; for example, there is evidence to suggest that general practitioners may have an insufficient awareness of issues relevant to older people, such as depression in later life:

“Two-thirds of older people with depression have never discussed it with their GP;

Of the third that have raised it, only half (or about 15 per cent of all older people with depression) were diagnosed and are receiving treatment;

Only six per cent of older people with depression receive specialist mental health care.”

Furthermore, research commissioned by the Department of Health has stated that:

“GPs have a key role to play in the care of older people who have chronic conditions or who are nearing the end of their lives. GPs need to ... understand more fully the support requirements of older people and what can actually be achieved for them.”

Recent research has suggested that under the new vision of GP commissioning, this awareness may not come through patient engagement:

“Research evidence suggests that GP commissioning organisations struggle to achieve effective patient and public engagement.”

What is certain is that the proposed arrangements only enhance the importance of general practitioners having a better understanding of the needs of older people. In addition to specific services for older people, relevant professional groups, e.g. occupational therapists, will also need to demonstrate their value to a new set of commissioners.

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53 Age Concern (2007), Improving Services and Support for Older People with Mental Health Problems, p. 19.
54 Department of Health (2008), Health and Care Services for Older People: Overview report on research to support the National Service Framework for Older People, P. 68.
55 Nuffield Trust, King’s Fund, NHS Alliance, National Association of Primary Care, Primary Care Trust Network, Royal College of General Practitioners (2010), Giving GPs Budgets for Commissioning.
Mapping the healthcare workforce to the aspirations

This chapter outlines the size and complexity of the health sector and its workforce. It presents our analysis of the most important career groups and roles for meeting the aspirations of older people, providing more focused analysis of how well the aspirations are reflected in the recruitment tools and professional guidance available.

3.1 Understanding the healthcare workforce

The health sector in England employs approximately 1.7 million people, and experienced growth of 30% over the decade 1999-2009, the highest of any industry within the public sector. The rate of increase of the workforce peaked in the early 2000s. Since 2006, the size of the workforce has fallen by around 0.2% each year. The health sector accounts for 7.3% of total employment in England, and for 79.7% of the total UK health sector workforce.

The health sector may be broken down into public, independent and voluntary organisations. The NHS dominates, employing around three-quarters of the workforce, with the independent sector accounting for the majority of the remaining 25%. Estimates of numbers working in the voluntary sector suggest it accounts for 1% of the health workforce.

Our analysis has used the NHS Careers framework to model the health sector’s workforce in order to build an understanding of how the workforce maps against both service provision to older people and the aspirations of older people. This framework breaks the NHS workforce down into nine main career groups, some of which have sub-groupings of career type (for example, within the medical career group there are a number of sub-groups or specialisms, such as surgery). These sub-groups are then split into individual job roles, of which there are over 240. The size and complexity of the workforce creates an immediate challenge in terms of supporting action to meet the needs of older people. It is clear that a degree of prioritisation is required.

One way of judging the relative importance of different parts of the health workforce is simply to look at the volume of staff in different roles and occupations. The NHS Information Centre provides information on the number of staff working in the NHS. We have been able to map this data to the Career framework, although there are some gaps and occupational sub-groups where this is not possible.

As of 2009, the total headcount of the NHS Hospital and Community Health Service (HCHS) and General Practice (the key areas for our analysis) workforce in England was 1,431,996, which is broken down into key occupational groups and sub-groups as follows:

- **All doctors:** 140,897 (9.84%) – corresponding to the Medical career group
  - Within this group there are 40,269 General Practitioners

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56 Skills for Health (2010), *Skills and Labour Market Intelligence Report for England*
58 Skills for Health (2010), *Skills and Labour Market Intelligence Report for England*
59 Sector Skills Assessment Summary Report 2009-10
60 Skills for Health (2010), *Skills and Labour Market Intelligence Report for England*. There is a definitional issue here. This report states that the voluntary sector employs 42,000 people in the health sector across England. However there are estimates that the NHS has 300,000 volunteers, but cannot substantiate the methodology for deriving this figure. See: Skills for Health (2009), *The Hidden Workforce: Volunteers in the Health Sector in England*, p. 8
62 The main differences are that the NHS Information Centre groups staff differently and does not include staff involved in health informatics, parts of the wider healthcare team, and some dental care professionals. The NHS Information Centre data is useful for viewing staff numbers at the broad service level (e.g. General Practice) and at for some career groups, whereas the NHS Careers framework is more useful for our later analysis as it breaks the workforce into roles.
- **Total qualified nursing staff:** 417,164 (29.13%) – corresponding to nursing career group

- **Total qualified scientific, therapeutic and technical staff:** 149,596 (10.23%) – corresponding to parts of the Allied Health Professions and Healthcare Science career groups

- **Qualified ambulance staff:** 17,922 (1.25%) – corresponding to parts of the ambulance career group

- **Support to clinical staff:** 377,617 (26.37%) – corresponding to parts of the wider healthcare team career group

- **NHS infrastructure support:** 236,103 (16.49%) – corresponding to parts of the wider healthcare team and management career group

- **Other non-medical staff or those with unknown classification:** 364 (0.02%)

- **Other GP practice staff:** 92,333 (6.45%)

A clear finding is that there are around 725,000 professionally qualified clinical staff in the NHS in England compared to an overall staff headcount of just over 1.4 million (around 50%). Therefore, non-clinical support staff as well as infrastructure and management make up a significant proportion of the workforce. This is a key figure to bear in mind when we begin discussing the influence of regulation on different groups of clinicians. There are few similar examples of regulation or guidance for the 50% of the workforce who are not clinically trained (and this includes some important roles such as healthcare assistants).

### 3.2 Defining the key job roles and occupations in relation to older people

It is possible to attempt a broad classification of health job roles in order to identify the roles that are most relevant to older people. We can distinguish between roles that have:

1. a specialist focus on older people (3 roles);
2. an all age focus, with older people a likely prevalent or predominant service user group (83 roles);
3. an all age focus (62 roles);
4. minimal engagement with older people (92 roles).

This system allowed us to remove the job roles that were not relevant for the purpose of workforce mapping (i.e. category four) and concentrate on the aspects of the healthcare workforce that come into contact with older people. It also allowed us to prioritise our focus on roles which have either a specialist focus on older people, or the roles for which older people are likely to be a prevalent service user group.

We also prioritised our sample by excluding roles with only very few practitioners. For example, we excluded immunologists, since there are only approximately 100 of these in the NHS, compared to 40,000 GPs.

These twin criteria allowed us to focus on both highly-relevant roles, even if these are relatively niche (for example, geriatricians of which there are only about 3,000), as well as professions with a large number of practitioners, even if these do not have a specific older person-focus (e.g. anaesthetists, of which there are over 11,000 in the NHS).

Based on these criteria, we reviewed the relevant occupational requirements and person specifications for a sample of 101 roles, using 154 documents. Table 3.1 displays the spread of these roles analysed across the career groupings as defined by the NHS careers.

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63 NHS Information Centre (2010), NHS Hospital and Community Health Services: Medical and Dental Staff England 1999-2009

64 We drew on work conducted by the NHS Workforce Review team in order to decide on which roles to focus on. See: [http://www.wrt.nhs.uk/index.php/work/care-groups/68-older-people](http://www.wrt.nhs.uk/index.php/work/care-groups/68-older-people)
framework. Table 3.2 goes further and displays those roles considered to be most important to the healthcare experience of older people, alongside numbers, where this is possible.

Table 3.1 Number of roles analysed split by workforce grouping

<table>
<thead>
<tr>
<th>Career group</th>
<th>Number of roles analysed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors including GPs</td>
<td>29</td>
</tr>
<tr>
<td>Wider Healthcare Team</td>
<td>23</td>
</tr>
<tr>
<td>Allied Health Professions</td>
<td>13</td>
</tr>
<tr>
<td>Healthcare Science</td>
<td>12</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>10</td>
</tr>
<tr>
<td>Ambulance Service Professions</td>
<td>7</td>
</tr>
<tr>
<td>Dental Care Professions</td>
<td>6</td>
</tr>
<tr>
<td>Management</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>101</strong></td>
</tr>
</tbody>
</table>
Table 3.2  The most important job roles for older people split by career grouping and sub-grouping

** = Category 1 role (the remainder are category 2); STAR worker = Support Time and Recovery Worker; SLT = Speech and Language Therapy

<table>
<thead>
<tr>
<th>JOB CATEGORY</th>
<th>SUB GROUP</th>
<th>INDIVIDUAL JOB ROLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance service profession – 32,284 (of which 14,362 are support staff)</td>
<td>Ambulance care assistant</td>
<td>Emergency care practitioner</td>
</tr>
<tr>
<td></td>
<td>Emergency care assistant</td>
<td>Paramedic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>Chiropodist / Podiatrist</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counselling psychologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SLT</td>
</tr>
<tr>
<td>Dental Care Professionals</td>
<td>Dentist</td>
<td>Dental Nurse</td>
</tr>
<tr>
<td></td>
<td>Dental Technician</td>
<td>Dental Therapist</td>
</tr>
<tr>
<td></td>
<td>Maxillo-facial prosthetists</td>
<td>Dental Hygienist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Orthodontic therapist</td>
</tr>
<tr>
<td>Doctors - 140,897</td>
<td>General Medicine 27425</td>
<td>Geriatric medicine** 3134</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Ophthalmology 28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiology 2476</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renal Medicine 1184</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastroenterology 1851</td>
</tr>
<tr>
<td></td>
<td>Surgical group 20858</td>
<td>Infectious diseases 343</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audiological medicine 68</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rehabilitation 270</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Endocrinology &amp; diabetes mellitus 1390</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rheumatology 1046</td>
</tr>
<tr>
<td></td>
<td>Public health medicine 3529</td>
<td>Palliative medicine ** 523</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neurology 1164</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical neurophysiology 116</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respiratory Medicine 1715</td>
</tr>
<tr>
<td></td>
<td></td>
<td>General (internal) medicine 7033</td>
</tr>
<tr>
<td></td>
<td>Psychiatry 9934</td>
<td>Dental public health 1978</td>
</tr>
<tr>
<td></td>
<td></td>
<td>General psychiatry 6348</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychotherapy 119</td>
</tr>
<tr>
<td></td>
<td>Obstetrics &amp; gynaecology 5440</td>
<td>Old age psychiatry** 1278</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obstetrician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gynaecologist</td>
</tr>
<tr>
<td></td>
<td>Pathology 4252</td>
<td>Haematology 1462</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nuclear medicine 83</td>
</tr>
<tr>
<td></td>
<td>Radiology 3580</td>
<td>Clinical Radiologist 3497</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical Oncology 1107</td>
</tr>
<tr>
<td></td>
<td>Clinical Oncology 1107</td>
<td>Anaesthetist 11330</td>
</tr>
<tr>
<td></td>
<td>Anaesthesiologists 11330</td>
<td>Oral/maxillo facial surgery 1721</td>
</tr>
<tr>
<td></td>
<td>Dental group 2791</td>
<td>Oral surgery 286</td>
</tr>
<tr>
<td></td>
<td>A&amp;E Medicine 4962</td>
<td>A&amp;E Doctor 4962</td>
</tr>
<tr>
<td></td>
<td>General Practice 40269</td>
<td>GP 40269</td>
</tr>
<tr>
<td>Healthcare Science -</td>
<td>Life science and pathology</td>
<td>Clinical biochemist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comm. pharmacy technician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community pharmacist</td>
</tr>
<tr>
<td></td>
<td>Physiological sciences</td>
<td>Cardiological technician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical resp. Physiologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Optometrist</td>
</tr>
<tr>
<td>Nursing and Midwifery – 417,164</td>
<td>Adult nurses</td>
<td>Community matron</td>
</tr>
<tr>
<td></td>
<td>Mental Health Nurses</td>
<td>Practice Nurse</td>
</tr>
<tr>
<td>Wider Healthcare Team</td>
<td>Clinical Support Staff</td>
<td>Cardiographer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Healthcare Assistant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy assistant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PCGM health worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counsellor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health trainer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OT assistant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacy assistant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SLT assistants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>STAR worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nursing healthcare assistant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High intensity therapist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry assistants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychological wellbeing practitioner</td>
</tr>
</tbody>
</table>
Translating the aspirations into skills and competencies

Table 3.2 above provides a high-level list of the health sector roles that are most significant in relation to the care of older people. The length of the list reflects the importance of older people as a patient group. However, in order to understand how different roles are aligned to the various aspirations, it is important to translate those aspirations into actual skills and competencies that might be reflected in professional requirements and job specifications of each key role.

While there is a workforce dimension to each of the nine Age UK aspirations, there is variation in the strength of that dimension. Figure 3.1 below presents a simple clustering of the aspirations in terms of the extent to which they relate to the workforce. Within this, there are some important observations about the aspirations themselves:

- Each of the nine aspirations has a workforce dimension. We would argue that ‘joined up care’, as articulated in Waiting for Change actually has two separate components:
  - a medical / diagnostic element relating to clinicians;
  - and a broader co-ordination component relating to health services in general;

- There is a degree of overlap between the aspirations, which suggest some over-arching workforce-related needs. The aspirations of a connected relationship between staff and patients and joined-up care are probably best considered as ‘underpinning’ aspirations of a more general nature than (but strongly linked to) the other aspirations.

- All of the aspirations (except respect for preferences, a connected relationship between staff and patients and joined-up care) are specific to older people, and typically to a sub category of older people (frail older people). It could be argued that ‘respect for preferences’ and ‘joined up care’, while being general in nature, have dimensions that are older person-specific (although it is not clear that this has workforce implications). The important point is that very little of any of the Aspirations will relate to older people across the board.

Figure 3.1 highlights two aspirations (respect for preferences and belongings and company and the opportunity to be listened to) that have a strong workforce component (in that they relate to the behaviour of healthcare professionals), but which do not easily translate easily into specific skills and competencies. They are much more amorphous in nature.

This is reflected in Table 3.3 (also below), which attempts to translate the aspirations into more specific skills and competencies. The table shows how, from a skills perspective, the aspirations are quite inter-related and, as noted above, there is a degree of overlap. It is a fairly subjective exercise, but it is crucial for going on to reflect on the alignment between the predominantly ‘soft’ skills supporting the aspirations and how healthcare roles are constituted in practice (e.g. the degree of emphasis that these type of personal quality and professional competence receive).
Figure 3.1  Strength of the workforce dimension to each aspiration

- HIGH
  1. Face to face, personalised appointments
  2. To retain control in the home
  3. Respect for preferences and belongings
  4. Company and the opportunity to be listened to
  5. Proactive healthcare and support
  6. Choice and control over daily routines
  7. A connected relationship between staff and patients
  9a. Joined-up care (medical / diagnostic)

- LOW
  8. Maintenance of privacy in hospital

< Strong workforce element - but a less tangible skills focus
Table 3.3  Skills and competencies related to each aspiration

<table>
<thead>
<tr>
<th>Aspiration</th>
<th>Key components</th>
</tr>
</thead>
</table>
| 1: Face-to-face, personalised, flexible appointments                      | ▪ Relationship building  
▪ Trust building  
▪ Continuity of care  
▪ Communication skills with frail older people (flexible service offer) |
| 2: Retaining control (in their own home)                                  | ▪ Enabling users to manage their own condition  
▪ Listening skills  
▪ Being able to draw out / elicit what a service user wants  
▪ Generic communication skills  
▪ Understanding of specific service options and the ability to communicate these clearly and non judgementally  
▪ A ‘non paternalistic’ approach |
| 3: Respect for preferences and belongings                                 | ▪ Respect  
▪ Politeness  
▪ Consideration |
| 4: Company and opportunity to be listened to                              | ▪ Relationship-based rather than task-oriented approach  
▪ Ability to provide joined-up care  
▪ Provision of information and advice (signposting)  
▪ Understanding of holistic services – ability to network with social and other opportunities (knowledge component)  
▪ Maintaining dignity |
| 5: Proactive healthcare and support                                       | ▪ Knowledge component (understanding of the support available to specific users)  
▪ Pro-activity – going beyond what is requested by service users in order to explain / outline options available  
▪ General communication skills  
▪ Ability to promote understanding – and to tailor communications to specific groups |
| 6: Choice and control over daily routine                                 | ▪ Communication – explaining the hospital routine  
▪ Service user-based rather than task-oriented approach  
▪ Focus on social interaction  
▪ Flexibility in dealing with service users and responding to service user preferences |
| 7: ‘Connected’ relationship between patients and staff                   | ▪ Relationship-centred care  
▪ Patient involvement in decision-making  
▪ Consideration  
▪ Listening  
▪ Wider communication skills |
| 8: Maintenance of privacy in hospital                                     | ▪ Patient involvement in decision-making  
▪ Consideration  
▪ Empathy |
| 9: Joined up care                                                         | ▪ Collaborative approach  
▪ Team working (between services)  
▪ Co-ordination  
▪ Person-centred approach  
▪ Condition management in the context of co morbidities (diagnostic skills)  
▪ Managing patient transitions  
▪ Communication (ongoing) with service users |
3.4 Mapping roles to aspirations

As well as looking at the overall strength of the workforce dimension in each of the aspirations, it is possible to assess each of 101 key healthcare roles individually to identify which are the most important aspirations on a role-by-role basis.

Table 3.4 presents the number of roles in our sample for which each aspiration was considered to be among the three most relevant. This reflects our a priori view of the alignment of aspirations to the workforce – those aspirations with higher numbers of relevant roles are more widely spread across the workforce, whereas those with fewer aligned roles can be seen either as having a narrower focus, or as having a weaker workforce dimension (they may be more structural or organisational in nature). For example, the aspiration of face-to-face, flexible care we already identified as having a strong workforce component – actually relates to relatively few job roles in the sector.

<table>
<thead>
<tr>
<th>Aspiration</th>
<th>Number of roles for which this aspiration was considered to among the three most relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>A ‘connected’ relationship between staff and patients</td>
<td>87</td>
</tr>
<tr>
<td>Joined-up care</td>
<td>30</td>
</tr>
<tr>
<td>Choice and control over daily routines</td>
<td>23</td>
</tr>
<tr>
<td>Proactive healthcare and support</td>
<td>23</td>
</tr>
<tr>
<td>Company and the opportunity to be listened to</td>
<td>16</td>
</tr>
<tr>
<td>Respect for preferences and belongings</td>
<td>12</td>
</tr>
<tr>
<td>Face-to-face, personalised, flexible appointments</td>
<td>11</td>
</tr>
<tr>
<td>To retain control in their home</td>
<td>7</td>
</tr>
<tr>
<td>Maintenance of privacy in hospital</td>
<td>0</td>
</tr>
</tbody>
</table>
3.5 How the aspirations are reflected in role frameworks and specifications

Having aligned the aspirations with corresponding roles, we can now assess the extent to which they are reflected in a sample of the key workforce frameworks and specifications relating to the health sector. In effect, we can look at whether the aspirations we would expect to see reflected in role-specific documents are actually reflected.

3.5.1 Overview of key frameworks and specifications

Our analysis looked at four types of workforce-related frameworks and specifications (job descriptions; person specifications; professional requirements; and proficiency standards), some of which are national/occupation-wide standards, others of which relate to roles at the level of specific health organisations. We did not focus on underpinning National Occupational Standards (NOS), because they are quite generic in nature, and are really only useful to the extent that they inform job design and role requirements in practice. Table 3.5 outlines the number of each type of document we reviewed.

Table 3.5 Types of document reviewed

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Number of roles reviewed using this document type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job description</td>
<td>89</td>
</tr>
<tr>
<td>Person/role specification</td>
<td>32</td>
</tr>
<tr>
<td>Professional requirements</td>
<td>28</td>
</tr>
<tr>
<td>Proficiency standards</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>154</strong></td>
</tr>
</tbody>
</table>

National standards developed by regulatory organisations and professional bodies were used for the analysis of each role where available. This encompassed 33 roles. Examples include:

- The regulatory body Health Professions Council (HPC) issues standards of proficiency which every registrant must meet in order to become registered, and must continue to meet in order to maintain their registration. All of the allied health professions (e.g. chiropodists, dieticians, physiotherapists) have HPC standards, and the HPC also regulates paramedics, biomedical scientists and clinical scientists.
- The Nursing and Midwifery Council (NMC) is another professional regulator. We have analysed NMC standards pertaining to a number of nursing roles in our sample.
- The General Medical Council is responsible for regulating doctors, while the General Dental Council has a regulatory function for dental professionals. We have reviewed core guidance and occupational requirements from these organisations for evidence of recognition of the aspirations.
- Beyond these key regulators, we analysed occupational proficiency standards and professional requirements from a range of other bodies such as The College of Radiographers, The Royal College of Surgeons of England, The British Dietetic Association and the British and Irish Orthoptic Society.

Many relevant health job roles are not regulated or defined by nationally-recognised standards in this way. Here, we analysed a sample of job descriptions (89 roles) and person specifications (32 roles)\(^65\). However, where a job role was particularly important for our analysis, we used these documents additionally where we also had recourse to professional standards or requirements. While these employer-level job and person specifications are not nationally representative, they provide an insight into how the relevant aspirations are reflected at that level across the healthcare workforce. They are given extra significance by the fact that they are a key element of most Trusts' recruitment practices.

\(^65\) It should be noted that some job descriptions contained partial or complete person specifications. By “person specifications” we refer to discrete documents of that type.
3.5.2 Variations by job role and type of framework / specification

Across the piece, the documents relating to the job roles in our sample showed only a schematic recognition of the aspirations most closely aligned with them. Often this was due to a lack of detail or clarity in the document, especially in relation to job descriptions and person specifications.

From our sample, a number of roles stood out as representing excellent recognition of the aspirations:

- **Psychological Wellbeing Practitioner**: The job role specification reviewed states that the practitioner: "undertakes patient-centred interviews which identifies areas where the person wishes to see change", "involve family members and others in treatment as necessary", "operate at all times from an inclusive values bases which respects diversity" and "attend multidisciplinary meetings, relating to referrals where necessary."

- **Emergency Care Practitioner**: This job description is strong on provision of individualised care, health promotion and multi-disciplinary working.

- **Health Trainer, Support Time and Recovery Worker, and Physiotherapy Assistant**: roles considered highly relevant to older people, all reflected many of the aspirations.

- **Dentists and Nurses**: The regulatory frameworks for these occupational groups show excellent recognition of the aspirations.

Conversely, several roles’ job descriptions and person specifications showed a particular paucity of detail reflecting the aspirations. This was particularly poor in the following roles, which should be expected to meet older people’s needs:

- Older person-related medical roles including *Old Age Psychiatry, Orthopaedic Surgery, Cardiology and Respiratory Medicine*. These roles, classified by the NHS Workforce Review Team as relevant to older people, have little or nothing on patient care.

- **Healthcare Assistant and Nursing Healthcare Assistant**: These roles are likely to involve close interaction with older people. However, the job descriptions analysed had significant gaps and at best contain only vague references to communication skills.

- **Community Pharmacy Technician**: This role involves work in intermediate and domiciliary care settings, with older people a likely prevalent service user group. However, the person specification makes little reference to the aspirations.

It can also be noted that, on the whole, very few explicit references to older people were made in our sample, either in job descriptions, person specifications or occupational frameworks. More generally:

**Job descriptions** displayed weak recognition of the aspirations, on the whole. In our analysis, two-thirds contained only a distant or indirect link between content and relevant aspirations, or significant gaps. A significant finding, especially among consultant-level medical roles, was that often lists of responsibilities gloss over patient care or omit it entirely. Few placed the patient at the centre of the professional’s responsibility, and fewer still made explicit reference to the aspirations of older people. Good examples of specified responsibilities sensitive to older people’s needs include:

- "Promote independent living by enabling their full participation in planning and review of care" (Support Time and Recovery Worker);

- "Preparation and participation in domiciliary care for elderly and housebound patients" and “Being aware of your surroundings and the property of patients” (Community Dental Nurse);

- “Undertakes patient-centred interviews which identifies areas where the person wishes to see change” (Psychological Wellbeing Practitioner);

- “Ensure a co-ordinated multidisciplinary service” (Orthoptist);
“Demonstrate a whole-system patient-focussed approach” (Hospital Pharmacist).

**Person specifications** tended to be aligned to the aspirations, but usually only on a very broad level (under catch-all competencies, such as communication skills). Given that the aspirations for older people can be partially realised by “soft” skills and dispositional attributes, the person specification is, arguably, the document in which they might best be reflected, but on the whole they are not given great emphasis. However, a number of cases show that it is possible to reflect the aspirations more specifically in the context of a person specification. Examples of requirements sensitive to the aspirations include:

- “Ability to treat vulnerable people with dignity and respect” (Healthcare Assistant);
- “Capacity to listen and engage others in open / equal dialogue” (Old Age Psychiatry);
- “Ability to work using a person-centred approach” (Counsellor);
- “Previous experience with the elderly” (Podiatry Assistant).

**Professional requirements** – issued by the Health Professions Council and other regulatory bodies – reflected the aspirations to a much greater extent. Part of this may be attributed to their increased level of detail, although as noted above, length is not necessarily a barrier. A more significant factor is the content of this guidance. Many of the documents reviewed take conduct and ethics as their foci; as such, it is reasonable to expect that the aspirations would be better reflected here than in a job description. Illustrative excerpts include:

- “You will recognise, respect and uphold the autonomy of service users” (The British Dietetic Association);
- “Plan appropriate interventions that take the clients’ perspective into account” (HPC – Practitioner Psychologists);
- “Support patients in caring for themselves” (General Medical Council);
- “Do not take any steps without patients’ permission” and “promote patients’ responsibility for making decisions about their bodies, their priorities and their care” (General Dental Council).

**Professional bodies’** non-regulatory standards and best practice guidance were also reviewed. Like the occupational requirements, these often showed strong recognition of the aspirations. Good examples include:

- “Address patient by name ... Show an interest in the patient ... Establish a rapport” (British and Irish Orthoptic Society);
- “Patients should be encouraged to take a leading role in the multidisciplinary team” and have “access to self-management programmes and appropriate information to manage their own disease” (British Society for Rheumatology);
- “Older people should at all times be treated as individuals and offered choice in treatment, discussion and planning of future care” (British Geriatric Society).

In general, we found that the broader professional frameworks were far more reflective of the aspirations. They are published by organisations, such as the Health Professions Council, which have a statutory role in ensuring quality of provision. It is perhaps unsurprising, therefore, that they reflect care quality concerns more readily. A key gap is the job role specifications and descriptions which tend to be quite generically produced by different Trusts. Nevertheless, they are a key recruitment tool for most organisations. A clearer description of skills and competencies which would benefit the care of older people would therefore be a useful mechanism for meeting the aspirations.
Variations and gaps by aspiration

Aspiration 7: A ‘connected’ relationship between staff and patients

This aspiration is important to all staff who engage on more than a superficial level with service users. As such, it was aligned with roles from across all nine workforce groups. The aspiration is described specifically in a hospital setting, although it overlaps with many of the community-focused aspirations (to the extent that it relates to the same skill areas).

The roles reviewed saw a wide variation, from those in which it was a clear gap to those that make explicit and extensive reference to the skills and competencies associated with the aspiration. However, in more than half of roles analysed, this aspiration was absent or only vaguely recognised.

Good examples include the College of Radiographers’ Code of Conduct and Ethics (2008), which states that: "Good communication with vulnerable people such as the elderly is imperative; you must always listen carefully to them and respect their views."

A Health Trainer role specification stressed the advocatory, non-paternalistic nature of the role. The post holder is required to "know when someone wants to change their behaviours and when they don't" and "empower people to make changes if they want to." In many other cases, however, little or nothing is said about patient-centred care.

The findings, both positive and negative, are not generally concentrated in any particular professional group. However, consultant-level job descriptions are notable for being extensive in length (often around 20 pages) but with very little on patient interaction.

Aspiration 9: Joined up care

There are two sides to this aspiration, relating to different groups within the workforce. One element, relating to the diagnostic/medical side of the health service, is particularly pertinent to doctors. The second relates to coordination and transition between services, and has a much wider applicability, though it goes beyond a pure workforce dimension.

This aspiration is relevant to all users of the health service, though it becomes a greater issue when health needs are more complex, and co-morbidities are more commonly found in older service user groups.

This aspiration was well-reflected in the specifications and professional frameworks considered. In particular, many person specifications across a wide range of roles list experience of working as part of a multi-disciplinary team as desirable or essential. Additionally, joined-up working is recognised in a number of professional frameworks and standards: "surgeons must ensure continuity of patient care" (Royal College of Surgeons of England); "you are obliged to co-operate with carers, and other healthcare professionals" (The College of Radiographers).

Aspiration 6: Choice and control over daily routine

This aspiration relates to hospital rather than community-based roles, and is relevant to all hospital-based staff. There is a likely emphasis on adult nurses, a range of doctor (general medicine) roles, as well as support services and clinical support services. It is also likely that level of seniority plays an important influencing role here – for example, senior nursing staff may play a role in setting the context for these interactions.

Documents analysed contained little to suggest support for this aspiration. In the roles interpreted as most closely related to this aspiration – including physiotherapists and occupational therapy assistants – no suggestion of maintaining the patient’s choice and control could be found.

Many of the roles analysed in connection with this aspiration were medical. As has been noted above, though, most doctor specifications contain very little on patient care.

Aspiration 5: Proactive healthcare and support

This aspiration is directly relevant to a range of job roles, particularly those in primary care and indirectly relevant to all patient-facing staff.
The aspiration is not necessarily specific to older people, but it can be particularly significant for them, especially those with long-term conditions. Though the prevalence of long-term conditions is associated with age, there is not much to suggest that the needs here are substantially different for older people (other than, perhaps, in the detailed nature of communication and how services are explained, especially online / telephone services). The real point here for older people, which is not about the workforce, is whether complementary information services are provided alongside the increasingly internet-based information services. In this sense, access to information is likely to be an older person-specific issue.

This aspiration is quite tightly focused in its workforce dimension, to roles with an information and guidance function. In these roles, the aspiration was generally well recognised. Nursing roles emerged as showing particularly strong recognition across document types – in job descriptions, person specifications and the Nursing and Midwifery Council’s occupational proficiency standards. The latter promotes proactive support by requiring nurses to “work with others to protect and promote the health and wellbeing of those in your care” and to “keep your colleagues informed when you are sharing the care of others.”

3.5.3.5 Aspiration 4: Company and opportunity to be listened to

There is a level of ambiguity concerning the breadth of application of this aspiration; it applies in some sense to all user-facing staff. This is highly relevant to the workforce but alludes to a skill set that is difficult to quantify.

This aspiration, which has wide and general application across the healthcare workforce, is most relevant to roles in the allied healthcare professions and wider healthcare team, categories containing a range of therapeutic and counselling roles. In these jobs – including Counselling Psychologist, Support Time and Recovery Worker and Psychological Wellbeing Practitioner – the aspirations were well recognised. The latter role describes a responsibility as follows: “[the individual] undertakes patient-centred interviews which identifies areas where the person wishes to see change.”

Looking beyond these professions, the overall picture is mixed. Some person specifications ask for listening skills or empathy, but these are in the minority. Most simply have generic references to “communication”, while some have nothing at all.

Conversely, a key guidance document for the medical profession, the General Medical Council’s Good Medical Practice (2006), contains the phrase: “ask for and respect their views about their health, and respond to their concerns and preferences” which indicates that this aspiration is understood.

3.5.3.6 Aspiration 3: Respect for preferences and belongings

This aspiration is relevant to multiple but defined job roles, particularly those that involve a worker entering service users’ homes. This would include GPs, District Nurses, Community Matrons, Mental Health Nurses, various clinical support staff (Nursing Healthcare Assistants, Support Time and Recovery workers, Speech and Language Therapy Assistants, Occupational Therapy Assistants), and a number of the allied health professions (Physiotherapists, Occupational Therapists, Clinical / Counselling Psychologists, Speech and Language Therapists). It may also be relevant for some ambulance service professionals.

However, as defined, it seems that a key element of this aspiration is the commissioner function and the variety of provider organisations (including private and third sector) potentially going into service user homes. Considerable difficulties arise in maintaining standards in this context.

Positive examples can be found in our sample. A job role specification for a Community Dental Nurse makes specific reference to “preparation and participation in domiciliary care for elderly and housebound patients....Being aware of your surroundings and the property of patients.”

However, the majority of roles analysed show no reflection of this aspiration. This includes the jobs closely related to domiciliary care, including: Health Visitor, Ambulance Care
There is therefore evidence to suggest that this aspiration is not explicitly recognised in the context of relevant person specifications.

3.5.3.7 Aspiration 1: Face-to-face, personalised, flexible appointments

This aspiration pertains to a narrow section of the workforce, specifically GPs and their support staff, and commissioners of local GP practice services and the booking of outpatient appointments.

There was very little reflection of this aspiration in the sample of documents reviewed. Only in roles where flexible appointments are particularly important was this requirement made explicit – for example, Sleep and Respiratory Physiologist.

3.5.3.8 Aspiration 2: Retaining control in their own home

This aspiration applies to a broad constituency and encompasses a wider cross-section of specialist support staff (for specific pathologies). It is relevant to those involved organisationally in service planning, management and commissioning of the provision of services close to home, and directly relevant for those involved in the personalisation agenda and the management of personal budgets.

It also relates to the manner in which healthcare professionals engage with older service users. For example, a supportive approach which allows the users to be engaged effectively in decision-making would be more conducive to realising the aspiration than a more paternalistic approach.

Some of the most relevant jobs, including Physiotherapy Assistant and Podiatry Assistant, do show good recognition. The former lists a responsibility “to encourage patients in an active approach to regaining and maintaining personal independence.”

3.5.3.9 Aspiration 8: Maintenance of privacy in hospital

This aspiration applies to a broad constituency of health sector staff – anyone who is responsible for patient care or the discussion of patient care – however it is not of central importance to anyone’s job. It fits with one of the key skills gaps identified in the fieldwork – that of empathy. As we have noted, there is significant variation in the extent to which the aspirations are reflected in the key documents which shape the health sector’s workforce: in some professional standards for job roles vital to the care of older people, the aspirations are explicitly and deeply reflected; in others where one would expect this to be the case there are very few references. Nevertheless, despite this variation, there is a bank of professional guidance, reflecting the aspirations, which guide key clinical roles throughout the sector.

The area where detail is most lacking is in the job descriptions and person specifications. In some cases this is partially explicable by the fact that with some of the aspirations it is difficult to break them down into specific skills and competencies. Additionally these documents tend to lack detail. However, they are vital tools used by Trusts in recruitment; the fact that very few of the documents reviewed specifically referred to older people should be seen as a key gap and missed opportunity.
4 Meeting the Aspirations in Practice

This chapter outlines the findings from our practitioner and stakeholder fieldwork, looking at the degree of priority placed on the needs of older people and how the aspirations translate into day-to-day professional practice. It also presents our analysis of where the gaps are in meeting the aspirations of older people.

Where possible we have differentiated between views expressed by stakeholders and practitioners. However the two groups are not intended to be compared to one another; the practitioner interviews formed the core of our research reflecting on the day to day issues facing health sector provider and commissioner organisations. The stakeholder interviews supplemented this research in their own particular area (a particular profession, clinical condition or level of organisation). Due to the variety within this sample, it is difficult to view them as a single voice.

4.1 Approaches to Planning and Organising the Care of Older People

4.1.1 Extent to which organisations focus on the specific needs of older people

One of the core principles underpinning the organisation of the NHS is that of subsidiarity. While the Department of Health guides the overall policy direction, where possible, the model of implementation is decided at the local level. Despite this, we found a degree of similarity in the way organisations organise the care of older people. Areas of convergence include:

- In acute settings, older people’s wards are seen as vital to providing a high level of care. This is seen as standard practice now across the country. Expert roles such as Geriatricians are found here, but are limited in number in the context the overall health workforce.

- When focusing on improving care, many HR leads do not see older people as a separate group: “Why draw an arbitrary line at 65? Care needs operate on a continuum”. Instead, working groups on issues such as privacy and dignity are set up. There is tacit acknowledgement that older people are the key focus of this but, nominally, the groups look at all patients’ experiences. The ambition not to discriminate between patient groups on the basis of age is laudable and seemingly done with the best of intentions; however, it is arguably also the source of many of the key aspiration gaps in practice.

- Furthermore, most organisations we engaged with look at patient experience data as a whole group and do not disaggregate data by age. A couple of Trusts we engaged with run consultations with older people focusing on their specific needs; however, this is not mainstream practice. There appeared to be a degree of scepticism more broadly in terms of the value and current importance of (all age) patient consultation as a mechanism for better understanding and meeting the kind of expectations set out in the Age UK aspirations. One of the broader themes that emerged from our research with practitioners is that the feedback loop of patient experiences regarding the services they have received is weak – with the notable exception of patient complaints.

A number of reasons were given for this widespread lack of a focused approach for older people:

- Trusts argue that: “If you get it right for all service users you will get it right for older people as well”. In short, the aspirations of older people are not separate from other service users.

- Many organisations manage their care through pathway models. Rather than viewing the service user as an older person, resources are allocated around strands of care which most closely relate to their condition, such as strokes, falls or dementia. As a result, many organisations refer to changing demand for these conditions, rather than an increase in the number of older people they are treating.
At the organisational level, older people’s needs are considered “by default because the vast majority [of patients] are elderly” rather than as a result of targeted planning. This is a critical point, and a key reason why it is important not to overplay the nature of any workforce gaps relating to the aspirations of older people. It is inevitable that the majority of health services are shaped around delivery to older people. However, there was a strong sense that the ubiquity of older service users and the diversity of the group meant that there was little explicit focus on their specific needs and expectations in practice.

4.1.2 Key drivers influencing health organisation planning

Although older people’s care is rarely organised around their status as older people, the ageing society is a major issue facing many practitioners’ organisations. However, it should be noted that the importance of this issue is related to the demography of the local area of provision. There are three dimensions to this:

- We spoke to a number of organisations in areas with a high proportion of older people (due to being traditional retirement areas). Interviews within these organisations were much more likely to raise the ageing society as a key issue.
- We spoke to a number of organisations in areas of high deprivation. Practitioners from these organisations reported that a very high proportion of older service users are more likely to suffer from conditions related to lifestyle such as diabetes, obesity and respiratory conditions. This again highlights the importance of the interplay between age and other characteristics.
- A number of practitioners differentiated between different elements of the ‘older people’ group. The number of those in the 85 years and above group is rising steeply as well. This group is likely to have the most challenging healthcare needs.

Overall, though, it is perhaps surprising that when asked about current and future priorities for their organisations, very few practitioners set this in the context of service users – and older services users in particular. There was a tacit acknowledgement that wider societal demographic changes will hugely impact on future health and care services and an understanding expressed that older people are the key users of the health sector, but little sense that this was a current driving concern at the organisational level. Organisations invest in tools and services which model the local populations they served. Most of the Trusts we engaged with carried out these forecasts over a period of about ten years; most are aware of the future service users they will have to provide for.

Practitioners raised a number of other issues important to their organisations over the next few years. The main issue is retaining and improving the standard of care as NHS budgets are cut (“Retaining the same quality of care while budgets are being squeezed”). Despite the fact that the government has ring-fenced health spending, many interviewees’ organisations are cutting their spending over the next two to three years. Some of these cuts may end up affecting frontline staff.

Other major challenges highlighted by interviewees include:

- The ageing workforce is an important issue to many HR leads. The challenge is to replace a large number of retirees over the next 5 – 10 years both numerically and their high level of skills and experience. This seems to be a bigger issue in the community sector which has an older workforce, on average, than the acute sector.
- Nursing moving to an all-graduate profession was mentioned by a number of interviewees. There is likely to be an issue with throughput of new nurses for a year or two after this change comes into force (in 2013).
- Other issues are only relevant to the local area, for example, attracting staff to work in rural locations and coping with local organisation changes (mergers of PCT, changes to local authority structures).
4.2 Overview of the appropriateness of skills and competencies

4.2.1 Reflections of the relevance and applicability of the aspirations

The aspirations are well-recognised across the sector. Practitioners thought they matched quite closely to their own patient experience and feedback. There was little contained in the aspirations that was surprising for practitioners and little that was contested. A typical, and broadly representative, statement was that the aspirations are: “perfectly sensible ... I’d be surprised if they weren’t there” and that they are “good, underpinning values you’d expect in any healthcare setting”. In fact, a number of respondents reported that it was sad or an indictment that aspirations, which relate to such fundamental healthcare values, needed to be expressed or told to the sector.

Many interviewees thought that rather than a set of aspirations for older service users, they should be understood as aspirations for all service users: “It’s very difficult to challenge them. Anyone, irrespective of age would want to be treated in this way” and, “the aspirations of older people are the aspirations of all service users”. This partly reflects the desire in many organisations not to discriminate between groups of service user and to work towards universal values for treating all patients.

There was, though, an acknowledgement that some (particularly frail) older people would place particular significance on the aspirations. A cultural-generational point was made here (different expectations; a more ‘traditional’ view of the ‘doctor-patient’ relationship), although practitioners tended to feel that this should not be over-played – and was rapidly changing when the wider cohort of older people is considered. Much more significant was the way in which the aspirations – and gaps in meeting the aspirations – are especially relevant to some groups of service user that carry a strong age-related dimension (people requiring long-term care; people with co morbidities).

4.2.2 How the workforce is meeting the aspirations of older people

Only a very small minority of the organisations we spoke to felt that they were fully meeting the aspirations. These organisations can be seen as best practice and exemplars of an approach to high-quality personalised care that it is very difficult to achieve in reality. The lion share of organisations were more circumspect in terms of their own performance in relation to the aspirations. Significantly, there was a wide recognition of areas for improvement, which suggests that Age UK’s interest in this area is pushing on an open door.

However, health organisations were generally much better at characterising the nature of the problem than they were at explaining how gaps were being tackled. Our view is that this does not reflect a lack of interest or prioritisation to meeting the needs of older people. Rather, it highlights the perceived intractability of some of the underlying causes of patient dissatisfaction.

There was a broad view from Trusts that they were heading in the right direction in terms of meeting the aspirations, although this was partly explained by the fact that the sector was responding to changing societal expectations. The view was that health organisations generally had a more patient-centred approach than in years gone by. This macro view does, though, have to be set alongside the numerous comments made by practitioners that related some of the aspirations in an acute context to what we might crudely call the standard of ‘bedside care’, which is often harder for nurses, in particular, to deliver given the organisational and performance structure of NHS Trusts.

Practitioners from Mental Health Trusts reported that they believed they were closest to meeting the aspirations. A typical response was:

“Mental health trusts are better placed to understand the issues of holistic care for an older person than other organisations ... We tend to have a much longer running relationship with a person than, say, an acute trust”

Workforce managers in Mental Health Trusts reported that the values of person-centred care have deeper roots in their service area than the sector as a whole. As noted above, there is
evidence that the aspirations are more difficult to meet in the acute sectors, where providers often face more stressful situations, reduced flexibility of provision and a more fragmented care pathway delivered by a number of clinicians. This is crucial for understanding the nature of the skills gaps in practice.

One respondent articulated this as being much more complex than a simple ‘gap’ – and relating to consistency and the ability of a wide-range of health professionals to manage pressurised situations. The ‘gap’ relates to the aspirations being ‘variably met because people’s interactions vary’. As the aspirations are quite commonsensical and widely recognised, the issue may be about minimising situations where the behaviour of the health professional falls short of (their own) expected standards.

Thinking about the key skills and competencies in practice, therefore leads one away from the skills and competencies that directly relate to the aspirations (communications etc) towards a different but related set of skills relating to decision-making, multi-tasking and managing pressure: ‘the intention is fine – but the delivery [in the heat of the moment] sometimes isn’t’. More worryingly, perhaps, is the assertion by one practitioner that some health roles are so pressured that clinicians are “left burnt out and not caring”.

The picture is a mixed one in terms of which aspirations practitioners thought were hardest to meet. The overall feeling was that none of what is contained in the aspirations should be too difficult to achieve. In the acute sector, practitioners thought that ensuring privacy in hospital was the most challenging area. Despite this aspiration having a workforce dimension, some practitioners considered the layout of the hospital ward to be a key influence on whether the aspiration could be met; some respondents working in older premises considered this to be an important, but largely intractable barrier. It was also mentioned on a number of occasions that meeting this aspiration through the provision of private rooms – a goal which many acute providers hope to reach – would actually work against meeting other aspirations such as a connected relationship between staff and patients as well as more clinical needs such as staff needing to informally assess patients in a ward situation.

Providing joined up care was also seen as problematic by a significant number of practitioners, partly because of the degree of cultural change and inherent organisational complexity associated with what in itself is a fairly wide-ranging aspiration. Again, the more intractable elements here are the non workforce elements – and while is impossible to separate workforce development from its resource-, organisational- and cultural-context, the implicit message emerging from our discussions was that, in reality, the most achievable and significant improvements relate to the quality of interaction and engagement between healthcare professionals and service users.

4.3 Reflections on the key workforce elements for meeting the aspirations

Many practitioners and stakeholders found it quite difficult to articulate specific job roles and occupational groups associated with meeting the aspirations – or where the aspiration gap is greatest. This is partly because we were asking respondents to generalise – and it is clear that the differences within any group of health staff (consistency of approach) are probably more significant than between different groups of staff. It also relates to the cross-cutting nature of the challenge and importance of looking at multi-professional teams when thinking at the experience of an older person.

One interviewee suggested that service users often have a “composite recollection” of their engagement with the health sector. This means that all workers with whom they come into contact can shape their view of the engagement, even if they have had no clinical engagement. Numerous interviewees reflected on the importance of non-clinical roles in contributing to patient satisfaction, such as receptionists, porters and domestic staff. The ubiquity of older people within the health sector means that virtually all health staff are responsible for shaping the experience of older people.

In fact, one of the recurring themes from the interviews – especially when thinking about aspirations relating to proactive and joined up care – was practitioners’ focus on the
importance of looking at engagement between different groups of health professionals rather than the skills and competence of any particular group of staff per se. Other interviewees argued that care is shaped by multi-professional teams more than by individuals and that cooperation between workers is the key to meeting the aspirations.

Interviewees from both our practitioner and stakeholder sample thought that a key point at which the aspirations of older people are not met is the boundary between primary and acute care, going in both directions. The barrier here is one of coordination between services. This requires organisational skills in ensuring a smooth care pathway, communication between different parts of the health sector (for example, a clinician in a hospital setting clearly outlining an individual’s care needs to their counterpart coordinating the care in the community sector), and commissioning the correct services within the community. The aspirations are also thought to be poorly-met as service users move between health and social care.

Having said that, some of parts of the workforce were much more routinely reported by interviewees as having a particular importance with regard to the aspirations:

- Nursing staff
- Doctors
- Allied health professionals

4.3.1 Nursing

Most workforce leads, whether from a HR/Management perspective or a clinical management perspective, considered nurses to be the integral workforce grouping for meeting the aspirations of older people. In community settings, nurses “have a key role in keeping people at home and giving them choice and control”. Regardless of a service user’s condition, it is likely that a nurse will be involved in their care at some point. As a result, they are seen as “the primary carer with whom a service user will have contact”. Nurses also play a key diagnostic role. In both acute and community settings, the high level of contact nurses have with older people means they should notice any low-level issues affecting patients such as nutritional or comfort issues. Some interviewees equated a large chunk of the aspirations as being about “good nursing” practice.

Within the nursing workforce, there are a number of roles that interviewees considered to be of particular importance. In the acute settings, nurses in a management role are considered vital. The Modern Matron role was highlighted as one which combines the highest level of nursing care with a requirement to set standards of practice for colleagues i.e. “the individual with the quality oversight”. In community settings, the Community Matron and District Nurse roles were highlighted as being the key players in co-ordinating the care of an older person. The community matron is a managerial role responsible for quality assuring the service provided by district nurses. They are also able to prescribe medication and have a key role in coordinating palliative care and pain management services. These clinical managers are vital for setting an example to junior staff members as well. As one Workforce Lead said: “What makes a young clinician like a district nurse go the extra mile in their care? It’s a strong line manager, leading by example and conscientiously ensuring that their staff are doing a good job”.

4.3.2 Medicine

Alongside nursing, doctors are seen as playing a vital role in the care of older people. One interviewee summed up the situation as “nurses [to] provide the TLC and doctors [to] look after the clinical needs”. Within the medical workforce the largest group numerically and, arguably, in importance, for older people is General Practitioners. They are often the first professional point of contact for an older person. This position gives them an important diagnostic role. With older people, this requires an understanding of the range of other mental, physical and social conditions that may be impacting on their health. As the first part of a care pathway, they play an important role in “connecting people to other services”, as one interviewee described it.
4.3.3 Allied Health Professions (AHPs)

The allied health professions are thought to be an important group to meeting the aspirations of older people with clinicians working in the community and acute settings. The role of AHPs, in this context, is centred on trying to keep an older person in the home or helping an older person rehabilitate sufficiently to return home following a stay in hospital.

Interviewees outlined a number of roles within this group that are considered particularly important:

- **Physiotherapists** are an important part of intermediary care teams working in the community, focusing on keeping older people mobile and healthy enough to stay in their homes. They also play a vital role in rehabilitation in the acute setting.
- **Occupational Therapists** play a key role in rehabilitation in both community and acute settings.
- **Podiatrists / Chiropodists** are considered to be important to the needs of older people due to their role in helping to retain mobility and independence.

A host of other AHP roles were mentioned. In the context of mental health care, for example, **Clinical and Counselling Psychologists** are often part of multi-disciplinary teams providing mental health care for older people, playing a particular role in diagnosis and assessment.

4.3.4 Other areas

Practitioners identified a wide group of other workers who are important for meeting the needs and aspirations of older people. As noted above, **receptionists** are seen as a vital group. They are often the first point of contact for an older person (either on the telephone or in person) and, as such, can have an impact on their experience. They are also important in trying to shape services around the individual. Services, such as outpatient appointments at the local hospital, have potential to be extremely disruptive and unpleasant experiences for a vulnerable older person. An empathic receptionist can minimise these difficulties.

Interviewees, particularly from the acute sector, outlined a range of other non-clinical, but frontline roles which can “make a real difference”. These include, **Hospital Porters**, **Gardeners** and **Domestic Staff**.

The **Healthcare Assistant** role is also seen as important for the experience of older people. They are responsible for many lower level care tasks such as feeding, bathing and ensuring comfort and, therefore, contribute to many of the aspirations related to ensuring personal preferences are respected. As they typically spend a great deal more time with older people than clinicians and as a result, may have a greater impact on their impressions of the care they have received.

Practitioners, and stakeholders specialising in the area of older people’s mental health, noted that a vital role for meeting these aspirations is that of **psychiatric liaison**. This role can be filled by a number of different professions (for example, Doctor, nurse, physiotherapist) as long as they specialise in psychiatry or mental health. Their role is to look after the mental health needs of a service user who has to move from a mental health setting to an acute setting (because they might need an operation or have suffered a recent fall, for example). The psychiatric liaison role ensures that clinicians at the acute provider are treating the patient’s mental as well as physical health needs. This was seen by practitioners as a key gap in care provision.

4.4 Nature of the perceived skills gaps in practice

Practitioners and stakeholders thought that the skills and competencies of workers – clinical or otherwise – had a key role to play in meeting the aspirations. To summarise, the provision of poor care is very rarely, if ever, wilful. However, gaps still exist. The most common gaps, or areas of competence which are not being met, can be split into three categories:
Attitudinal gaps;
Communications skill gaps;
Clinical skills gaps.

4.4.1 Attitudinal gaps

A senior stakeholder working in mental health argued that the continued failure to meet the aspirations of older people was a result of “an endemic ‘gerontophobia’ at a societal level ... old age is not valued in this country”. The implication is that to some extent, the health sector’s workforce reflects the ageist attitude of the rest of society and has led to, as described by a senior stakeholder working in the area of older people’s care, “A covert discriminatory attitude”.

On a more practical level, practitioners thought that one of the major competency gaps was in empathy. HR leads reported that in the caring professions, they “want people who have high levels of empathy and who see the role as more than a job”. However, it is not present in all staff and can be difficult to develop within individuals.

Some interviewees reported that many clinicians lack general care skills, particularly in providing care in a holistic way. This is particularly problematic with older people who are more likely to be suffering from “a conglomerate of little ailments”. A stakeholder thought this was particularly prevalent within the medical profession which is focussed on fixing “certain conditions, but not the whole problem”. It might actually be workers from lower bands of the workforce such as Healthcare Assistants who “get it more intuitively ... looking holistically at people, taking a common sense approach, not having a professional ‘hat’ on which leads them in a particular direction”. This skills gap is well recognised. Practitioners we engaged with thought that the presence of multiple conditions was probably the clearest indicator for older people.

4.4.2 Communication skills

The most common skill gap highlighted by practitioners and stakeholders, and also an area of competency which is seen as vital for delivering high quality care for older people is a set of skills, broadly labelled as ‘communication skills’. The gaps in this broad area include:

- Motivational communication: a key area where staff are not reaching the required standard is in motivating older people, who may be suffering from depression. If an older person is not responding positively to suggestions of other care options (encapsulated in the ‘proactive care’ aspiration) this reticence may be linked to depression. It is the clinician’s job to recognise this and then communicate in a way as to encourage them to improve their situation through seeking treatment. One senior stakeholder argued that: “Older people can be ‘internally ageist’ ... they don’t want to be a burden to the health service (this can be particularly the case in hospitals). It is the job of the staff to address this and ‘enable old people to have a voice’.”

- Communication with service users’ families / carers: communicating with the informal care network that may surround an older person is a vital skill for those in all healthcare settings. It is a means of gathering information which can help make the service user’s care experience more personalised (e.g. what sort of food do they like). It is also a way of learning about other care they may receive, for example, a day care centre they attend, and what services they receive there. These conversations can be particularly important if the service user is suffering from dementia.

- Communicating with a patient suffering from cognitive or hearing problems: a key skill is to be able to achieve this in a “non-patronising way”.

- Advocacy: important for service users who may have communication problems themselves, this skillset requires clinicians to act in the interests of older people, listening to them and communicating their needs clearly. If personalisation continues to develop in the health sector and service users gain greater control over building their care packages (with or without personal budgets), this skill will become even more important.
Older people, in particular, are likely to need a guide or someone to act for them in building a care package from a complex healthcare market.

▪ There is also a need for clinicians to avoid “Speaking down to people and feeling you’re more knowledgeable than them.” This is seen to disempower service users.

Other areas where skills gaps exist include:

▪ Provision of information, advice and guidance: as well as communication skills interviewees outlined having up to date knowledge of local services as being important. This is related to the advocacy skills required: health sector workers need a detailed knowledge of the services (both health and non-health) available locally. This is particularly important for district nurses and community matrons. A new social activity or a change in care setting may make an enormous difference to an older service user so community-based workers should be able to facilitate this.

▪ Risk Management: as outlined by a senior stakeholder leading on mental health provision for older service users, in many cases, staff are not managing and protecting older people from risk. The key areas where this is not happening sufficiently well are:
  – Is the older person at risk of abuse?
  – Is the medication being prescribed correct (older people metabolise substances differently to younger people)?
  – Is the older person at risk of suicide? This is a key area because, in the majority of cases where older people commit suicide, the person has seen a healthcare professional in the month before they commit suicide.

This is another skill area which will become more important as personalisation progresses within the health sector. A key element of personalised policies is to increase the autonomy of the service user (through, for example, a more equal relationship between patient and clinician, or the granting of a personal health budget). This entails a necessary risk which clinicians will have to learn to manage.

4.4.3 Clinical skills gaps

Interviewees from both the stakeholder and practitioner elements of the fieldwork highlighted a number of areas where clinicians are not meeting older people’s clinical needs. There are number of dimensions to this, but it is striking that much of what has been reported relates to managing multiple conditions:

▪ There is a broad lack of knowledge and understanding about the effects of ageing on the body. Many interviewees stressed the importance of specialist gerontologists (within the medical or nursing profession) being a key element of an older person’s care however all clinicians should have a low level of knowledge. Interviewees reported that basic knowledge of the effects of ageing on the body, and what this means for various medical procedures such as taking blood, is lacking in certain parts of the workforce such as nursing.

▪ Mental health conditions: clinicians throughout the workforce lack detailed knowledge in this area. Misdiagnoses are a prominent issue in the sector with a lack of awareness of the early signs of dementia a key issue. A nurse manager thought that there was a particular lack of knowledge of diagnosing minor mental health issues such as mild anxiety or depression. A senior mental health expert thought that these skills gaps were particularly frustrating as such conditions can be treated (as opposed to incurable conditions such as Alzheimer’s) There is a lack of understanding of the effects of mental health problems on the cognition of service users. This means that aspirations such as respect for preferences and belongings are not met. The magnitude of the gap in meeting older people’s mental health needs is illustrated by the fact that it is only in the last couple of years that psychiatric care has become available for over 65s. Up to this point, services were breaching the very first standard of the National Service Framework for Older People (*The NHS will provide a universal service for all based on
clinical need"). This may have stymied the development of expertise in this area with old age psychiatry still being a niche area.

▪ General practitioners have issues assessing ‘capacity’. This is the term for the mental awareness of a service user and their ability to make decisions.

▪ Poly-pharmacy: many clinicians, including General Practitioners and nurses, are not able to help older people manage multiple medications.

▪ A general gap in managing co-morbidities is present across the workforce. This is something which can be particularly prevalent among the allied health professions who can focus on their part of the care pathway without knowledge of other conditions that may be affecting the service user.
5 Barriers to meeting the aspirations

In order to understand the types of policy response that are likely to be more successful in narrowing the gap between healthcare practice and the aspirations of older people, it is important to explore the barriers experienced by health professionals ‘on the ground’. In a sense, there are fairly favourable conditions for meeting the aspirations:

▪ As we have seen (in the Chapter 2), there has been a top-down policy focus on the needs of older people for some time. There have been a number of developments within the NHS nationally that can be seen as going with the grain of the aspirations identified by Age UK.

▪ Furthermore, we have seen (in Chapter 3) that while there is inconsistency across organisations and occupations, there is a bedrock of standards and (where applicable) professional requirements that map across to the aspirations. There may be a lack of specificity here and arguably a lack of emphasis on the ‘softer’ skills and competencies that relate to the aspirations; but, nevertheless there is a strong degree of alignment here.

▪ We have also seen (in Chapter 4) that there is widely-held acknowledgement within the sector among those people with responsibility for workforce development of both the importance and current weaknesses in the context of meeting the aspirations. Yet practitioners also highlighted how the reality of workforce planning and healthcare delivery can also work against the effective mobilisation of skills towards the needs of older people. This can be understood in terms of barriers at a number of levels, which are interrelated, but provide distinct insight about ‘what works well’ and, perhaps more significantly, ‘what works less well’:

▪ Policy influence: Interviewees outlined a number of policy drivers which work against the achievement of the aspirations;

▪ The influence of the healthcare organisation: Practitioners, in particular, outlined barriers at the organisational level (Trust / provider) which inhibit the achievement of the aspirations, which may relate to systems, work organisation or culture;

▪ Barriers relating to specific workforce development activities: Interviewees outlined barriers related to training, recruitment and other factors at the workforce level which hinder the achievement of the aspirations.

5.1 The influence of national policy in practice

Practitioners thought that government policy changes could have massive impact on the service provided.

5.1.1 The ‘volume’ of reform

A number of practitioners thought that the “Sheer overload of constant change from government” acted as a barrier to the workforce being able to meet the aspirations. A clinical manager we interviewed acknowledged that “the NHS is seen as a political pawn, which means policies change regularly”; but argued that “this can get in the way of a high level of quality”.

Another interviewee went further, arguing that the main policies of recent years had been inherently contradictory with some of the White Papers (‘Putting People First’ and ‘Our Health, Our Care, Our Say’) moving the workforce towards the aspirations and others (‘Transforming Community Services’) driving in the other direction. The publication of the recent White Paper, ‘Equality and Excellence: Liberating the NHS’, was mentioned in a small number of the latter interviews. Views on the publication were at a formative stage; however practitioners view it as a further layer of reform which may obstruct the provision of quality care. It is also thought to be essential that the skills and workforce implications of the white paper are considered at an early stage.
5.1.2 The role of targets

A number of interviewees thought that the previous government's focus on targets as a means of delivering reform had reduced clinicians' focus on delivering high quality care. The issue was summed up by a stakeholder:

"Targets are set on issues such as waiting times but not on the behaviours which contribute to the aspirations. What's going to get Chief Executives the sack? Harder targets, not softer aspirations."

A number of practitioners agreed including one who thought that the various management systems and performance targets “overcomplicate things and the non-clinical elements get missed out.”

Stakeholders gave examples of how large scale national policy changes could lead to change. The National Dementia Strategy is beginning to show signs that dementia care is improving (albeit from quite a low baseline). A senior stakeholder from one of the Royal Colleges thought that the focus had been shifted so clearly to dementia that other mental health conditions, such as Parkinson's, had lost out. Another example cited was the national focus on hospital infection rates, which have been reduced in recent years.

5.1.3 Scarce resources

As highlighted earlier, most practitioners we spoke to anticipate cuts to their budgets in the coming years. A number of their organisations are already planning cuts to this and next years' budgets. Given the high proportion of NHS budgets spent on staff (around 60-70%), many practitioners believe they will have to reduce the headcount of their workforce. This will be a key barrier to meeting the aspirations because, in many cases, meeting them takes time.

A useful illustration of this barrier is a comparison of the independent sector and NHS practitioner interviews. A senior clinical leader from the independent sector did not believe that staff in the independent sector are more 'older person-centred' or exhibited fewer skills gaps. The interviewee did argue, though, that they were "meeting the aspirations 100%". The key reasons, they thought, are the standard of the premises they are able to offer (all single rooms) and the amount of time they are able to spend with patients (there are fewer patients per nurse). Many practitioners in NHS Trusts are concerned that budget cuts could lead to this gap growing.

5.2 Organisation level barriers

A number of the barriers that were outlined to us operate at the organisational level i.e. within and between different care providers.

5.2.1 The complexity of organisations and the role of key influencers

Our practitioner consultation has provided insight into where influence and knowledge of workforce issues lies within NHS Trusts. HR leads are a step detached from the day-to-day delivery of care and issues around the quality of delivery. Their core concerns are ensuring that sufficient numbers of clinical and non-clinical staff are recruited.

Detailed knowledge of quality of care issues lies with clinical leads from the key workforce groups: medicine and nursing. These groups are harder to engage, but are the key influencers of practice on the ground. Moreover, as one practitioner argued, there is evidence that: “Increasingly, initiatives are clinically-led therefore it’s the clinical directors and not the management – be it Board level or organisation level – who lead on projects”.

Therefore, key individuals within provider Trusts are individuals such as the Clinical Director, Director of Nursing / Chief Nurse and Director of Older People’s services. Many Trusts also have working groups on issues pertaining to older people’s care such as privacy and dignity groups, falls and dementia. These groups are key forums for ensuring high quality care of older people.
A number of practitioners thought that the Trust’s Board was vital in implementing change in the sector. They have the ability to set the priorities for the organisation. It is seen as important to have those connected with patient experience at this level: it is “absolutely imperative that there is clinical representation – particularly nurses – at the Board level”.

The value and importance of any intervention being set within a supportive organisational culture was a recurring theme (we return to it below in the context of CPD/on-the-job training), but was, perhaps unsurprisingly, the most difficult for practitioners to think about practically. Weaknesses relating to organisational culture were quite easy for practitioners to identify, but were described far more as the reality against which any solution needs to be contextualised – rather than something that can realistically be changed. That may be an oversimplification, but it is an important signal when thinking about the policy interventions that will make a difference (i.e. what is practicable to actually achieve from a ‘bottom up’ perspective).

5.2.2 Transitions between primary and acute care

Practitioners suggested that acute settings are less well prepared for service users rehabilitating (something which is of importance to older people, who often have longer recovery periods than younger service users): “[Hospitals are] geared up for patients who are injured or require an operation but less so for patients rehabilitating”. There is a sense that “the responsibility of the acute Trust ends after surgery”.

Discharge from hospital is a key juncture of the care pathway. It requires knowledge of how health conditions affect older people differently. It also requires links with community providers to ensure that recovery continues once the older person has left the hospital. Organisations need to “ensure that people are discharged into appropriate places”. A senior clinician who led on this issue argued that this was an area where specialist skills and knowledge of how illness affects older people is required. However this is an area where policy drivers can act against meeting the aspirations: “things break down when pressure is put on acute Trusts to move patients on”.

One of the underpinning reasons for this failure, which was highlighted in an interview with a senior stakeholder from the medical profession, is the: “dislocation of primary and secondary care over the last decade”. In short, there is a lack of communication between GPs and hospital doctors.

5.2.3 The interaction between health and social care

A major barrier to achieving this smooth transition within the sector was described by practitioners as silo thinking. A Practitioner working in a Care Trust, which fully integrates health and social care provision (one of only nine in the country), thought that a function of silo thinking was to allow health professionals to focus on their role (their part of the care pathway) at the expense of considering some of the non-medical factors that affect vulnerable groups such as older people. Formally integrating the health and social care systems under the Care Trust model means this sort of thinking is eliminated, but creates its own challenges in terms of developing effective multi-disciplinary teams (issues such as line management, as well as shared culture etc).

For a practitioner from a Mental Health Trust which provides care to service users who often cross the boundary between health and social care, the major barrier is that “there isn’t one body that deals with older people and this is a major barrier to caring for older people, particularly in their home. The third sector, health, housing and social care are all involved but there is no one accountable group.”

Practitioners also noted a difference in skills and approach to care between the health and social care sector: “Social care staff are used to responding to need whereas health staff are used to responding to diagnosis”. Healthcare staff have traditionally focused on the main problem a service user is facing whereas social care staff view the whole person. With older people, who are likely to have multiple needs, the healthcare approach is arguably limited. One practitioner even thought that the incompatibility of the respective information technology systems was a barrier to good care which means social care assessments
cannot be shared with health colleagues, which results in duplication of effort. The variation in quality of care provided in some residential homes is also seen as creating a resource burden for the health sector. One practitioner thought that despite regulation, there are still some very poor quality “institution-like” care homes which create an enormous burden for the health sector as the health of residents can deteriorate rapidly. Much of the very important preventative work should be taking place in these settings.

5.3 Barriers relating to workforce development activities

There are a number of barriers to meeting the aspirations within the context of actual workforce development activities undertaken by health organisation (as well as the broader approach to Human Resources). These barriers are related to the training of clinicians (both pre and post registration) and other staff, recruitment of staff and the sort of people who choose to specialise their careers in the care of older people.

5.3.1 Career pathways and specialisation

A key debate within many of interviews, both with practitioners and stakeholders, has been on whether training of clinicians, and the subsequent career paths, have become too specialised. One HR Manager thought that clinicians had become “too blinkered ... too specialised.....there is a lack of general awareness of conditions”.

The over-arching view was that while specialism is clearly a ‘good thing’ in terms of promoting positive health outcomes, it was an important root cause of what are arguably the most significant aspiration gaps (joined up care, pro active health care and the ‘connected’ relationship).

This is particularly pronounced within the medical profession where doctors have protected learning time to pursue their own research interests. There was support from both practitioners and stakeholders for the argument that: “education and training has left them short of the knowledge and skills required to deliver care which can meet the needs of older people with a wide range of problems”.

In the absence of sufficient emphasis on the underlying barriers faced by older people, expertise can become silo’d into specialist roles relating to older people. These roles arguably take on even greater importance given that they encompass expertise that is of such relevance to the wider workforce, but which often ‘falls between the cracks’ of professional development. A senior stakeholder specialising in older people’s care outlined the importance of having a dedicated workforce with specialist skills in gerontology and, potentially more importantly, the motivation to work in this area:

“If you [as an elderly service user] are in an elderly ward, then you’re lucky because the staff generally want to work there and they know what they are doing. If you [as an elderly service user] are in a mixed ward there have been cases where the older people have been left to the end by workers as they are a more complex case and staff are keen to display productivity”.

The issue may be linked to the age of the workers. Many younger, recently trained clinicians are more: “process oriented... with less complicated (and younger) service users they can go through the numbers quicker” and, stated simply, “It’s a working environment that’s not for everyone ... young people do not like to see their own mortality”. Older people’s medicine is “not seen as sexy” and that work in this area is “too much like hard work”. Consequently, “the brightest and the best of the nurses tend to gravitate towards ICU [intensive care] and A&E not the care of older people”.

As a result of this, some acute Trusts find it difficult to recruit specialist skills in this area. There is a particular issue among nurses who often: “spend five or six years after qualifying working in a hospital before settling down in their personal life and wanting to move into a community care setting”. The same interviewee argued that acute settings work against clinicians (and nurses in particular) gaining the required skills and unsupervised experience to progress to Band 7, where they have a recognised specialism.
5.3.2 Pre and post registration training for the professions

There is a general consensus among the practitioners we spoke to that pre and post-registration training for the regulated professions is not providing clinicians with the competencies to meet the aspirations. This is one of the clearest gaps to meeting the aspirations, although it is arguably one of the most intractable ones, because it relates to:

- The fullness of the existing curriculum for pre registration education and training.
- A cultural lack of recognition of the importance of ‘softer’ skills in that training (exemplified by the comments from some practitioners about the impact of professionalising the nursing role on core, traditional work-related nursing skills)
- The key role of placements in developing the relevant experience and the challenge of providing sufficient depth to the placement experience (especially in the context of the ‘busy curriculum’)
- A lack of demand among health professionals for CPD exploring the needs of older people.

Within the medical profession there was some debate about the degree of engagement and focus on the care of older people that there currently is and should be. One stakeholder, representing Doctors, thought that aside from some obvious exceptions (such as paediatrics), the care of older people is covered inherently during medical training. However, another stakeholder, representing General Practitioners, questioned the proportion of a doctor’s training that was on geriatrics: “I’d be interested to know how much training doctors actually get in geriatrics”. This interviewee also argued that it should be essential for all doctors to work with older people during their placements; at present this is not the case. Pointing out the high number of older people within society she stated that:

“The training that medical students receive has not moved with the times and is not prepared for an ageing society”.

There is also an argument that pre-registration courses are so packed with content that some of the important competency development work (developed “at the bedside”) gets missed out. The move to nursing being an all-graduate career may exacerbate this as it risked losing out some of the apprenticeship-style learning which takes place on the ward.

Reflecting on the fieldwork, there is no clear consensus, particularly regarding medical education, on whether the training is too specialised or not. There is a strong argument from practitioners (both clinicians and HR managers) and stakeholders, that career paths encourage specialisation at the expense of general care skills which would contribute to the meeting of aspirations. Conversely, there were a significant proportion of interviewees who argued that specialisation is vital for high quality care and it drives improvement in the health sector. However, a major barrier overrides this debate: there is actually very little opportunity, within medical and other clinical curricula, to add modules either on the care of older people or on generic care skills.

Interviewees from different stakeholder organisations and practitioners emphasised the importance of clinical placements in ensuring that health professionals are delivering a suitable quality of service. A senior mental health stakeholder highlighted PSIGE (Psychology specialists working with older people) guidance: “specific clinical experiences should be gained, at least in part, in a specialised Older Persons’ service”. A senior general practitioner thought it was integral that clinical placements for medical staff involve time working specifically with older people. A key barrier to a high-quality work placement is the senior clinicians with whom the students work. An SHA Education Commissioner felt that in some cases “role modelling on placements can be poor” and this can affect the overall quality of learning.

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66 PSIGE (2003) Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Older People
Practitioners also report that budgets for continuing professional development are subject to the competing priorities that characterise all health sector spending. An Assistant Head of Nursing reported that, given a choice between upskilling the ICU (intensive care) nursing workforce and those specialising in the care of older people, she would be more likely to choose the former as there is more demand for learning in this area, both from the learners themselves and senior management. Addressing this disparity would require “care of the elderly training budgets to be ring-fenced”.

In the context of CPD, there was also a strong sense that a significant difference could be made quite simply through the availability of better resources relating to older people. This is because much of the discussion of ‘gaps’ in practice related to awareness and the ability of the health professional to emphasise with situation of the patient.

We spoke to a number of workforce managers and clinicians who have responsibility for care quality and who emphasised the potential value in resources based around patient stories, both negative and positive: “only through telling patient stories can mindsets be changed”. There is also value in encouraging clinicians to think empathically. A PCT workforce manager stated that: “it’s helpful if service providers could act as the patient once in a while” and for them to question how their behaviour might have made the patient feel.

This needs to go hand-in-hand with an organisational culture that emphasises the care/quality dimensions to health service provision and embeds an effective learning culture that allows staff to talk openly and honestly about their development needs. That takes us well beyond the workforce element to meeting the aspirations – and is such a complex area in itself that we found few coherent examples of how such cultures had been developed or supported. One Trust attempted to set the expectations for behaviour at an organisational level by producing a handbook for all staff detailing the standards and characteristics that should be displayed. Another required staff to carry pledge cards detailing similar behavioural commitments they had made. The cross-professional nature of the handbook necessitates that it focuses on softer skills and behaviours. This can only, in itself, send a signal about what is expected from staff – but it was perhaps telling that this was approach was thought to be more influential ‘on the ground’ than the various national (DoH) and regional (SHA) approaches to supporting the needs of older people.

5.3.3 Training for non-regulated staff and workforce redesign

Even though training and development barriers exist for the regulated professions, there is at least a formal structure of initial training and ongoing development based around a common set of standards in place. There was very little detail provided as part of the interviews about CPD for allied health professionals and the wider healthcare teams. In fact, a number of stakeholders made the point that this was, in effect, the most significant gap in relation to workforce development to meet the aspirations. That may be a slight over-statement, but the perceived lack of resource and structure for training beyond the key professions is striking when set alongside the picture that has been painted of the breadth of the workforce shaping the experience of older people in practice.

This issue is made even more complicated by the changing nature of healthcare roles. A number of practitioners discussed how new roles can impact upon the experience of older people. In general, interviewees reported that the existing workforce structure was quite inflexible (“some jobs and careers have become ossified and this limits talented people”). Some health professionals adhere to their job description too closely and this is to the detriment of the care of older people. Some organisations believe that meeting the aspirations requires flexible new roles as much as a flexible skill set.

An area of the workforce where this innovation is prevalent is the boundary between nursing and the allied health professions. Roles are developing which “blur the boundaries” of these career areas to ensure that service users have one point of contact rather than multiple visits from different professionals.
This sort of workforce redesign is particularly important in organisations with low turnover of staff, where improvements are not necessarily achieved through bringing new staff in, but adjusting the roles and responsibilities of staff already in place.

A number of interviewees discussed a role they are developing in response to nursing moving to an all-graduate profession. The role will be: “halfway between a healthcare assistant and a nurse” responsible for some of the lower level care needs such as cleaning and feeding. The boundary between acute and community care is a key area for new roles. The Support Time and Recovery (STAR) worker, recently developed by some healthcare providers and cited by one interviewee, is one such example. This role fills an apparent gap in care coordination identifying care needs and proactively seeking out provision that can meet these needs. One of their core duties is to promote independent living, often after an acute intervention. They also fill a much needed gap in allowing informal carers time off.

### 5.3.4 Workforce systems: Frameworks for recruitment and appraisal

A key barrier to meeting the aspirations is recruiting a workforce with suitable skills and competencies to meet the aspirations of older people. Some practitioners we engaged with thought that the existing national-level tools for recruitment and appraisal are not suitable. A Director of HR argued that the Knowledge and Skills Framework has brought in a more consistent approach to looking at skills and competencies nationally. However, this was at the expense of the personal discussion element of staff review, which is a key mechanism for assessing some of the softer skills which are of importance to meeting the aspirations.

Each role set out in the Knowledge and Skills Framework has communication within its core competencies. The question is whether this, alongside other national frameworks, has been set at too generic a level to provide traction on the ground.

Another practitioner, who leads on recruitment in a Mental Health Trust, thought that Agenda for Change, the NHS guidance on paying workers (which the Knowledge and Skills Framework supports), was the key barrier: “it’s the wrong way round. It asks: ‘Is this person a good team member?’ but it should ask: ‘Can this person be part of a team that can provide person-centred care?’”. In short, it does not highlight the importance of behaviours which contribute to meeting the aspirations highly enough.

Building on the organisational culture point above, a number of practitioners reported that they are trying to instil the values of high quality care into their recruitment and appraisal system. The goal is to link the behaviours which meet the aspirations with real-life examples and to outline consequences for not meeting them. Interviewees emphasised the importance of applicants displaying values such as compassion and respect for equal rights during the application process. Some of this is done through the use of scenarios in interviews.

A similar approach is taken during staff appraisal. Staff are asked how they display the values that the organisation is trying to promote. One organisation we engaged with has developed a set of in-house core competencies relating to treating a patient with compassion and empathy. They are considered to be as important as the skills outlined in the person specification. Another organisation is in the process of developing a disciplinary policy for staff who do not meet the organisation’s vision for care (Compassion, Attitude, Respect, Equality). The important point, here, is that rather than just articulating a vision for their organisations, they are trying to formalise the vision and develop a policy for staff that breach this.

These are examples rather than general practice across the organisations we spoke to; and nobody appeared to believe that the HR systems in themselves could do more than reinforce an organisational and training culture that was either supportive or detrimental to the aspirations of older people.

The more tangible area that a number of experienced practitioners felt did make a difference related to how (as part of formal appraisal and ongoing team management) complaints records were used (and, indeed, if they were used) for development purposes. It was striking that our interviewees who either currently of or previously had responsibility for managing / handling complaints in a clinical setting had a far more sophisticated understanding of the
‘low level’ but very important actions and behaviours that upset patients – and within this, older patients in particular.

A number of people reported that in a sufficiently mature organisation, the log of complaints provided a very powerful resource for, not so much challenging professional behaviour, but, holding a mirror up to it in a way that encouraged healthcare professionals to think more empathetically about patient experience and the patient perspective. Perhaps the telling point here, though, is why this resource is often under-utilised. The information is inherently sensitive and requires a real commitment from all parties (the organisation; managers; practitioners) for it to have a positive effect. Yet it also arguably requires many of the other themes flagged up in this section: strong clinical leadership; a truly positive learning culture; time and resource for development; and a genuine emphasis on the importance of care quality and the patient as an individual.
6 Conclusions and Recommendations

6.1 Conclusions

There is a significant degree of alignment between the direction of health policy over the last decade and the aspirations of older people. This goes back to the National Service Framework for Older People and incorporates a wider policy shift towards shaping services around the needs and preferences of users (e.g. Our Health, Our Care, Our Say). One could argue that the degree of emphasis on the aspirations has varied at different points over the last decade (and there is huge uncertainty about the future direction of policy), but the overarching narrative relates to a greater recognition of:

- The central importance of older people as core users of health services
- The need to deliver not only on health outcomes, but underlying care quality dimensions, which are what is at the heart of many of the aspirations.

It is not clear, though, that the broad policy climate translates into organisational practice and, specifically, has impacted on workforce development. There is much less of a focus on delivering the workforce improvements implied both by national policy developments and by the aspirations themselves.

National policy, to the extent that it drives health organisation behaviour, appears to do so much less from a workforce development perspective than as a sometimes competing influence relating to resources, efficiency, performance targets (in the past, at least) and the organisation of the sector. From a workforce and HR perspective, the focus is much more on managing (constant) change than broad, overarching workforce improvement activities of the sort implied by the aspirations.

It is unclear whether national policy could have much more of an influence anyway – other than doing what it already does, which is setting expectations around what good healthcare delivery looks like. The aspirations themselves are largely about the ‘bread and butter’ of professional engagement between healthcare staff and service users and have to be addressed using a bottom up approach. Even levers that have been in place at sub-national level (SHAs, in particular) appear to have little traction on the ground from the perspective of reducing gaps in the aspirations (even though regional workforce planning often shows a regard to exactly the sort of issues raised in the aspirations).

All of this only reinforces the importance (as a top down driver) of the new equality legislation. The legislation was seldom mentioned by practitioners, which is not necessarily surprising, but the issues raised in this report do dovetail with the view from some wider stakeholders that NHS Trusts specifically may not be fully prepared for managing its impact.

There is already considerable support (toolkits etc) available to help with this and it is not yet fully clear how the requirements of the legislation will play out for organisations in practice. Either way, it can be seen as a useful avenue for Age UK and others to support and influence health organisations by emphasising what the sector is doing well (intent, the broad sweep of engagement) and what it is doing less well (delivery – quality and consistency; the provision of ‘holistic’ healthcare).

The aspirations themselves were recognised and considered valid / important ambitions by the wide range of practitioners we spoke to. They are also fairly comprehensive in nature – we saw little in the way of suggested omissions. In terms of taking forward this agenda, though, it may be possible for Age UK to hone the aspirations down into a number of key themes and skill areas that would allow for a more concrete response from the sector (because the aspirations overlap and are inter-dependent).

It was striking that in discussion with the sector, it was the two aspirations we defined as underpinning (a ‘connected relationship between staff and patients and joined up care) that received the most attention. This is not because they are necessarily more important, but because they get to the heart of what lies behind some of the ‘low level’ frustrations that
older people reported in the 2009 research and which our interviewees (especially those with direct clinical experience) were all too familiar with.

In essence there are three broad areas which appear to be general gaps and which relate to the aspirations:

- **1. Skills relating to multi-disciplinary team working, supporting patient transitions and, in essence, providing patients with sufficiently clear communication about their treatment and care pathways (and doing so in a timely way and in a way that recognises patients’ own preferences – although these will not always be able to be accommodated).**

- **2. Skills relating to empathy, listening and relationship building. There are numerous ways to describe what is basically the same competence, much of which ultimately related to the point we heard repeatedly about healthcare professionals being able to put themselves in the older person’s position.**

- **3. Related to the point above, there is a clear gap in knowledge and understanding (outside of specialist geriatric roles) about the likely needs and experience of older people. This is a relatively straightforward knowledge gap and arguably relates to the way in which services are organised. It also relates to the paradox of older people being recognised as a key patient group, but of such ubiquity that they receive little of the focus of other, much more tightly defined groups of service users with specific needs. It is a more substantial gap in the sense that it plays out from a clinical perspective as a tendency for specialised healthcare professionals to fail to treat older patients (with multiple health needs) in a holistic manner.**

Having talked about these areas as gaps, it is important to recognise that any such assessment generalises across a wide array of varying practice. There will be healthcare professionals who are generally not competent with regard to this skill set (although they may be excellent clinicians – and how Trusts manage these individuals says something about their approach to broader-based workforce development). There will also be many professionals with effective communication skills and a strong empathetic understanding of patient needs and concerns.

Some healthcare professionals in this latter group will be challenged in maintaining effective patient engagement at the same time as dealing with considerable day-to-day pressures. In many ways, the indirect skills associated with managing pressure and multi-tasking are as important for delivering on the aspirations. The point, though, for Age UK is that any influencing and support activity should be framed in a generally positive way – it may have a negative impact (and is probably unfair) to suggest that the kind of gaps we are talking about relate to a general lack of competence across the workforce.

While we have been able to identify particular job roles and occupational groups that may be deemed more significant in meeting the aspirations, it should be recognised that much of what we are talking about is a general need. It may or may not therefore be beneficial to target action at specific job roles.

Having said that, the mechanisms available to influence practice do vary by job role. There is immense value in ensuring that standards and good practice promoted by regulatory bodies and Royal Colleges for doctor and nursing roles have sufficient explicit reference to healthcare professionals being empathetic and understanding the specific needs of older people.

Nothing that is suggested by the aspirations is out-of-synch with existing standards (or indeed job and person specifications produced by individual health organisations), but the apparent lack of emphasis on the softer skill set is both striking and probably indicative of how peripheral those with responsibility for workforce development treat these areas of professional competence. In reality, they are also much harder to assess as well.

The real issue is that a form of lip service can be paid to the importance of skills relating to the aspirations of older people; but at the level of the health provider, the only way to embed, renew and develop these skills across the workforce is where there is strong leadership and a culture that supports effective organisational self-development (for example, being a mature enough organisation to use evidence of practice, including complaints, as way of
supporting individuals and the service itself to provide excellent patient engagement and support. This then feeds through into the type of continuing professional development undertaken within organisations.

Making a difference in supporting this kind of organisational culture change across the health sector is well beyond the scope of Age UK (and beyond the remit of this study), but it helps to highlight where Age UK can make a difference (providing the tools and materials to promote understanding of the experiences of older people; influencing those organisations that support workforce development to promote greater emphasis of the relevant skills and competencies within professional standards etc), as well as showing that any such activity can only ever be one part of the puzzle.

6.2 Recommendations

1. Internal structures of NHS Trusts: When engaging with NHS commissioning and provider Trusts, Age UK should focus efforts on the clinical leaders rather than the non-clinical workforce and HR Managers. The former group are more knowledgeable about the skills and competencies required to meet the needs of older people as well as being more influential over the practice of the clinical staff in the sector.

2. The new equalities legislation: Age UK should look for opportunities to promote the defining messages from the aspiration gaps (joined up care; empathy; knowledge of the views and preferences of older people) to NHS organisations with a view to those organisations being able to show that they are meeting the requirements of the legislation.

3. Highlight older people’s care experience with the key workforce development organisations: Age UK should consider producing a bank of case studies on older people’s experience of healthcare (both good and poor practice) drawn from its own networks. Age UK should act to persuade the leads on the care of older people, within the key Royal Colleges, regulatory bodies and unions, to use these resources in their workforce development activities.

4. Focus attention on the lower workforce bands: Age UK should work with Unison to lobby the sector to ensure that all service user-facing staff are receiving appropriate and sufficient training in areas that would improve the experience of older people. A particularly important role in the coming years is that of Healthcare Assistant working in the area of nursing. As nursing moves to an all-graduate career, healthcare assistants will take on further low-level clinical duties. For the standard of care not to be risked, this group of employees requires further development. Clinical support workers represent a vital workforce group who are not as well regulated as the clinical workforce.

5. ‘Sense check’ future regulation and guidance: Age UK should actively contribute to the development of workforce regulation and guidance (where opportunities exist to do so). It should, wherever possible, work with regulators and Royal Colleges to inform and ‘sense check’ materials being produced to ensure that they sufficiently capture the older person perspective. The General Medical Council will be leading on the new requirement for doctors to revalidate their fitness to practice every five years from 2012. Age UK should use this as an opportunity to work with the GMC to ensure that the care of older people is properly represented in this new approach.

6. Work with the Royal College of General Practitioners: Age UK should actively seek to contribute to the Royal College of General Practitioners’ campaign to increase GPs’ consultation time to fifteen minutes (from ten) as this will contribute to meeting a number of the aspirations.

7. Work with the British Geriatrics Society: Age UK should work with the British Geriatrics Society to assess the demand for specialist geriatric clinical skills in the medical, nursing and psychiatry workforces. Age UK and BGS should also work together to address the barriers to clinicians specialising in this area.
ANNEXES
Annex 1 Practitioner interview summaries

#1 - Director of Workforce and Learning (Mental Health and Social Care Foundation Trust)

Understanding the interviewee organisation and context
The interviewee is the senior figure in the HR Department and as such has overall responsibility for all activities but a particular focus on learning and development, leadership and workforce planning. The main challenge his Trust’s workforce faces over the coming years is an ageing workforce and replacing the large number of retirees over the coming decade. During the recession, a career in the health sector has increased in popularity as other non-health sector options in the private sector have diminished however the interviewee envisages that when the private sector fully recovers, it might be more difficult to fill some posts. Jobs in mental health are also seen as more physically and emotionally demanding than in other healthcare settings. Patients can be violent, in some cases, or seriously immobilised. As a result, mental health Trusts have the highest rate of sick leave amongst their staff in the NHS an issue which will grow in importance as the average age of the workforce continues to increase.

In terms of service users, the interviewee’s Trust is considering how to cope with an increasing number of the very old (those over 85). He understood that around one-quarter of this group faces mental health issues of some kind and was concerned about the difficulty of funding this sort of care.

Meeting the aspirations: Assessment of the current situation
There is no specific approach taken to workforce planning with regard to older people. Their workforce is dominated by specialist mental health practitioners, for the obvious reason that all their service users have issues of this sort. The difference with older service users is that they often have a mental health problem alongside a physical issue. This requires collaboration with other health sector or social care providers.

The interviewee felt that the aspirations were being quite well met by his organisation. His reasoning for this is that mental health care is often carried out in the community and that workers in this setting are more used to providing person-centred care and building long-term relationships with patients (as interventions are usually ongoing in this sub-sector).

The interviewee’s Trust was in the process of implementing the Yorkshire care pathway model which he thought was best practice in terms of mental health care. The model uses a set of care clusters for grouping the different types of mental health conditions patients may have. Each of the 21 clusters represents a type of mental health condition (e.g. depression) and each patient is assessed for the severity of the condition alongside the cluster. Based on these two assessments, a standard care package with a number of stages has been developed for each cluster. A number of activities are attached to treating a patient of this description with the job role and skill level needed for each stage of the pathway.

In the interviewee's opinion, key skills gaps in the sector are not related to care or clinical skills. These are well covered by an experienced workforce. The only areas of weakness highlighted were in IT skills, which can impact upon the efficiency of some clinicians who end up spending less time on caring. Some skills are more important in the mental health sector than the health sector. Most importantly, conflict resolution skills are vital in mental health settings; dealing with confused and sometimes violent patients is quite a regular occurrence.

Improving health services and priorities for action
The interviewee thought that one of the reasons for the relative success they have achieved in terms of meeting aspirations is down to his Trust having a low turnover of staff. This is something he thought was a feature of the mental health workforce who are, typically, slightly older than the average for the rest of the sector and often enter the workforce in order to specialise. Partially as a result of this, gaining service improvements is more about redesigning the existing workforce through designing new roles than focussing on bringing new people into the workforce, or upskilling the existing workforce.

A new role is being developed in response to nursing becoming an all-graduate profession. They are looking at a role that is “halfway between a healthcare assistant and a nurse”. This role will have quite a lot to do with meeting the aspirations of older people however this not its main purpose.

Another role they have recently developed which will impact upon the experience of older people is the STAR worker (Support Time and Recovery). The role involves working in patients’ homes and trying to coordinate their care, promote independent living as well as assisting Community Psychiatric nurses in their duties. A key part of the role is to provide respite for any informal care (family, friends) they may have.

The interviewee thought that the key roles for influencing services within Trusts were those on the clinical managers (rather than in non-clinical management / HR). These roles are the Directors of Nursing and Older
People’s Services. The Dignity and Privacy group within the Trust leads on this as well. Looking externally, the interviewee was enthusiastic about the work of Skills for Health. He thought that it was an organisation better known and more favoured by those in the HR profession (rather than clinicians). The Strategic Health Authority has less influence over the Trust as they have Foundation status. The SHA role is more around sharing best practice: “influence but not control”.
#2 - Assistant Director of HR (Primary Care Trust)

**Understanding the interviewee organisation and context**
The interviewee is Assistant Director of HR whose main responsibilities are workforce development, managing and analysing information on the workforce and promoting leadership in the Trust.

The major challenges facing the PCT in the next few years are:

- The move towards nurses requiring a degree. In the short term, this means they may not get the same throughput of nurses so there may be staff shortages.
- In community services the workforce itself tends to be older than in acute care (a typical career path, for example, is to move from hospital nursing to district nursing). There is a challenge in replacing retirees over the next few years.

The ageing population is an issue which is always on the agenda. One of their key strategic goals in the coming years is working more closely with local authority social care services. Older people will be a key beneficiary of this goal.

**Meeting the aspirations: Assessment of the current situation**
The interviewee clearly understood and recognised the aspirations. She viewed them as being an extension of the personalisation agenda, something which the Trust is closely linked to through projects on personal care plans, for example.

The interviewee thought that managers of providers were most important to meeting the aspirations; “There is an important organisational aspect to meeting these aspirations.” Full achievement of the aspirations required a wholesale change of attitude in provider organisations in community settings so “leadership and change management skills” are vital. Managers in these settings also need to improve relationships with the third sector, acute trusts and commissioners in order to achieve these aspirations.

The interviewee was involved in projects looking at the implementation of personal health budgets. She thought that this was a major opportunity for service users, including older people, to gain more control over their care. She thought that the budgets could be a key driver in meeting the aspirations of older people but did acknowledge that it was not appropriate for all older people. Many older service users would actually feel less in control receiving a health budget and prefer a clinician to continue to lead on all aspects of care.

The Trust does its own consultation with older people. The three main concerns that this work highlights are: a single point of access (“older people want to reach the right care professional the first time they engage with the health service”); coordinated care (“older people want the left hand to know what the right is doing”) and choice. Interviewees agreed that these findings were very similar to the aspirations.

**Improving health services and priorities for action**
The main barrier to achieving these aspirations was the “sheer overload of constant change from government”. While health is an inherently political policy area, there have been a large number of policy drives in recent years that have perhaps been contradictory. Interviewees thought that some of the main white papers in recent years have articulated policies which move the workforce towards the aspirations (“Putting People First”; “Our Health, Our Care, Our Say”) whereas others have worked in the opposite direction (“Transforming Community Services”).
#3 - Director of Workforce and Organisational Development (Hospital Trust)

Understanding the interviewee organisation and context

The interviewee leads on all workforce-related issues, including employment, recruitment, professional registration, training and development and competencies.

She views the major challenge faced by the Trust to be the "shift in the way people are cared for" with a greater move to care in the community and self-directed care. The ageing population is "hugely important" because there is a significant increase in the number of patients who fall within the 60-70 age band who have complex needs, particularly within orthopaedics. In addition, the workforce itself is ageing and is employed for longer, which means "we need to consider the public health of our own staff as well".

Meeting the aspirations: Assessment of the current situation

Older people are not treated as a separate group but rather "treated as a patient". The Trust's Single Equality Scheme is the framework for ensuring equality of access and service across all patient groups.

The interviewee recognised the aspirations as logical and coherent and felt that the key themes of choice and communication "chimed with feedback from Care Quality Commission inpatient surveys". She described the aspirations as "fairly typical" and did not consider the content to be surprising.

In terms of the extent to which the needs and aspirations of older people are currently being met, the interviewee described a range of mechanisms that are in place to increase patient involvement and choice. These include: a patient and public involvement strategy; a patient experience survey; patient groups; and a patient advice and liaison service. While the mechanisms and infrastructure are established, she was "not sure to what extent they are actually delivering on the agenda". She felt the next step for the Trust is to develop the quality of what is being delivered by, for example, increasing the number of patients involved and joining up the findings of all the different feedback channels so that coordinated action takes place.

The interviewee expressed the view that all roles, "front line and behind the scenes" have a responsibility to ensure that the aspirations of older people are met, and did not identify any particular roles that play a key role in supporting older people. She highlighted good communication skills and the ability to respect privacy and dignity as fundamental generic skills. The Trust ensures that staff are equipped with these skills through standard recruitment procedures, a focus on training in customer care and a value-based appraisal system which assesses staff against values which represent the Trust's organisational culture, and which include respect for privacy and dignity.

No skills gaps were identified by the interviewee and she considered that "a huge proportion of the NHS budget is spent on education" and this equips staff with the skills they need to effectively meet the aspirations of older people.

Good practice: The interviewee found it difficult to identify examples of good practice in delivering health services to older people because "we don't have anything that is specifically geared up to elderly people – we deliver to everybody in the same way".

Improving health services and priorities for action

The interviewee expressed concern that as there is a shift to self-directed care, which offers patients greater choice over the care provider they use, safeguarding regulations will need to be improved.

Finance was not considered to be a barrier to developing the workforce and meeting the needs of aspirations: "you could use finance as a barrier to anything"

In terms of key internal stakeholders, the interviewee suggested the safeguarding lead. This individual has a responsibility for all vulnerable adults and therefore influences workforce development and design. External organisations with influence in this area include SHAs, which provide and facilitate forums for discussions of best practice, and local partnership groups.
#4 - Matron (Independent Hospital)

Understanding the interviewee organisation and context
The interviewee works at a long-established private hospital covering a wide range of specialities. The vast majority of the patient base is older people. Although the challenges for this hospital are distinct from those in the NHS, and the basis on which services can be provided are different (e.g. staff patient ratios; flexibilities in delivery and management), resources are tight. In a difficult financial environment – even in the independent sector – there is the risk that “training is the first thing to go”.

Meeting the aspirations: Assessment of the current situation
The aspirations are not surprising. They really apply to all generations and not just older people. Looking at it from the outside, generally the NHS is less good at coping with chronic illnesses that needs managing (and are often associated with age), so that issues like never seeing the same doctor and having to spend “a day of your life” dealing with hospital transport can have a large effect on people’s lives.

The hospital is in a fortunate position of being able to provide some of the attention, flexibility and personalised care that is implied by the aspirations, which is much harder to achieve in the state sector. In this hospital there are more nurses per patient and so, for example, the patient can decide when they want to be bathed.

That these areas are important for patients is apparent in the conversations the interviewee has with patients – many of whom have experienced both independent and NHS care. The patients emphasise the value for them in the degree of privacy, joined up care and time nurses can spend with them.

The interviewee has been in role for well over 20 years. Over that time, the patients have not changed – but their expectations have. Even among older people, there is much less of the attitude of “whatever you say” from patients to health professionals. Patients are more informed. There is a far greater focus on mediated trust (having to explain to the patient about their care) and active involvement (“patients coming in with laptops” showing information from the Internet that they feel relates to their medical condition). Many older people are just as likely to do this and it represents a general shift in culture (“patients being demanding in a good way”).

The interviewee felt that, in general, the sector has lost its focus on basic (“old fashioned”) nursing care. She sees this in the students coming through – it’s not their fault, but reflects the way in which nurse training has become so academic and task-driven.

Improving health services and priorities for action
Even though there has been a shift in the fundamentals of nursing care, it is hard to say whether this can be fully explained by changes to education and training. The interviewee agreed with the shift to professionalise nursing, so it is not that it is a degree subject per se (one function of specialisation is that nurses have more time to spend with patients than a consultant – so the role has become more critical to overall patient care over time). The problem is the balance in training between the academic and hands on / practical elements.

CPD is vital. Some nurses that the interviewee works with say that they have no desire to do anything other than bedside training. If you work with older people, there are a lot of resources out there – including resources about conditions associated with older people (Alzheimer’s; hip replacements etc). But if you do not work with older people predominantly or in a specialised sense, then it is unlikely that you will be interested in these resources as part of your CPD.

Some of the more proactive and supported types of CPD, such as mentoring and knowledge transfer, are very helpful, but finding the time to undertake these activities is a challenge (when everyone is “trying to get the care done”).

Ultimately it comes down to the organisation. Nurses come from a wide range of different backgrounds, as an organisation you need to have a strong ethos on treating whoever you treat with the same respect, empathy and understanding. The organisation sets the expectations here – and can only set and reinforce them through teaching, training and mentoring.
#5 - Professional Head of Nursing (Community Healthcare Provider)

**Understanding the interviewee organisation and context**

In her current role, the interviewee has two main areas of responsibility:

a. Leading on the quality agenda, including ensuring that appropriate systems are in place to safeguard vulnerable adults.

b. Training and workforce issues, including audit, at an organisational and individual staff level i.e. to support staff to develop themselves.

Prior to taking on this role, the interviewee was a Clinical Nurse Specialist for Older People. This was a clinical role with strategic responsibility that used “advanced nursing practices” to support more complex geriatric cases. The interviewee described the role as a “precursor to the community matron role” and explained that it was intended to “bridge the gap between medicine and the patient” and to coordinate a healthcare package that suited the patients’ lifestyle needs and was in line with the outcomes they desired.

The greatest challenge faced by the organisation is budget cuts and the merger of 2 PCTs and a mental health trust, which has led to a lack of strategic direction. The interviewee described being in a period of “limbo” in which it was difficult to take services forward.

The interviewee highlighted the ageing population as an additional challenge for the organisation. It serves an area of high deprivation with high rates of morbidity (obesity/diabetes/respiratory diseases) and as well as a significant over 65s population “there is a burgeoning local population of over 85s particularly in more rural areas”. Inevitably, this group has complex health needs and equipping staff with the skills they need to care for people is considered to be a challenge. In addition, the ageing population is also affecting the workforce profile and work patterns. The interviewee emphasised that they have a very stable, non-migratory workforce and that many more staff are returning to work part time after retirement age.

**Meeting the aspirations: Assessment of the current situation**

The organisation does not consider the needs of older people separately; rather it has a focus on meeting the needs of all people.

The interviewee reported that having the skill to be “advocates of patients” (i.e. listening to them and communicating their needs clearly) was a fundamental skill required by nurses.

The appraisal system is the main mechanism for ensuring that staff are equipped with these types of interpersonal and communication skills. They have developed core competencies in-house, which relate to attitude and involve demonstrating the ability to support patients in a compassionate and empathetic manner. These are considered to be as important as the skill competencies in person specifications.

In addition, the training department has procured some courses for nursing professionals that are relevant to the care and treatment of older people. These include training in recognising deteriorating patients, blood transfusions and chronic health conditions. In addition, all staff undergo continence and nutrition training.

Age UK’s aspirations were described as “good, underpinning values you’d expect in any healthcare setting”. In her view, the provision of joined-up care is the most difficult to achieve in practice because it relies on cooperation across a range of organisations.

The interviewee believes the organisation is successfully meeting the aspiration for maintenance of privacy, evidenced by high scores in this area in patient satisfaction surveys and external observations. The organisation has a dedicated dignity and privacy champion in place. Although the organisation endeavours to offer choice and control over daily routines, the interviewee noted that “it is difficult to say we achieve this”.

She pointed to practical barriers which mean meals can only be provided at certain times. Similarly, while district nurses “are flexible to a degree, they can’t always make visits when people request them”.

In terms of the most important roles for supporting older people, she highlighted the important role of community matrons in proactively coordinating care for people with long term health conditions. She also commented that the intermediary care team (occupational health therapists, physiotherapists, speech and language therapists, nurses, social care workers) plays an important role in keeping people at home and ensuring that health and social care needs are addressed holistically. She gave an example of a woman in her early 60s who had had her arm amputated as a result of a stroke and had been supported very effectively by the intermediary care team to return to living independently in her home.

Apart from pointing to the challenges in providing joined-up care (in particular, referrals to social services), the interviewee was unable to identify any specific skills gaps.

**Good practice:** In an effort to move care closer to home, the organisation is currently training its staff to provide sub-acute care (such as intravenous drips), which would traditionally be provided in hospitals, in the home.

The interviewee also described how nursing roles are being developed so that there is more of a “blurring of
boundaries between nurses and allied health professionals" to ensure that patients have one point of contact, rather than multiple visits from different professionals. In practice, this might involve, for example, a nurse taking a measurement for a walking stick when she visits, rather than an occupational health therapist having to visit separately.

The interviewee also reported on her organisation’s good practice in the area of lean discharge, which has been recognised by the NHS Institute for Innovation and Improvement and included in a training DVD. She described the process whereby “from the moment patients are admitted to a community hospital ward, patients and their families are involved in discussions about discharge. A potential date of discharge is provided and a series of therapeutic aims are set out. They are not told what happens – it’s collaborative”. The community matron plays a key role in coordinating support required on discharge.

As part of its mission statement, the organisation has defined its own set of values, which are well aligned to the Age UK aspirations.

When collecting feedback from patients on wards and community settings, volunteers from a public participation group are used to administer questionnaires, in recognition of the fact that patients may find it awkward to give honest feedback to the person who is providing their care.

A 'you said, we did' board is displayed in reception, which describes patient feedback and the action taken to address it.

**Improving health services and priorities for action**

The interviewee considered that a commitment from the government to make meeting the aspirations of older people a national priority was key to influencing practice at provider level. She described the National Service Framework for Older People as “having no teeth” and felt that because of the weakness of this strategic document, organisations had responded in a “piecemeal” fashion.

The interviewee considered the third sector played an important role in lobbying for older people’s rights. She mentioned Age UK, the Beth Johnson Foundation and Aspire in particular. In terms of the influence of Royal Colleges on workforce planning and development issues, she felt “they don’t flex their muscles as much as they should”.

A priority for the organisation is developing the Assistant Practitioner role. A workforce development team is currently reviewing the Skills for Health career framework and incorporating competencies into the Assistant Practitioner role. There is an intention for non-qualified staff to subsequently be supported to be equipped with additional skills.
Understanding the interviewee organisation and context
This interviewee is the HR Director at a Trust with Foundation status that provides a mixture of community, acute and dental care across a large geographical area. They have a particular focus on mental health care. The biggest challenge his organisation faces in the coming years is to focus on prevention and productivity in care services so that they can reduce their costs (and part of this will come from a headcount reduction).

Meeting the aspirations: Assessment of the current situation
The organisation has a directorate for older people’s services (as well as an adults’ and children’s directorate). This is due to recognition that older people have different needs (dementia is significantly more prevalent, they need more community services, and there are service issues around end of life care, particularly allowing it to take place in the home).

The most important roles are considered to be “those who provide the links between hospital and community”. The key competencies for the care of older people are considered to be care, respect and patience: “We look for a sense of vocation”. He thought that they were close to meeting these aspirations but noted that the aspirations are not static: “they are increasing all of the time”.

One of the main tools the organisation uses to keep care quality on the agenda is through collecting and analysing service user feedback. The organisation has a post-holder assigned to deal with quality issues. They focus on evidence capturing this, primarily, through independent surveys. Where there are incidents of poor care / complaints, they are subject to more analysis. The interviewee argued that this focus on “learning from mistakes” is something which is related to their mental health focus – it is bound up in the culture of this sort of care.

The interviewee argued that mental health trusts are, in general, better at meeting these sorts of aspirations and caring for older people. There are two reasons for this: firstly, a very high proportion of service users in mental health care are older people (higher than in acute provision, for example). This means that staff are more sensitive to their needs. He also thought that there were “more people motivated by vocation in mental health care provision”.

Improving health services and priorities for action
The restricted finances facing healthcare organisations over the next few years will be the key barrier to meeting the aspirations. This is sharpened by the rising expectations of service users (which is entirely justifiable). The example he gave was that in recent years, service users at the end of life have expressed a desire to die in their own homes rather than a hospital. It is up to the health sector to meet these aspirations. As well as the quality lead within their organisation, the interviewee thought that it was up to senior clinical leads to drive these sorts of changes.
#7 - Workforce Development Manager (University Hospital Trust)

**Understanding the interviewee organisation and context**

The interviewee is a Divisional Manager (one of four – the others are Women and Children’s services, Surgery and one in charge of corporate issues) working in the HR Department of a University Hospital Trust. However he also has a number of years experience working in the local PCT and could speak with some authority on this as well. His Division is in charge of medicine and long-term conditions and is, therefore, the most appropriate of the divisions for looking at the aspirations of older people. Within this division there are 954 staff, most of whom are nurses of different specialities and bands. The Trust will shortly be merging with the local primary care trust in order to provide an integrated acute and community service for the residents of their Borough. This was agreed before the Coalition government’s white paper on the changes to commissioning arrangements however the decision was made with the potential policy change in mind. It was also done with a focus on improving the links between primary care services and acute care; it will allow the Trust to think about, and plan the care of patients, more around care pathways than particular clinical procedures.

**Meeting the aspirations: Assessment of the current situation**

The interviewee was familiar with the content of the aspirations; he had consulted with the matrons in his division prior to the interview and they felt they were similar to what their own patients wanted. He also thought that they described the main tenets of person-centred care. He thought that: "As with everyone else, we could be meeting them better". The particular weakness is that nurses (who are the key career grouping for older people – Matrons are actually the vital role as they manage groups of nurses and wards) are often unable to provide truly person-centred care and this is very often what service users (including older people) will remember from an experience in hospital. The examples of person-centred care given are a carer bringing a cup of tea to a patient, or remembering which toothpaste they use. This level of personalised care should be the goal of all health professionals.

The gaps in provision are not really around clinical skills; this conclusion was reached after the interviewee consulted with HR colleagues and clinical leads. The education and training, coupled with the registration requirements from regulators such as the Nursing and Midwifery Council ensures that new recruits have the required clinical skills and knowledge. The gaps are more around generic skills such as management experience, being able to work with autonomy and providing a truly person-centred service. There are also specific gaps in being able to find senior nurses who have specialised throughout their careers into gerontology. The reasons for these gaps are explained in the section below.

**Good practice:** The interviewee thought that the move to merge the PCT with the Acute Trust would work to improve a key issue in the care of older people: the move between hospital and community settings. Because they will be working as one organisation, commissioning could be carried out in a more patient-centred manner.

At present, the interviewee’s Trust has a ward focused on ensuring patients are ready for the move back to their home after a procedure / acute intervention. There are facilities such as a communal kitchen available for helping patients adapt back to ‘normal’ life. This process helps to reduce readmissions.

**Improving health services and priorities for action**

As mentioned, one of the main difficulties the interviewee’s organisation faces is recruiting specialist skills. While they have specialists in heart surgery and other clinical specialities working in all roles (including medical and nursing) they find it challenging to recruit specialist gerontology nurses and doctors. The interviewee was unable to explain this other than to argue that many of the nurses who might accrue the adequate skills and experience to specialise in gerontology move into community care. There is a question around experience here too. The interviewee argued that the acute workforce, in general, is younger than the community workforce. “Nurses will often spend five or six years after qualifying working in a hospital before settling down in their personal life and wanting to move into a community care setting”. While the interviewee acknowledged that this was a generalisation, he argued that there was value in it. It results in nurses in community settings having greater experience and confidence.

Such nurses also specialise more in a person-centred approach as they are often working in service users’ homes and have more of a focus on respecting and working towards a patient’s aspirations. This sort of thinking is less prevalent in acute settings. The main reason for the difference is time – there are pressures which come from government targets to move patients on to community care and this restricts the focus that clinicians can put on the quality of care. The interviewee also argued that clinicians are forced to spend too much time carrying out administrative tasks which also restricts the time that can be devoted purely to care.

Nurses working in acute settings are also more closely managed than their counterparts in the community: “there is always a senior nurse who can answer questions, such as a matron, in close proximity in hospitals ...
this restricts their development of skills in autonomous thinking and their development of confidence.” As a result, his acute Trust has “no problem recruiting band 5 nurses (those that have just finished their training) but it is difficult to find band 7 nurses”. Band 7 nurses are where the specialisation and management takes place: “The difficulty is getting this unsupervised experience in an acute setting”.

Finally, the interviewee thought that given the difficulty some hospitals are facing in recruiting sufficient clinicians, the standards that they are looking for are often lowered. The job descriptions used are not robust enough to prevent this lowering of standards, for example, the interviewee thought that the standard competencies laid out for a band 5 and band 6 nurse are almost identical. He also thought it was vital that Trusts ensured that they checked the English and numeracy skills of applicants who used the NHS Jobs website to apply. This website is open to manipulation i.e. getting someone else to fill out an application for you if you have difficulties with English (particularly important for recent immigrants who may have been clinicians in their own country).
#8 - Assistant HR Director (Foundation Trust Hospital)

**Understanding the interviewee organisation and context**
The interviewee is responsible for training and development; equality and diversity projects; workforce planning; and staff engagement.

She considers the spending cuts announced by the coalition government to be the greatest challenge the organisation faces. They will need to implement a cost improvement programme which will inevitably mean that fewer staff are recruited.

The ageing population has been identified as an issue in the organisation’s HR strategy and she has recently been tasked with assessing the implications of the ageing population for the workforce. The organisation is very aware of the demography of the local population and understands “that the needs of the older patient are greater and more complex and therefore affect how a service needs to be delivered”. She highlighted, in particular, the higher proportion of patients who have dementia. The interviewee also noted that the workforce itself is ageing (“we have around 70-80 over 65s-it’s drifted up a bit”).

**Meeting the aspirations: Assessment of the current situation**
Older people’s needs are not considered separately but the organisation recently consulted on its single equality scheme and a high proportion of responses were from older people. In recognition of the fact that the needs of people with dementia are very specific, the Trust is currently considering whether there should be separate wards for people with dementia or whether wards should remain a mix of older and younger people.

The interviewee recognised Age UK’s healthcare aspirations as logical and coherent. She noted that feedback from the single equality scheme consultation suggests that “we could do more” to meet the aspirations effectively. They are currently paying particular attention to how the needs of older people on wards which are not specifically for older people, such as day surgery, are met. They are focussing on making sure patients are well-hydrated, meal times and opportunities for communication with the Trust through a comments book particularly for older people. In addition, the trust has a current focus on improving discharge processes so that, for example, “people are not left hanging around pharmacies for ages”. Coupled with this, they intend to develop more effective methods for calling people into clinics to ensure people with sight and hearing impairments are aware when their turn is called.

The care assistant and nursing workforce were identified as the most important roles in ensuring the aspirations of older people are met. “Good communication and sensitivity around privacy and dignity” were considered to be the main skills required, as well as “an understanding of the expectations of older people”. She felt, for example, there was a “heightened need for courtesy, for example avoiding use of first names” when supporting older people. The interviewee was not able to identify particular staff groups which were least prepared in terms of meeting the aspirations.

No special mechanisms are in place to ensure that staff have these skills, apart from the standard person specification, interview process and appraisal system. In terms of ongoing skills development, there are designated practice development nurses, who are responsible for cascading new systems and requirements down.

**Good practice: The Trust has had a recent focus on dementia and has invested resources in training to raise awareness of dementia across the workforce.**

As a result of feedback from the single equality scheme consultation, the Trust has implemented a number of changes to meal time practices. These include providing older people with a red flag sticker, which they can display if they require greater assistance with eating. Large print menus, coloured crockery and larger cutlery have also been procured to make eating easier for older people.

The Trust has also developed links with local third sector organisations, including local Age UK branches, elders’ clubs and other day centres. "We want more of a communication channel with these groups so that when we’re doing impact assessments, we can consult with appropriate groups”.

**Improving health services and priorities for action**
There are some structural barriers to ensuring that older people are provided with joined up care, particularly “trying to ensure that people are discharged into appropriate places”, although this has been less of an issue recently.

The interviewee reported that internally, the key stakeholders who can influence workforce development are the Director of Nursing and Occupational Therapies and the HR director.

As a Foundation Trust, the organisation is governed by Monitor. Monitor agrees the Trust’s annual plan and therefore exerts significant influence over all functions, including HR and workforce development. The Royal Colleges are not seen as particularly central to the workforce development agenda.
Understanding the interviewee organisation and context

The Foundation Trust is a leading cancer centre and a national specialist in radiotherapy and chemotherapy. The HR Manager’s role is split between managing the Trust’s HR function and business development. She also leads on employee experience and wellbeing and workforce efficiency projects. The Head of Workforce’s team is responsible for analysing workforce data and producing divisional reports to inform workforce planning.

The biggest challenge facing the Trust is how to make cost efficiencies without affecting the patient experience, ensuring “staff are fit for purpose” and mitigating all risk. The interviewees expressed particular concerns that training and development budgets would be significantly reduced in forthcoming years.

Although the ageing population was reported to be important to strategic decisions related to workforce planning and development, no detail was provided. Interviewees commented that chemotherapy techniques have been refined over recent years so that, whereas in the past older people would not have been able to receive chemotherapy treatment, they now can. This has implications for the type of care and support that is required for patients.

Meeting the aspirations: Assessment of the current situation

The needs of older people are considered within the framework of the Trust’s equality policy but not separately. Feedback from all patients is collected via the patient satisfaction survey but there are no separate feedback or consultation exercises focused on older people.

Age UK’s healthcare aspirations were recognised as appropriate and coherent. In terms of the extent to which the Trust is currently meeting these aspirations, interviewees highlighted that there has been a focus on the maintenance of privacy in hospitals, with many single sex wards established.

Interviewees were not able to identify particular roles with a responsibility for meeting the aspirations of older people but felt that “it’s everyone’s responsibility”.

Communication skills, and particularly the ability to listen to people, were considered to be important and linked to the aspiration for choice and control over daily routines.

In terms of internal processes for ensuring staff are equipped with the skills they need, every role is linked to the knowledge and skills framework which includes communication and adherence to equal opportunities policies as core competencies. Potential employees are assessed during the interview process against the competency framework. In post, all staff undertake mandatory training in the core competencies of communication skills and conflict resolution.

The interviewees did not feel there were any skills gaps in the clinical arena but highlighted that skills within the support functions (e.g. corporate communications and marketing) to understand the needs and aspirations of older people were lacking, although this is to be expected given lack of frontline contact with patients.

Improving health services and priorities for action

Few comments were made on barriers to effectively meeting the aspirations of older people. When probed, interviewees reported that they did not consider there to be barriers to working jointly across settings.

The interviewees do not work closely with Skills for Health and were not very familiar with Skills for Health support and resources on workforce planning. The Strategic Health Authority was considered to be relatively influential in terms of workforce planning because it assesses data submitted by the Trust in order to inform education commissioning.
### #10 - Deputy Director of Workforce (NHS Acute Foundation Trust)

#### Understanding the interviewee organisation and context

The interviewee is responsible for planning workforce development across the organisation and has a particular responsibility for leadership development. He considers the current cuts in public spending to pose a significant challenge to workforce planning in terms of "how to get an affordable workforce in place at a time when demand for health care increases" because of, for example, the ageing population and increased rates of dementia. More broadly, the full integration of health and social care is considered to be a key challenge.

#### Meeting the aspirations: Assessment of the current situation

The interviewee felt that the needs of older people could be more systematically considered. He attributed some of the current gaps in assessing the needs of older people to be related to lack of joint planning across health and social care. More effective and coordinated planning would support the creation of new roles that straddle health and social care and which would therefore better meet the needs of older people.

He recognised the aspirations developed by Age UK and felt the list was comprehensive. He reported that his Trust is successfully achieving the healthcare in hospital aspirations. For example, "the Trust scored well with external agencies that came in to assess privacy" and data from patient and staff surveys suggests that good relationships are formed between staff and patients. In terms of ‘choice and control over daily routines’ the interviewee highlighted that people on elderly care wards are able to wear their day clothes rather than pyjamas as an example of good practice.

Nursing staff, physiotherapists and occupational therapists are considered to be the most important roles for ensuring that the aspirations of older people are met. According to the interviewee, the key skill they require is: "the ability to look beyond health care to understand how social circumstances can affect health, and especially mental health". Communication and interpersonal skills were described as “extremely important” to ensure that services were “tailored to the needs of individuals”. The interview process is the main mechanism for ensuring that staff have these skills and good communication is a core competency within the knowledge and skills framework for every role.

The main skills gaps are among “those who come across the elderly incidentally such as phlebotomists or receptionists in the outpatients ward”. He considers the lack of awareness of the needs and aspirations of older people to be "getting worse as the population increases".

**Good practice:** The SHA coordinates ‘Workforce Collaborative Clusters’ which bring together representatives from each Trust within the SHA’s footprint, as well as social care representatives. They plan what is required in terms of training and development, which informs the SHA’s commissioning of medical education.

#### Improving health services and priorities for action

The interviewee felt that to address skills gaps, training and development need to have a higher profile within the organisation. He also considered that at present “we make a lot of assumptions about older people’s needs and whether we know what they really want or need is open to debate”, suggesting that consultations and needs assessment procedures could usefully be reviewed. The main organisational stakeholders who could lead on workforce improvement in line with the aspirations of older people are the Director of Nursing and the in-house training team.

The main challenge faced in meeting the aspirations of older people is that “every client group has its own needs and the problem is how to fulfil them without it being to the detriment of other groups”, within a context of cuts in resources. In addition, the fact that health and social care commission medical education separately and that university education is sometimes disjointed from organisational realities is a barrier to effectively meeting older people’s needs. The interviewee gave a specific example of a local university developing a course that led to students qualifying as both social workers and mental health nurses but graduates subsequently failing to find positions that allowed them to practise in both areas.

The interviewee felt that the medical Royal Colleges are influential in terms of medical education but that the Royal College of Nursing still functions mostly as a union.
Understanding the interviewee organisation and context

This interviewee is a senior workforce manager for a cluster of three primary care trusts – while each of these remains an organisation in its own right, their management is centralised. They also manage a hospital. The major challenge facing the organisation over the next five to ten years is the ageing population. Modelling of the local population reveals that it’s likely they will need a new hospital to cope with the healthcare needs of the local ageing population. The interviewee was not sure of the likelihood of this happening and so she thought there would have to be a concerted effort to move services into the community. The organisation has recognised this need and as a result “the ageing population, and particularly end of life care, is certainly part of our strategic plan”.

Meeting the aspirations: Assessment of the current situation

The interviewee’s initial reaction to the aspirations is that they are “very similar to the areas of complaint we receive”. “I would certainly hope and expect that we were close to meeting these”. They have a small team within the organisation whose role it is to analyse these complaints and highlight areas of change to management. This is one of the main tools they use to ensure that quality of care receives sufficient focus. The others are worth recounting: staff appraisal which is done with both HR professionals and an individual’s clinical lead and a staff survey as the interviewee felt that “how a worker feels directly influences the standard of care they provide” (there is an indicator for this included within World Class Commissioning).

The interviewee thought that care pathways had more value in terms of understanding the workforce than particular career groups / roles. However when pressed, she highlighted “care management roles” such as community matron (responsible for district nursing). This role is also important for palliative care and pain management services, two key areas for older people. Some of them also have prescribing powers. GPs “remain responsible for a patient’s overall care”. Band 4 assistant practitioners/Healthcare Assistant are a critical group of staff for providing care in the community.

In terms of the key competencies for meeting the needs of older people, the interviewee referenced Skills for Health and Care’s ‘Self-care principles’ as being critical competencies for meeting these needs. They are related to enabling service users (not just older people) managing their own care, and health professionals providing person-centred care. The interviewee then focussed on the Community Matron role - what she thought was probably the most important role (in the community) – and what competencies were most important here. This role needs quite high clinical skills due to the range of issues they may have to face, and the autonomy with which they often work. They need to be “proactive in noticing if there’s a problem with an older person, and not necessarily just a health concern”.

The ability to signpost patients to other services is also important. In lower level roles, such as home workers (who probably fall in the social care sector), a key skill is the ability to motivate older people who may be suffering from depression. In terms of gaps in skills and competencies, she mentioned that the National Dementia Strategy was recognition of a key area where services are not up to standard. She thought that the Strategy had raised the prominence of the issue but that the next stage was for this to be translated into the skills needs of the staff.

Improving health services and priorities for action

The interviewee thought that a key barrier to improving the skills and competencies of clinicians was the long lead time for most of their training. By the time the content of a course has been altered, it’s at least three years before clinicians who have been trained in the new way enter the workforce. The interviewee also thought that organisational culture was a key barrier but also an opportunity. Turning this around, so that care quality becomes a significant issue requires leadership and the Board of Trusts is vital in this. The Skills for Health competence framework is also “being used quite a lot. It’s becoming a common currency. People are getting used to the framework and the language it uses”.

#11 - Head of People Development and Training (Integrated network of Primary Care Trusts)
Understanding the interviewee organisation and context

The interviewee has responsibility for a range of services delivered by the PCT (mental health service; older people’s service etc).

Meeting the aspirations: Assessment of the current situation

The Age UK aspirations are “perfectly sensible….I’d be surprised if they weren’t there”. Rather than seeing gaps in relation to the workforce and any of these aspirations (which, at heart, are aligned with the reasons why most people go into a caring profession), the issue is that the aspirations are “variably met because people’s interactions vary”. The basic elements for meeting the aspirations are in place, in, for example, the Department of Health standards for domiciliary care. It is about meeting these standards all of the time.

Sometimes the behaviour of the health professional falls short of expected standards: they can “get caught up in the ‘now’” – e.g. the phone goes and a curtain needs to be drawn around a patient. “People prioritise – and that’s inevitable”, but it can lead to poor decision making in the heat of the moment: “the intention is fine – but the delivery sometimes isn’t (sometimes people forget)”.

We also need to keep perspective on the scale of the issue and understand how patient views of their own experiences are mediated by the structure of the system. Service users often have a “composite recollection” of their engagement – which is generalised across a number of service areas and professionals. All health sector staff engaging with patients are therefore important to the overall experience – and those in a gate-keeping role particularly so: “you might get a busy receptionist at a clinic on the phone who is gruff and puts you on hold for 5 minutes. When you get to the clinic, the support staff are lovely and the intervention is great – but you still remember the gruff receptionist”. The point is that one bad engagement can colour the overall experience. The objective reality is therefore complex to understand: health care is provided in a range of settings (“a rapid assessment in A&E will be different”); and some people are never satisfied.

The interviewee’s experience as a complaints manager emphasised to him the importance of expectations in all of this. Sometimes it is not unreasonable to make a patient wait, say, for 30 minutes given the reality of delivery. “It’s very hard to deliver services where there are different expectations, different backgrounds, and different pressures”. All we can aim for is “equity of service” and having an “adult to adult relationship”. In terms of the former, staff need to understand that all old people are not the same (“it’s your age, love”). In terms of the latter, the interviewee gave the example of a domiciliary worker turning up 10 minutes late to an appointment – does that matter? It is probably not hugely significant for most people, but for some vulnerable, older service users that may be the only visitor the service user has and a really important issue for that individual. It is not something (being late) that can be avoided, but the health professional needs to consider whether they, for example, phone ahead. This kind of approach depends on an understanding of the service user’s needs and wishes (what is important to them set against what is achievable) and moving from a ‘practitioner and patient’ to ‘adult and adult’ engagement: setting up expectations and having a negotiation upfront (where there is an ongoing care engagement). These kind of honest discussions – and the setting of parameters – are difficult to do and not always done.

Also, it has to be recognised that some older patients do not want an ‘adult to adult’ engagement - and this can create a different set of challenges to the health professional. There is a great skill in being able to broach a discussion with some patients about whether, in fact, they want to be a passive patient and how to manage that engagement in a way that still meets their health needs and (unspoken) preferences.

Improving health services and priorities for action

A key area of skill development need – across the board – relates to multi-tasking and decision-making. In particular, health professionals need to develop strategies to be patient-centred in pressurised situations: “they need to ‘think patient’”. This is a simple enough idea, as it relates to the health professional “imagining themselves as the patient”. Most health staff can do this most of the time, but it is in situations of stress that the approach to engagement can fall short of standards.

Addressing these needs is partly about training, but it might also be about just having the right ‘visual cues’ in the working environment (you can use posters – but they lose their impact after a week). There is value in just attempting to reinforce the message using a variety of routes: “be creative – using patient stories can be really powerful”. It is helpful if “service providers could act as the patient once in a while”, or at least consider the question of how did their behaviour make the patient feel: “how did it make you feel when I put the dog out of the home on a home visit, or just pulled back the curtains when coming in for an assessment”.

It should be noted that this is a sensitive and often emotive area to manage – in terms of healthcare professionals’ behaviour. To do so requires an honest reflection on behaviour and one that can only take place if it is not set in a defensive context – and where there is a strong ‘no blame’ culture.

There is a risk, though, that the pressures of some health roles lead to well-intentioned people becoming “burnt out and not caring”. It may not generally be as extreme as that, but one can see symptoms of that kind
of feeling in how some health professionals speak to patients / service users ("the way they speak disempowers the patient"). There perhaps needs to be recognition that some health professionals get stuck in a professional rut and should move roles.

There are structural barriers to meeting the aspirations of older people. Much of this can be ascribed to the various performance targets and management systems in which health care takes place: "we over-complicate things and the non-clinical elements of quality get missed out".

The NHS can learn from the third sector. The interviewee’s perspective was that third sector organisations often do more in terms of focusing on the softer needs of patients – and the specific needs of groups such as older service users. This is often embedded in contracting with commissioners, but it is also part of the ethos and culture of many of the wider organisations supporting the health sector.
Understanding the interviewee organisation and context

The interviewee’s main role is to assess patient experience and base interventions with the workforce on this information. This includes commissioning and designing training for all staff (not just nurses). The main challenge her Trust is facing in the next few years is very simple: “To retain the same quality of care while budgets are being squeezed.” The experience of older people is important to the Trust and manifests itself in two ways: older patients stay in hospital longer than other service users; and, older patients are more likely to have complex needs. Despite these particular needs, the Trust does not treat older people as a separate service user group. There is a feeling that, “If we get privacy and dignity right we’ll meet the aspirations of most service users”. To focus on these needs, the Trust has a privacy and dignity working group focusing on the needs and aspirations of all service users.

Meeting the aspirations: Assessment of the current situation

The interviewee focussed on the aspirations most concerned with care in hospital. The level to which the aspirations are being met in the hospital is varied. The most significant workforce areas for influencing the experience of older people are the allied health professions and nursing. Non-medical senior clinicians are the most variable in providing care of sufficient quality. The interviewee thought that the qualifications of such clinicians do not necessarily reflect the competencies required by the Trust. As a result, the Trust runs a probation period in which clinicians are not able to treat patients unsupervised until they have proven that their “theoretical knowledge matches the practical application”.

The interviewee focussed further on the parts of the workforce least prepared in meeting the aspirations. Rehabilitation services – allied health professions (occupational therapists and physiotherapists in particular) – are of most concern to the Trust. The interviewee thought that this was due to the Trust being an acute hospital trust and therefore: “geared up for patients who are injured or require an operation but less so for patients rehabilitating”. However, she thought the gaps in meeting the aspirations were reducing. The piloting of a new role has contributed to this. The role will combine a number of rehabilitation disciplines (occupational therapy, physiotherapy and nursing). The Trust is in the process of developing a qualification with a local training provider.

The interviewee thought that there was an important skills gap which crossed all of the professions working in the hospital: clinicians do not have a sufficient understanding of the effect of ageing on their particular area of practice. The example given was nurses who often do not pay sufficient attention to the fact that a different technique should be used to take blood from older people.

**Good practice:** Much of the good practice in care of older people stems from the Privacy and Dignity working group that was set up in 2009. This, therefore, is the first example of good practice (although it is important to note this is not a group specifically for older people but for all patients). Smaller examples of good practice include the fact that patients do not wear hospital pyjamas. They are able to bring their own in thereby increasing the personalisation of the service. The organisation tries not to move patients around the hospital because for those who are staying in hospital for a while it is important that they become familiar with their surroundings (something which is particularly important for those who have continence problems). The Trust also encourages clinicians to get a service user’s carer (if they have one) involved in the development of their care plans. Finally, the Trust consults regularly with a local pensioner’s convention. This keeps them up to date with the aspirations of older people.

Improving health services and priorities for action

Recognising the gaps in meeting some of the aspirations of older people, the Trust has developed a handbook for all staff, regardless of profession called ‘Proud to Care’. It details the standards and characteristics staff should show in their care of patients. The fact that it is the same document for all staff is part of an effort to break down professional barriers within the organisation. An example of what this handbook is trying to combat is a physiotherapist who focuses only on their part of the care pathway (something which the interviewee thought the allied health professions are particularly susceptible to) If their patient needs to go to the toilet, rather than getting a nurse to do this job, they will see it as part of their duty of care.

Another way that the interviewee is trying to affect change is through CPD for the Trust’s staff. In the last year, there has been greater focus on training in a number of areas important for the needs and aspirations of older people e.g. dementia awareness and falls. They have also used e-learning covering similar areas. This training was supplied based on analysis of patient’s complaints as well as engagement with the pensioner’s convention. It is often difficult for non-medical staff to attend such courses as they do not have protected learning time in the way that Doctors do.
The interviewee thought that her Trust’s links to the local university were an advantage in ensuring that graduate clinicians (particularly nurses and allied health professionals) were able to provide the type of care required upon graduation. This is because the Trust influences the curriculum and teaching that is provided.
#14 - HR Director (Acute Trust)

**Understanding the interviewee organisation and context**

The interviewee was Head of HR dealing directly with a number of workforce issues, including recruitment, contracts and employee relations. His core concerns were the ability to continue to provide the same level of care despite the financial restraints that he thought would affect frontline services (despite government statements to the contrary). He also considered that an ageing population would put further pressure on services, particularly in his local area which had a high proportion of older people. This is because older people tend to stay in hospital for longer and are more susceptible to picking up infections while in hospital.

**Meeting the aspirations: Assessment of the current situation**

The interviewee felt that there were difficulties in meeting the aspirations in hospitals. While acknowledging the importance of meeting these “softer” aspirations, he thought that his staff were very “condition-focussed” i.e. aiming to address the reason the patient is in hospital as quickly as possible before moving them back into community settings for their recovery, rather than viewing the individual’s situation in the round. He also felt that the rise in hospital-contracted infections, such as MRSA, and the subsequent focus (and targets) on bringing them down had diverted staff attention from meeting these aspirations (but also argued that such was the importance of reducing the risk of these infections that this was a fair trade off to have made).

An important skills gap in the workforce is workforce planning skills among NHS managers and clinical leads. It is a challenging task involving “future proofing, anticipating future care need and maintaining links with local universities” which could be improved, particularly on the clinical side. It is arguably, therefore, more a coordination issue between different parts of the Trust than a skills gap.

**Improving health services and priorities for action**

The interviewee thought that alongside the policy focus shifting to coping with hospital-contracted infection, one of the major reasons for workforces (in general) not meeting the aspirations was the increasing specialisation of clinical staff. He thought that clinicians had become “too blinkered ... too specialised. There is a lack of general awareness of conditions”. Using Doctors as an example, he thought that the key driver behind this was that they got paid to conduct additional research. 25% of their week is protected for self-study, and this usually involves following their own interests: “Doctors are their own boss”. Commissioners drive this as well demanding and commissioning services in niche areas of medicine. The increasing specialisation is also present in nursing. As a result of specialist wards, nurses develop expertise in particular areas at an earlier stage of their careers and this too can restrict their development of general care skills.

The structure of the NHS is also a weakness in providing this sort of care. A gap in meeting both the health needs and the aspirations of older people is caused by the dislocation between acute and primary care. Many in charge of acute care feel that: “the responsibility of the acute trust ends after surgery”. However for many services users, particularly older people, they often don’t have an adequate level of care available to them after leaving hospital. This might be because there is no informal care network in place or because the PCT has not commissioned appropriate services.

In terms of influencing the day-to-day care of older people, the interviewee thought that changes to overarching government policy were most influential. To illustrate this, the interviewee argued that: “One of the government’s main agendas over a number of years has been to try and keep people out of hospital”. As a result, his Trust has invested in providing more services in the community. Where possible, they want to offer services in the home and are investing in technologies to facilitate this. The other major influence, particularly on the work of clinicians is the National Institute for Clinical Excellence (NICE). Their guidelines affect the decisions clinicians take.
# 15 - HR Consultant (Acute Trust)

**Understanding the interviewee organisation and context**
As well as managing the Trust's HR function, the interviewee is the Trust's equality lead. This involves producing the annual report and reviewing the Trust's equality activity every six months.

Forthcoming staff cuts resulting from budget reductions is the major challenge faced by the organisation.

**Meeting the aspirations: Assessment of the current situation**
The interviewee was "not able to categorically answer the question" but did not think that the needs of older people are considered separately. "We have to provide services that meet the needs of all people in our local population".

She felt that the aspirations were logical, coherent and comprehensive but was unable to comment on the extent to which the Trust is currently meeting the aspirations. She reported that there is a focus on ensuring that all staff have equality training to ensure that "stereotypes are improved" and to "improve relationships between staff and patients". In terms of maintaining privacy in hospitals, several mixed wards have now been separated into single sex wards and other new builds are planned to provide greater privacy. A lot of work has also been done in terms of improving the physical environment by improving access to hearing loops, disabled ramps and light switches. Stickers have been introduced so that people who are hard of hearing can easily flag this up to staff. The interviewee considers the complaints process is also strong.

The interviewee felt that all staff had a role in ensuring the aspirations of older people are met but highlighted that matrons and ward sisters play an important role.

There are no special mechanisms, apart from the interview and appraisal process, to assess whether potential and current employees have the skills required to meet the needs of older people. There is no specific training related to working with older people, rather it is embedded in all training.

**Improving health services and priorities for action**
The interviewee considers that the Director of HR and the Chief Nurse would be the leads on workforce development in line with the Age UK aspirations.
Understanding the interviewee organisation and context

The organisation is one of nine Care Trusts nationally, bringing together health and social care services. While being a Care Trust would seem to make the achievement of some of the aspirations of older people easier (joined up care; proactive support etc), it is arguably more challenging – because there are “unwritten expectations” about the Trust, including from staff and potential staff.

When undertaking recruitment, it is obvious that people make assumptions, not so much about what a Care Trust is, but how it is different. These can be idealised expectations – and the fact that potential recruits have them, perhaps says something about the desire of staff working in the sector to tackle some of the same challenges that the Age UK aspirations talk at: “they think that because we’re a Care Trust, we’ve cracked it”. In reality, they have just spent a lot of time trying to formalise the basis for better joint working and more integrated services – but that has been a huge challenge in itself.

Meeting the aspirations: Assessment of the current situation

The aspirations fit in with the general direction of travel in health policy, especially in the context of social care and the focus there on personalisation of services. The Trust has various work streams that relate to some of the aspirations – such as ‘virtual wards’, which involves caring for people at home in the same way as on a ward.

In terms of some of the aspirations, it is disappointing that they still need to be spelled out – especially respect for preferences and belongings. That should be a given by now and embedded in the system.

In terms of the provision of more holistic or joined-up services in the context of a Care Trust: the workforce element it is the easy bit, it’s the organisational element that sits on top that is more difficult. Some of the traditional frustrations in terms of how services interface are less apparent in the Trust (e.g. the district nurse deciding that a patient needs a hand rail at home and then having to contact social services and there being an assessment etc). As it is a single organisation, there is more of a ‘trusted professional model’ and far greater leeway for the nurse to make the decision and get things done.

The more challenging bit has been trying to create teams incorporating social workers, nurses and care support workers, co-located and with a single manager. That has taken around 3 years to set up and is hugely complicated culturally and logistically (a social worker being line managed by nursing professional, for example?). They have undertaken lots of team development sessions to develop shared values. The key elements, after much time and effort, for this type of arrangement are:

- Staff knowing their boundaries in terms of expertise and knowledge
- Professional respect underpinning the teams.

Improving health services and priorities for action

Even before the recent White Paper was published, the Trust knew that it had a challenge. Older people are an explicit focus in the Trust’s strategic plan. The Trust’s bigger issue given its broad care focus is the wider health inequality agenda. It sounds perverse, but a function of the traditional silo approach is that it protects health professionals and allows them to focus on their role, ignoring some of the more difficult non-medical factors that can affect vulnerable groups (“they can say – it’s somebody else’s problem! – we can’t”). In the context of a Care Trust, staff have to not only be comfortable having a more wide-ranging conversation with service users, they sometimes have to do this without opening up expectations.

One of the challenges is how to ensure the competence of staff in terms of communications, patient engagement etc. When the NHS introduced the Knowledge and Skills Framework, it brought in a more consistent approach to looking at skills but took away the personal discussion element of annual staff review. The Trust has reintroduced this to annual appraisal – and it provides a forum of sorts for being able to tackle any gaps head on. This is structured in terms of asking staff to show how they demonstrate the organisation’s values (respect; equality etc). There needs to be a strong message from senior managers that “just delivering is not enough – it’s how you deliver”. This can help to shift to greater focus on improvement and a more mature discussion (e.g. in this context, being able to use examples of where things have gone wrong for development purposes).
Understanding the interviewee organisation and context

The interviewee explained that, since 2006, SHAs have devolved greater responsibility to PCTs to ensure that the providers they commission have appropriate workforce plans in place, which are in line with commissioning priorities. She oversees this work and a primary responsibility is producing an annual PCT workforce plan that draws on the workforce plans of individual providers.

She considers the PCT to be relatively forward thinking and highlighted the PCT’s participation in one of the personal budget (‘self-directed package’) pilots.

The ageing population is important to the Trust’s strategic decisions and workforce strategy over the next year and the interviewee considers the fact that the health workforce is ageing at the same rate as the wider population to be a major issue faced by the PCT. The challenge for them is to “bring in new blood, without being discriminatory”.

In her view some roles such as health visitors and staff within estates and facilities departments are more likely to draw older people. Another related challenge in terms of workforce planning is that it is no longer easy to predict when people will retire because staff are increasingly forced to work past the retirement age due to their financial circumstances.

The increase in demand for services, especially those addressing long term conditions, including dementia, is considered to be a particular challenge for acute trusts, ambulance services and out of hours services.

Meeting the aspirations: Assessment of the current situation

A relatively systematic approach is taken to considering the needs of older people in workforce design and development. The starting point of all commissioning and therefore workforce planning is the joint strategic needs assessment, which is informed by data provided by the public health observatory. Data is analysed to develop projections of incidents and illnesses among older people and is used as the basis for workforce plans.

The interviewee recognised the aspirations and expressed the view that they are clear and comprehensive. She considers her PCT to be working towards the aspirations (“the direction of travel is right”) and in particular highlighted work that has been undertaken around privacy and dignity such as reviewing provision of single sex wards. In some cases, where it has been evident that provision does not adequately meet these aspirations, de-commissioning is planned. The Trust is also working towards making care more joined up by working closely with the county council and independent providers to review services to ensure duplication is avoided and that access is more equitable. The intention is that the review will result in the development of integrated care pathways which will reduce variation in practice and allow the same quality of care to be delivered to patients across multi-disciplinary and multi-agency teams.

Community nursing staff are seen as important in supporting the aspirations of older people because “they have a key role in keeping people at home and giving them choice and control”.

Communication skills, including avoiding “speaking down to people and feeling you’re more knowledgeable than them”, are seen as fundamental. This also includes clear and effective communication with carers as well as service users. Empathy and the ability to "walk in someone else's shoes" were emphasised.

In terms of ensuring the current workforce is equipped with appropriate skills, the Trust has a monthly Quality Management Committee, which assesses different providers each time, including an assessment of workforce information. Different data sources such as patient surveys, staff attitude surveys, incident rates and appraisal metrics are used to monitor quality of provision. If gaps are found, they are taken up with the provider and monitored.

Key workforce indicators have been developed which providers are required to report on (these include staff sickness, turnover, level of qualifications etc which are used to improve quality of service provision. A specific example was provided of a case in which analysis of data about pressure damage and staffing on an older person’s ward revealed a correlation between the use of agency staff and cases of pressure damage. The Trust worked with the provider and as a result of the analysis, staffing practices were changed so that agency staff lacking appropriate experience were no longer used. In addition, clear recruitment criteria have been developed, which the Trust ensures are implemented by providers.

In terms of gaps in current skills and knowledge, the interviewee considers that the quality of service provided by GPs is variable. Because GPs are independent practitioners, the PCT has less control over them.

In addition, the level of “customer service skills - the skills that are about compassion and listening” have been found to be underdeveloped among specialists. The interviewee highlighted that previously a smaller proportion of specialists were likely to be working with older people but because of the ageing population more specialists are required to interact with older people but have not necessarily acquired the appropriate communications skills through their training. To address this issue, the Trust has established a new
programme of blended training that combines e-learning and classroom-based work.

In addition, because the workforce itself is ageing, they have found gaps in IT skills which can hinder effective joined-up delivery of services (e.g. using single patient records effectively)

The skills of ambulance staff to assess whether hospital referrals are necessary for older people are not as robust as they need to be. The interviewee provided an example of patients presenting with relatively minor problems but, because they have dementia and the ambulance staff do not know how to cope with this, being inappropriately admitted to hospital. The Trust has established a ‘community-based night sitting role’ in some parts of the county to help, for instance, older people who have minor problems during the night and require assistance but not necessarily hospital care.

**Good practice:** The interviewee considers the Trust’s work to improve early identification of dementia and to improve older people’s access to psychological therapies to be an example of good practice. Training courses at different levels have been developed for a range of professionals from counsellors to clinical psychologists, with the aim of improving mental health assessment in the early stages.

**Improving health services and priorities for action**

A barrier to developing the workforce to meet the aspirations of older people is that, currently, PCTs have little opportunity to influence medical education because this is developed between deaneries and SHAs. The interviewee described her local context, within which the deanery is currently dividing its commissioner and provider functions and which should lead to improved partnership working between the deanery, SHA and PCT.

In order to address gaps in skills and knowledge, “we need to think differently about how we train professionals and develop them more in the social marketing mindset so they can change the way they work in relation to who they are working with - it’s about adaptability and resilience”

Breaking down barriers with the independent sector is also seen as a priority if the aspirations of older people are to be met, as currently rates of inappropriate referrals from care homes to hospitals are high. This will require an upskilling of staff within independent care homes. The interviewee also commented that the PCT has limited authority over providers to oblige them to provide certain management data that would inform quality assurance.

The interviewee indicated that the National Service Framework for Older People produced by the Department of Health and the Skills for Health competencies framework have supported workforce development within the organisation. Royal Colleges have played a lesser role. She also considers third sector organisations as important for ensuring that the voices of older people are heard.
Understanding the interviewee organisation and context
The interviewee is the HR director for a NHS Foundation Trust. He considers “doing more with less” to be the greatest challenge the organisation faces, which necessarily involves delivering services in a different way. He considers the ageing population to be crucial to the Trust’s strategic decisions over coming years. As well as recognition that the age profile of the local patient population is changing, he commented on the related issue of the workforce itself ageing and, in particular, highlighting that fewer nurses are retiring at 55.

Meeting the aspirations: Assessment of the current situation
Age UK’s aspirations were recognised: “it’s very difficult to challenge them. Anyone, irrespective of age would want to be treated in this way”
In terms of the extent to which the Trust is currently meeting the aspirations, the interviewee described a mixed picture.
He suggested that at present “we focus more on the disease pathway and think less about the care pathway and we should be better at that”. He felt that there was a “division" between medical wards and rehabilitation and care settings and that, overall, professionals based in care settings “are more attuned to the needs of older people than surgical specialists”.
The Trust has received positive feedback through the patient survey and given that a high proportion of respondents to this survey are older people, he considers this to be a positive indication that they are meeting aspirations relatively well.
Nurses and allied health professionals were considered to be the key staff groups responsible for ensuring that the aspirations of older people are met. He also highlighted the importance of healthcare assistants who are responsible for basic healthcare needs, such as daily feeding. Strong leadership skills within the nursing workforce were highlighted as crucial to ensuring high healthcare standards and the interviewee expressed the view that, at present, service across wards and hospitals is variable.
Overall, the interviewee did not feel there was a gap in interpersonal skills across the workforce but commented that “we forget the right to respect and dignity, for example using people’s first names by default”. He was not able to point to any other skills gaps and thought the workforce is generally prepared to meet the aspirations of older people but did emphasise that care settings are particularly good at “treating a person as a whole – thinking about the whole care pathway” in comparison with acute settings.

Improving health services and priorities for action
A significant barrier to fulfilling the ‘healthcare in hospital’ aspirations is the short length of time for which patients generally remain in hospital (3-4 days on average). The interviewee expressed the view that building a rapport with patients underpins the Age UK aspirations and “that’s difficult when the length of stay is short”. He therefore felt that community healthcare professionals were better placed to meet the aspirations and that better integration of community care with acute services should be a priority for action.
In addition, the interviewee highlighted the difficulties of involving patients with dementia in their own care as a significant challenge but did not consider lack of resources to be a barrier: “the three healthcare in hospital aspirations don’t cost anything to implement”.
Lack of responsiveness of higher education institutions in validating new degrees was also considered to be a barrier to workforce development that needs to be addressed.
More generally, the interviewee suggested that commissioners would benefit from “a better understanding of the health services they are commissioning”.
In terms of the bodies who are most influential in affecting workforce change and improvement, the interviewee considered SHAs, education providers and the Royal Colleges to be important. However, he felt that a focus on accredited learning was not always helpful as some of the skills are soft and accreditation is not required.
#19 - Deputy Director of HR (Mental Health Trust)

**Understanding the interviewee organisation and context**

The Trust has around 100 community sites and a number of inpatient units. It works closely with other health providers in the region. The Trust has an older people’s mental health service. The Trust has moved towards an increasing focus on community care (which leads to better outcomes) and therefore works closely with commissioners, local authorities and the third sector.

**Meeting the aspirations: Assessment of the current situation**

The interviewee was “not surprised” by the aspirations for older people set out by Age UK. The gaps in relation to the aspirations tend to relate to “service ethos”. It is how staff are led and managed. Arguably, the ‘marketisation’ of the health sector can address some of the problems here in if it focuses on the crucial need – which is to see recipients of care as ‘customers’.

In terms of the key staff for meeting the aspirations, the interviewee distinguished between three groups where the issues are slightly distinct:

- In an institutional setting, nursing and other staff have to concentrate on physically looking after patients. This can be difficult where there are multiple health needs.
- Non-professionally affiliated (Band 3) staff, who often play a crucial role in engaging with older people but who are “not invested in” and not required to meet the same kind of professional standards.
- In terms of medical staff, though, it is clear that CPD does not equip health professionals to develop and refresh the kind of skills and competences associated with the aspirations (CPD appears to be based on the ‘mistaken assumption’ that these core areas of professional practice are a given).

**Improving health services and priorities for action**

The issue of managing people with multiple health needs is critical to meeting the aspirations. The interviewee sounded a note of caution (in a mental health context) in trying to draw too clear a line between the complications associated with age and multiple needs. The same issues are true for young people as well. In fact, it could be argued in general terms that the issue can be more complicated for young people with a mental health issue, because other conditions can also be associated with drug and alcohol problems.
#20 - Director of Transformation and Organisational Development (Primary Care Trust)

**Understanding the interviewee organisation and context**

The interviewee is Director of Transformation and Organisational Development at a Primary Care Trust. The major challenges facing the interviewee’s workforce are managing people with long-term conditions more effectively; improving this is probably their key clinical objective – the national projects on this have, so far, not worked – and, commissioning services more effectively across organisations and care pathways so as to deliver person-centred care (there is a cost element to this as well). Older people are probably the biggest target group. There are two ways in which the organisation considers them:

- The conditions they may face e.g. orthopaedic issues such as new hips / dementia care
- How to set up accessible services and meet the demands of older people.

**Meeting the aspirations: Assessment of the current situation**

The interviewee’s organisation is “absolutely aligned behind these aspirations as a principle” however due to the breadth of services that they commission, it is difficult to believe that they are meeting the needs in all cases. Furthermore, they do not have indicators which map across to the aspirations so there is little evidence on this.

The interviewee commented on most of the aspirations. Face to face appointments: she didn’t think this was difficult to meet - “you just need to challenge archaic practice”. Retaining control in the home: this empowers patients and, importantly “helps them to get better, quicker.” There are some examples where this is happening e.g. an in-home IV service (delivering antibiotics through a drip) is in development. Respect for preferences and belongings – generally being met. Company and the opportunity to be listened to – the interviewee thought this was something that was more important to the social care sector. Proactive healthcare – they are doing well with regard to this aspiration. One of the reasons for this is that all of their community services come from one provider which allows more efficient referral (e.g. "Many of the managers know each other"). Choice and control over daily routines – yes this is being achieved as is the connected relationship between staff and patients. With regard to privacy in hospital they have implemented single sex wards, and concentrate on having clinicians and service users discuss care in private rooms. Joined-up care is the most problematic to achieve. “Between community care and the local authority we’re very strong” - they meet on a weekly basis to discuss discharge from hospital which is one of the most problematic points “however things break down when pressure is put on acute Trusts to move patients on”.

Important roles – leadership and role modelling on wards (in their hospital settings – they have rehabilitation wards) is vital for setting high standards. This is the matron rather than the medical staff as the latter “come onto the wards periodically”. The matrons are there all the time (“they play a hugely important role”). GPs and district nurses play important roles in “connecting people to other services”.

The interviewee thought there were few skills gaps in the sector. Communication is something that, across the workforce, is not taught particularly well: “People tend to learn it from other clinicians”. In relation to older people, the key issue is communicating in a non-patronising way. However, at the same time, there needs to be a counselling element to workers’ skillsets. They will often have to communicate with older people who have gone through emotional periods. The interviewee thought that these were skills which are related to experience. As a result, newer qualified staff are, perhaps, not meeting these needs as well.

**Good practice:** the interviewee knows of a provider organisation who outline the core values of the organisation at the interview stage – these values may well map closely to the aspirations. They also include patients on the interview panel as a way of assessing an applicant’s approach to patients as well as gaining a different and very valuable perspective on the applicant. As a commissioning organisation, the interviewee cannot be so prescriptive in who she commissions. They have to commission for outcomes and then let the providers meet these goals in their own way.

**Improving health services and priorities for action**

The major way of addressing gaps in the quality of the care, in the interviewee’s opinion, is role modelling and leadership. “What makes a young clinician e.g. district nurse go the extra mile in their care? It’s a strong line manager, leading by example and conscientiously ensuring that their staff are doing a good job”. There is a possibility that commissioners could put a key performance indicator into contracts with providers which cover some of the aspirations. This would be a realistic means of trying to shape providers’ approaches.
#21 - Assistant Director of Nursing (Foundation Hospital Trust)

Understanding the interviewee organisation and context

The interviewee is Assistant Director of Nursing in a hospital foundation trust. She is in a managerial role although continues her clinical practice in a reduced form. Her main duty as manager is to assess patient experience. This involves dealing with complaints, assessing what went wrong and trying to change practice in the future. She also delivers training to all clinicians (with a focus on the allied health professions and nurses). The focus of the training is improving patient experience i.e. it is closely related to delivering on the aspirations.

The major challenge facing her Trust over the coming years is to continue meeting public expectations for care in the context of financial cuts. In addition, she thinks there is a challenge around improving the patient experience while also meeting many of the targets which were set up by the last government (and expects to continue with the new administration). She thinks these targets have improved the service and, in particular, been a key driver for removing aspects of poor care. However they also encourage hospitals to have a high throughput of patients and can work against providing high quality personalised care.

Meeting the aspirations: Assessment of the current situation

The hospital organises care provision around the age of patients, to an extent. Where possible, older people go onto a ‘medicine for the elderly’ ward. This allows them to be treated by specialist geriatricians and is seen as best practice. For some service areas affecting older people, though, other specialist skills are seen as more important e.g. orthopaedic surgery.

Surveying the aspirations, the interview concluded that they are very similar to the feedback she sees in her work as patient experience manager. While she thought that her organisation was doing quite well on meeting the aspirations, there are some that it is very difficult to achieve. An example is choice and control over daily routines. It is impossible for the hospital to provide service users medicines exactly when they want them. This is because drug rounds can only realistically be done every four hours without making significant efficiency losses elsewhere: “The ward routine has to be there to ensure some efficiency”. Similarly with privacy in hospital: her hospital has recently moved premises to a new building which has a much higher proportion of single rooms (all of which are en suite – something which is very important to some service users). While this has improved privacy, there still needs to be a degree of collegiality in the setting. Without this, service users can become isolated; in addition, clinicians favour some open settings in order that they can make informal assessments of service users. Even in the open wards, though, the beds are set out in a way which maximises privacy (not directly facing one another, for example). She also pointed out that the aspirations were contradictory, to an extent. Ensuring complete privacy through having private rooms makes it more difficult for service users to build up ‘connected relationships’ with clinicians. This is something which was far easier in the old style Nightingale wards where wards were open plan.

The interviewee did not believe there are particular groups which are more important to the needs of older people and she thought that the complaints she analysed as part of her job backed this up. There are skills gaps within the workforce though. A general gap across all workforce groups is dementia care – there is a lack of understanding of this condition which is also a training gap. Some health sector workers display poor attitudes at times. The key gap is empathy however this is difficult to address: “You can provide all the skills and training you want but it’s about the hearts and minds”. There needs to be a greater understanding within the workforce that people coming into hospital are vulnerable (something which is possibly even more pertinent for older people). Every action of every member of staff should be mindful of this fact.

Good practice: The Trust has developed a care policy for the whole hospital summed up by the following phrase: Compassion; Attitude; Respect; Equality (CARE). The Human Resources department are in the process of developing a policy for disciplining workers if they breach this policy.

Improving health services and priorities for action

The main barrier to delivering good quality care and meeting the aspirations of older service users is attitude. Some health sector workers just do not act in a truly caring manner. There are also political barriers: “The NHS is seen as a political pawn which means policies change regularly. This can get in the way of a high level of quality ... the media can be a negative influence as well because they can create fear among the public unduly”. Linked to this is the target culture put in place by the last government. As mentioned, there are positives to these targets however they can also drive clinicians to concentrate on outcomes at the expense of quality care.

The interviewee plays a role in trying to focus clinicians’ minds on the CARE values (outlined above). She does this through sessions delivered using both good practice examples and some of the patient complaints. She believes that: “Only through telling patient stories can mindsets be changed”. This rolling programme of training is delivered to allied health professionals, nurses and doctors. These values are also being included
in the recruitment process. Potential recruits are told about patient stories at this stage and their reactions are tested and evaluated. It is important to note that the interviewee’s role as patient experience manager is quite new. She thought that this showed her Trust beginning to understand the importance of patient experience. In terms of driving change within the organisation, she thought the Board were absolutely vital. However it is important to engage with the clinicians as well – “it needs to be top down and bottom up ... ‘Board to Ward and Ward to Board’”.
#22 - Assistant Director of HR (Acute Trust)

**Understanding the interviewee organisation and context**
The interviewee has responsibility for a range of HR duties including recruitment and retention, ensuring workers with children are catered for, employee relations (particularly related to sickness) and supporting the frontline managers with workforce planning.

The main challenges facing her organisation over the coming years include:
- Their hospital site is expanding to become a major regional trauma site.
- There is a shortage of nurses – they have been looking to recruit internationally but the new government’s rules on immigration are likely to create problems on this.
- Their local area has an above average elderly population.

The new hospital will have a ward devoted to elderly medicine. At present they do not have the facilities to provide this specialist focus. There is not a strategic focus on older people at present, either; this is managed through an Equalities and Human Rights Department.

**Meeting the aspirations: Assessment of the current situation**
The interviewee thought that the aspirations had a community focus. Many of them are linked into their work on dignity and respect. Devising approaches to meeting them is difficult, though. There is variation on a ward-by-ward and person-by-person basis. There is also a difficulty in meeting them because they are not all related to skills and competencies; some are related to systems and this can be a difficult barrier to overcome. Underpinning them all, though, is a feeling that: "In society, older people can be forgotten and overlooked".

She thought that trying to move older people into the community quickly is important. This is particularly prescient for her organisation as they are based in an old hospital and space is an issue: "Older people go downhill the longer they are in hospital ... we are working with social care to address this."

The recruitment process involves a number of stages. The application form will be informative about the skills that the applicant has. For the interview process, clinicians from the wards on which the applicant will be working are involved. Scenario-based questions are asked to gain an insight into the softer skills. The Trust has close links with the local university. Many students work at the hospital during their studies – primarily healthcare assistant-type work. This is seen as a positive in an application.

**Improving health services and priorities for action**
The major barrier is how highly prioritised the issue of care quality is. The feeling is that if it is seen as important enough, these aspirations for older people can be met. "Ultimately, it needs to be led from the top. If it’s seen as important to the Chief Executive then others will see that it is important." Other important roles include the “Chief Nurse, Service Manager (not ward-based but managing a healthcare area, such as endoscopy), Matrons ... Everybody that’s in a position of leadership".
#23 - Director of HR and Organisational Development (Mental Health Foundation Trust)

**Understanding the interviewee organisation and context**

The interviewee’s role is to ensure that workforce strategies are in place to contribute to the Trust’s strategic and organisational development objectives. Her responsibilities include coordinating staff recruitment campaigns and employee relations.

The greatest challenge facing the Trust is considered to be “the economic climate and how we ensure we are providing increased productivity and quality but at a reduced cost”. In addition, the challenge of retaining staff and “making sure we don’t lose them to the private sector” was seen as vital.

The ageing population is important to the Trust’s strategic decisions and it is committed to understanding “what the ageing population means in terms of our service provision”. The Trust is currently undertaking a mapping exercise with the local authority to try and better understand the demand for mental health services among the local population and to assess how demand can be met.

A particular issue is that the workforce itself is ageing. In addition, among mental health professionals working with older people is “not a specialty people are interested in” because service users are likely to have a number of physical healthcare needs as well as mental health needs, which means specialists require a broad range of expertise and knowledge. The interviewee also commented on the challenge of working closely with community care settings and ensuring that when patients are discharged, appropriate facilities such as housing, are available.

**Meeting the aspirations: Assessment of the current situation**

Older people are not considered as a separate or distinct group of service users. The Trust’s focus is on ensuring that “patients are at the heart of all that we do”. It endeavours to be sensitive to all its patients, including older people.

The interviewee recognised the aspirations as coherent and logical and felt that they were applicable to all service users, not just older people.

The interviewee considers that the Trust “aspires to deliver” the aspirations set out by Age UK. She commented that a lot of work has been undertaken in relation to privacy and dignity, which are considered to be “underpinning principles” to the Trust’s work. A Working Group has been established to monitor progress in this area.

The key skills required by professionals are communication and interpersonal skills. The Trust ensures that staff are equipped with these skills by including relevant competencies in person specifications. This is ongoing work: “we have not got to the point where we are doing this for all staff but we do it for all our nursing and managerial staff”. The appraisal system and regular supervision are also seen as important mechanisms for ensuring the staff’s skills and competencies are assessed and developed on a regular basis.

Overall, the interviewee considered that “there are not many groups within mental health who lack the skills” and noted that “interpersonal skills are at the heart of what we do”. She perceived mental health consultants to be “better than acute sector consultants at remembering that individuals want to retain control”.

Because all staff come into contact with patients, no single group is considered particularly important in meeting the aspirations of older people.

**Good practice:** The Trust has undertaken a lot of work recently to ensure that staff are able to make robust assessments of whether patients have the capacity to make choices. A discrete training programme has been established that staff are able to access.

In addition, the Trust has a vulnerable adults strategy and steering group.

The Trust has appointed a director who is dedicated to services for older people, which ensure “this is seen as a speciality in its own right”.

**Improving health services and priorities for action**

The interviewee considers the main gaps in working practices to be in provision of joined-up care and highlighted the challenges of working with colleagues from the acute and community sector. She also felt university education could be significantly improved: “it’s our responsibility that for university students we place as much emphasis on interpersonal skills as well as clinical skills – there is a lot of room for improvement”.

Third sector organisations are considered to play a key role in ensuring the voice of older people is heard and the interviewee reported that the Trust consults regularly with patient voice organisations.
Understanding the interviewee organisation and context

The interviewee has responsibility for education across the whole non-medical workforce and is also in charge of the care of vulnerable adults. She specialises in the nursing workforce, but has responsibility across other workforce areas as well.

The ageing population is a major challenge facing the organisation. Whereas in the past, older service users would often stay in hospital for longer periods of their recovery from a procedure or care episode, service users are now moved into community settings much earlier in their recovery. As a result, the vast majority of service users in a hospital setting have higher care requirements. This has an impact on the workforce resources required to care for them.

The ageing population also has an impact on the care requirements in the community setting. The main challenge is providing adequate care and keeping people safe once they leave hospital, particularly in the context of what the interviewee described as the “disintegration of social networks” i.e. fewer older people have family able to care for them once they leave hospital. This means there is greater responsibility on the health and social care services.

Finally, improved technology and skills mean that more complex procedures are being attempted on older patients. In the past, some operations would not be carried out on very old patients (the interviewee used the example of a 90 year old undergoing a complex cancer procedure as her Trust is a regional cancer centre); increasingly, such procedures are. This has an impact on the care required.

The ageing population is very much part of the Trust’s future strategy. The challenge is framed, primarily, in financial terms i.e. how to afford to provide a sufficient standard of care for a growing number of older people who are able to be offered more advanced care procedures.

Meeting the aspirations: Assessment of the current situation

The Trust does not consider the needs of older people separately from other service users: “If you get it right for all service users you will get it right for older people as well”. It does not consider there to be a specific set of skills for the care of older people. They do have streams of work on issues which may affect older people, for example, dementia care. Age UK's aspirations were recognised by the interviewee. However, the interviewee thought that “the aspirations of older people are the aspirations of all service users”. It is therefore questionable how older-person specific they are.

The interviewee felt that her organisation was doing “quite a good job” in relation to meeting the aspirations. In the last year, it has had a major push on dignity and privacy. It also runs a programme called Patients 1st, which includes a number of sub-projects grouped under the themes of: Safety and Quality; Access and Convenience; and, Compassionate and Respectful Care. There are a number of aims within Patients 1st which have particular importance to the care of older people including reducing the number of falls among inpatients; providing customer care training for the staff; and, the ‘Productive Ward’ project which aims to increase the efficiency of wards thereby increasing the time clinicians and carers can spend on patient care. The Trust also analyses patients’ care pathways within the hospital and aims to smooth these out e.g. recuing the amount of movement within a hospital a patient may face.

Nurses, physiotherapists and Occupational Therapists are seen as the most important occupations for meeting the aspirations of older people. On further examination, Healthcare Assistants (level 2-3 workers who support clinicians) are also important mainly for the day to day contact with older people. She thought that Doctors are also important, particularly those at consultant level: “Older people still have a reverence for doctors”.

In terms of ensuring that staff have the appropriate skills and competencies, the interviewee referenced the probation periods in place for new staff. With newly qualified nurses, for example, they have a year in which to prove that their training can translate into the competencies required.

Junior Doctors are the only group that the interviewee thought were significantly less prepared in terms of meeting the aspirations. She thought there were two reasons for this:

c. The fact that they have to rotate around so many departments within the hospital means they do not get the opportunity to integrate into teams or focus on the care needed in a particular branch of medicine;

d. The interviewee thought that medical training did not include the particular skills required to communicate with and offer personalised care for older people.

The interviewee argued that it is not specific workforce groups that experience significant skills gaps, but rather that there is an overall weakness with older people’s care. Historically, older people’s wards are “not seen as sexy”. In general, nurses working in this area are older than the average for the rest of the workforce. They also tend to stay in the job longer. As a result, the interviewee argued that the motivation for going on training courses was less. “The brightest and the best of the nurses tend to gravitate towards ICU [intensive
Communications is a key competency for older people. There should be more detail to this, though, perhaps competencies on communicating with older people or people with dementia.

Good practice: The interviewee provided the example of the hospital’s orthopaedic unit. The unit has a high proportion of older patients due to the number who come in as a result of falls. Within the unit, they have set up a ‘dementia bay’ where patients with dementia are cared for. The bay has a small amount of extra funding and it is “slightly nicer” than the rest of the ward. There are also specialist dementia nurses working there who can provide extra expertise.

Improving health services and priorities for action

The main barrier to meeting the aspirations of older people is related to the Trust’s training budget. The interviewee is more likely to choose CPD for her workers in ICU training than in a care of the elderly course because this training is in greater demand. In order to address this, care of the elderly training budgets need to be ring fenced.

The aspirations of older people are very much in line with the prevailing policies in the health sector at present and the main driver for workforce improvement is the HR Department.

In terms of external influencers, the DH is the main organisation. The influence of different policy themes varies within the health sector. For example, there may be a major push on dementia care which originates with a DH strategy document. Such a development might mean that a commissioning Trust would specify that a certain percentage of an organisation’s workforce that they commission have to undertake a particular training course: “until there is a government directive in this area [older people’s care], nothing changes.”
#25 - Director of Nursing and Professions (Primary Care Trust)

**Understanding the interviewee organisation and context**

The interviewee has a commissioning role and has overall responsibility for patient safety, which includes clinical governance and safeguarding. She considers responding to the current coalition government White Paper to be the major challenge faced by the organisation at present because it implies “massive change in management, not just a restructure”, at the same time as ensuring that “previous good work is not lost”.

The ageing population and the increased demand it places on health and social care services is a major consideration when it comes to workforce design and development.

**Meeting the aspirations: Assessment of the current situation**

The joint strategic needs assessment is important to understanding the needs of older people and is used to assess the proportion of people within the wider population who have long-term conditions, for example. This analysis is then used to inform workforce planning, in terms of the number and types of staff required to meet need. As well as the high level data provided by the JSNA, more local level data is obtained from the public health observatory. There is also some benchmarking against other areas to understand, for example, what the district nursing needs are.

The interviewee recognised the aspirations and reported that “they are the basic principles we use to move our services forward”. She considers that the community healthcare aspirations are currently relatively well met. There is an emphasis on arranging face to face appointments at a time chosen by the patient, wherever possible, although a lot of ‘telehelp’ is also offered. The Trust uses personalised care plans, which are developed in collaboration between patients and professionals so they are largely self-directed. The Trust has been a forerunner in the personal budget pilots and personal budgets are offered as routine. To ensure they are implemented effectively and that care is continuous and joined-up, the interviewee reported that they “work collaboratively across agencies”. Partnership working with other agencies is also seen as key to meeting the aspiration for company and the opportunity to be listened to. Even if health professionals are unable to provide this type of support for any length of time, they have strong links with local authority and voluntary sector organisations so they can signpost or refer on. In terms of the aspiration for proactive healthcare and support, the interviewee pointed to the telephone health coaching service the Trust offers to influence and support behaviour change that underpins preventative strategies.

In terms of key roles for supporting the aspirations of older people, the interviewee emphasised that all frontline staff should be capable of providing flexible and personalised care but that community matrons and GPs should be leaders, with mental health services also playing an important role in supporting “clients who have limited capacity to make choice and have control over their care”. In these cases, mental health staff have a important role in working closely with carers.

The interviewee identified interpersonal and communication skills as “crucial”, especially when supporting patients with multiple pathologies and sensory impairment. In addition, treating patients with “sensitivity, understanding” and patience were considered to be key competencies. More specifically, the interviewee highlighted the importance of ensuring that staff have the skills to make sound assessments of patients with cognitive decline, such as those suffering from dementia, and to be able to identify memory loss. The Trust has recently started to provide training in this area, targeting acute hospitals initially, with plans to roll out training to other staff groups.

Providing a mandatory training programme at the induction stage is the main way in which the Trust ensures staff have the skills they need. At present, training on safeguarding and self-directed care is undertaken by all new staff. Although so far there has not been mandatory training related to sensitivity and communication, the interviewee reported that they “are moving on to this” and that “it has not been at the top of the list so far although it should have been”.

A major skills gap identified by the interviewee is behaviour change skills such as motivational interviewing, health coaching and cognitive behaviour therapy. These skills are crucial if the required “shift in mindset, across both the population and the workforce, from dependency to responsibility” is to be achieved. At present, “pockets of staff” undertake training in these areas, but the interviewee considers that behaviour change skills should be part of all basic skills education and training, rather than being simply available as specialist postgraduate training.

The interviewee also mentioned that she considers community healthcare settings to be better equipped to understand and meet the needs of older people than wards in acute trusts. She considers that there has been progress in recognising that “older people are more than geriatric wards”, that the majority of patients requiring healthcare are older people, and that as a result the differences in capacity of acute and community settings will narrow.

**Good practice:** The Trust has developed a Care Navigation Function within a ‘telephonic hub’. In practice, this means that a telephone information, advice and guidance helpline has been established as a single point...
of contact for patients. The service does not merely signpost to other sources of support, but “dispatches someone with the right skills to support the needs raised by the patient”. Initially, this has been piloted in the dementia service area, but there are plans to extend the service to patients with other long term conditions. Significantly, the hub includes a team of nurses trained in health coaching who can provide an important behaviour change service to patients.

**Improving health services and priorities for action**

Changing the skills of the workforce to better support older people requires “changing the way we deliver education ... in health care we have a tendency to tell people what they need and how and when they should get it, rather than recognising that while we can give helpful advice, the patient is often an expert in their condition and likely to know what will work for them”. The ‘customer service’ skills required to be more flexible and patient-centred need to “start from pre-registration training and go right through to post grad, as well as tackling the existing workforce”.

The workforce must also quickly become more flexible and responsive as patients start to have greater choice and control over their care, for example through personal budgets. The specific example of older people choosing to use direct payments to fund a support worker to escort them to go to their local shopping centre once a week, rather than accessing a more traditional day care setting was provided.

Patients and carers should be the main stakeholders influencing workforce change and the interviewee considered that “as personal budgets start to work better, this is happening more”. Change at a local, practitioner level will only be realised if there is a strong drive from national government and national strategies are put in place as workforce assessments are mainly done as part of the implementation of national strategies.
Understanding the interviewee organisation and context

The interviewee manages the mental health directorate within a Primary Care Trust. The main issue which he believes his Trust’s workforce faces over the next few years is an ageing workforce. This is particularly important in mental health care because the workforce is older, on average. There is also a rule (which now only applies to certain groups of older workers) that those with ‘Mental Health Officer’ status can retire at 55 (recognition of the fact that the area of work is seen as more emotionally and physically demanding than other areas of the sector). There is also an issue in “making certain sub-specialities appealing” in order to address recruitment gaps. These gaps include clinicians specialising in older people’s care.

Meeting the aspirations: Assessment of the current situation

The interviewee thought the key jobs for the experience were clinicians trained in a particular area of specialist but with mental health skills as well. Examples include physiotherapists and occupational therapists who understand that when caring for the physio/OT needs of a patient suffering from dementia, they have to change their approach. Another key role is Consultant Psychiatrist and Consultant Old Age Psychiatrists. These are quite difficult roles to fill. Mental health nurses are also important. The major skill gap in workforces across mental health provision is in managing older people with challenging behaviour. This is becoming increasingly important due to improved physical health of older people. Many older people suffering from mental health problems which might lead to irrational or challenging behaviour are still quite physically fit. Mental health issues do not necessarily go with physical frailty and this needs to be managed.

Improving health services and priorities for action

The interviewee focussed on barriers to meeting the aspirations rather than the aspirations themselves. A key barrier for the interviewee is the increased specialisation of clinicians (although specialisation in gerontology is seen as important). He thought that “silo thinking can lead to professionals focussing on their own areas too much. It is a protection for clinicians”. A career path specialising in one area means that clinicians have poor skills / knowledge in the other areas that may be affecting their patient. The interviewee’s organisation operates joint health and social care teams which has linked the two sectors quite well. However, evidence of the difference in systems is that there are still disagreements between nurses and social workers about whose responsibility something is.

The dislocation of the health and social care system is also seen as a barrier. He described it as “Two different organisations trying to meet similar needs of the same population”. The variable quality of care in nursing homes also contributes to many of the issues which the health sector has to pick up. Despite regulation by the Care Quality Commission, there are still some extremely poor “institution-like” care homes which lead to deterioration in health.

The interviewee thought that the mental health care and general care systems were too separate: “It means general nurses are weak on mental health care issues.” A vital role, which is not catered for properly, is that of ‘Psychiatric liaison’. This can be fulfilled by a number of different clinicians (physiotherapist, doctors, nurses – but all mental health specialists); their job is to monitor the care a mental health patient is receiving if they have to go and be treated in the ‘general care’ sector (e.g. a hospital). The expertise for meeting the patient’s mental health needs is invariably not present in hospitals and the job of the psychiatric liaison team is to address this gap.

The interviewee suggested that knowledge of dementia was increasing among the general practitioner workforce and ascribed this to the National Dementia strategy raising the profile of the issue (however he criticised it for not having the funding behind it to make a real difference).
#27 - Director of Performance and Transformation (NHS Acute Foundation Trust)

**Understanding the interviewee organisation and context**

The interviewee is responsible for overseeing performance and workforce redesign. The organisation is a small specialist unit for reconstructive surgery, cancer and burns, dealing in plastic surgery and maxillofacial surgery.

She cited the "public sector context" as the main challenge facing the Trust’s workforce. They have had a number of years of expansion and are now looking at cutting the workforce. Cuts have to be made very carefully as they need to retain the skills mix and avoid impacting on patient care.

On the ageing population, she commented that “for all Trusts, it has to be an important aspect, because that’s the way our demographics are going”. She suggested that as a national institution the NHS has a tradition of not treating older people particularly well. She feels there is a “culture of gratitude” among older people that differs to the more self-assertive and demanding attitudes found among younger users of the NHS, and that this culture is to some extent exploited by the NHS as an institution. She welcomes the culture shift that has seen older individuals and their carers asserting their rights.

**Meeting the aspirations: Assessment of the current situation**

The interviewee’s first comment on the aspirations was that “all of them fit with what we are aspiring to do.” She explained that there has been a culture shift already within the organisation as, for example, there used to be a practice of rigid ward routines, but patients are now given much more choice about their own care. Difficulties arise, however, when individuals do not have the capacity to make choices for themselves.

The interviewee only talked about the aspirations collectively, expressing general approval. This appeared to be because she has no direct contact with patients, and is only involved at a strategic level (and so cannot comment on how well the individual aspirations are met). For example, when asked about what could be improved on she commented “I'm sure they can all be improved on. I doubt we're getting all nine of those right.”

Due to the specialised nature of their institution and staff (of whom there are around 700) she does not feel that there are any particular groups for which the experience of older people is more important – “I think it’s an issue for everybody”. There are some particularly prevalent issues, however, such as dementia, which are difficult to deal with and require specialised skills for those staff who are treating them. They provide ongoing training to fill these skills gaps.

She suggested that the medical staff have “some way to go” on how they treat patients, as the nature of their training and the pressured circumstances they work in mean they may not treat patients as individuals. The only way to deal with this is ongoing training.

At root, most problems arising in the provision of healthcare come down to communication, and so older people are more at risk when their ability to communicate is impaired.

**Improving health services and priorities for action**

The interviewee suggested that improvements could be made by incorporating the needs of older people more explicitly into their policy and strategy. “It is corporate initiatives and policy making that encourages changes in behaviour.” She did not feel able to make any more specific comments.

She did not feel that there were any major barriers to change, again because of the small and specialised nature of the Trust. “I don’t think there are structural barriers, I think it’s more about mindsets and behaviours.”

She named the PCT, as commissioner of their services, as the most influential external organisation. On being asked about the Royal Colleges, she said that they are “pretty influential”, as they produce guidance and parameters for staff to work within. The relationship is based on shared values, and involves reasonably regular discussions and meetings.
#28 - Deputy HR Director (Acute Foundation Trust)

**Understanding the interviewee organisation and context**

The interviewee has a broad range of responsibilities including managing recruitment across the workforce with a particular focus on medical recruitment, workforce informatics and workforce planning. The main challenge facing her organisation in the next few years is the economic environment. She anticipates a headcount reduction in her organisation over the next few years with a concurrent need to increase productivity to retain care standards. The Trust does not deal with older people as a specific issue but rather has strands of work on related issues such as falls.

**Meeting the aspirations: Assessment of the current situation**

When considering the design and development of the workforce, the Trust does not consider the needs of older people to be different from other service users. The interviewee recognises the aspirations as representing a good level of care for older people: "there are no shocks in there". In terms of their achievement of these aspirations, the interviewee thought they were "probably middle of the road ... there's definitely scope for improvement".

The interviewee thought that nursing was the most significant occupational area for older people’s care. Nurses are seen as "the primary carer with whom a service user will have contact regardless of their condition." There are a number of other roles with elevated importance for older people. Ward staff – roles such as Assistant Practitioners, who help nurses and other clinical professionals discharge their duties, and Ward Clerks – have a major influence. Administrative staff who make outpatient appointments can also have a major influence on whether these aspirations are met; if this job is carried out with the needs of the service user in mind, appointments can be made in locations / times which minimise the disruption for service users (something particularly important in the aspirations). The interviewee also highlighted the importance of staff in the lower levels of the NHS careers framework such as hospital porters and healthcare assistants who may spend more time with a service user than the clinicians themselves. Finally, catering staff are vital, particularly in meeting the aspiration of 'respect for preferences and belongings'.

The interviewee did not point out a particular group of workers who were meeting these aspirations less well than other groups. However once the service user leaves the care of the interviewee’s Trust (an acute Trust), and enters the care of the Primary Care Trust and community-based care there is a gap in the standard of care. She thought that: "The PCT does not commission the right services". This gap in care standards between acute and primary care is due to primary care commissioners protecting their own interests. There is an inherent conservatism in the system as the interviewee thought "it's much easier to commission than decommission".

**Good practice:** The Trust carries out analysis on the incidence of falls within the hospital looking at where and when they occur and if there are any specific external factors which may have increased the risk. They then address these issues based on the analysis.

**Improving health services and priorities for action**

The interviewee believed that if the Trust had an explicit focus on older people as a specific service user group, the standard of service (and likelihood of meeting the aspirations) would improve. This would be to the detriment of other groups though and that does not fit with the philosophy of the organisation.

Other barriers to meeting the aspirations are more related to the hospital environment itself. For example, pressure on beds means that older people get moved around the hospital, something which is an extremely disrupting experience. Accident and Emergency departments are seen as being particularly detrimental to the experience of older people.

The interviewee views Unison as a particularly important organisation as approximately 80% of the non-medical workforce are members. The Department of Health is thought to be the most powerful body for providing large scale policy steers, for example, a recent influential policy, which dominated their internal policy making, of focusing resources on bands 1-4 of the NHS careers framework came from them. Finally, the strategic health authority is important in shaping the workforce as they commission the university places in the region. As a result, they can affect the supply of qualified staff.
Understanding the interviewee organisation and context

The interviewee is responsible for supporting workforce redesign by writing workforce plans, modelling, and monitoring change issues. The Trust both provides and commissions services.

The main issue the Trust faces is considerable uncertainty around the changes being brought in by the government, both in terms of the funding they will be receiving and the structural change that will be taking place. For example, they may be merging with local Trusts, but they are not sure. This makes workforce planning very difficult.

In addition, they have difficulty recruiting health visitors (who are required in larger numbers by the government). There are also 'learning development issues', in that they are working towards shifting care out of the hospitals into the community, and an ageing workforce.

The ageing population is very important to the organisation's strategic decisions, as a reflection of demographic changes. However, the interviewee emphasised that they base their decisions around many aspects of demographic change and age is only one factor among many.

Meeting the aspirations: Assessment of the current situation

Workforce design currently takes place on the basis of public health information, and within this context the ageing population is of particular concern. Two of the most prominent health issues in the area are CVD (Cardiovascular Disease) and COPD (Coronary Obstructive Pulmonary Disease), which tend to affect older people (after a lifetime of smoking or working in an environment where they inhale small particles). In trying to combat these they have altered the care pathways to bring care out of the hospitals and into the community.

While older people are more likely to have these diseases, the strategy is designed around the medical condition rather than concentrating in any way on age as a defining characteristic.

Looking at the aspirations, the interviewee commented that "they seem fine", though drew out aspiration 4 (company etc) as slightly out of place when talking about healthcare. It is more an aspect of social care. Aspiration one on personalised appointments fits well with the work they have been doing on altering care pathways and moving care out into the community. Aspiration two (retaining control of the home) fits well with the telehealthcare pilot (described below in good practice).

She recognises the aspiration around joined-up care as "really important". They already work very closely with social services, but feel they could be better integrated with GPs and other care providers like nursing homes. At times there is duplication across services and a lack of communication: "this must be frustrating for patients, because there's so many different people to go to, and different names"

When asked to what extent they meet the aspirations, she said "I think we're on the way, maybe medium to high?", and added that they are currently undertaking a lot of redesign work to improve it further. She did not consider them to be specific to older people, however: "I think everybody would want that. I would want those things."

On being asked about skills gaps, she understands them to occur where skills have not had a chance to catch up with changes made to the structure of the workforce or the equipment it uses. For example, there is concern that with moving care out of hospitals, community nurses will not be equipped to treat patients adequately. To combat this, an interim outreach programme is being set up where hospital nurses provide support in the transition period. She did not identify any pre-existing skills gaps in terms of the aspirations.

Good practice: The Trust has piloted telehealthcare and has so far found it to be effective. The equipment is being trialled in the homes of people with CVD or COPD and automatically sends information to health professionals. It does, however, require careful control of staff competencies to ensure they are equipped to deal with the information the equipment provides and the altered way of working.

They are also about to implement a rapid response service that provides an alternative to calling an ambulance and being admitted to hospital. Individuals with chronic illnesses who are known to the service will have access to a visit from a nurse within two hours. It is generally older people who would use this service.

Improving health services and priorities for action

The interviewee had a clear idea of the steps that need to be taken: a skills audit is needed, which takes into account the skills and competencies of the existing workforce as well as the workforce of the organisations they are working with (should the merger go ahead). Once this is complete training will need to take place, though there are doubts about whether the funding will be available for this. There may also be a need to create new roles.

In addition, there will be a big cultural change involved, but this is something that needs to be taken into account rather than something that will prevent change. Uncertainty is also a big factor.

Generally the ideas driving policy and the needs and desires of patients are fairly well matched. The
execution of these ideas, however, combined with a lack of funding, means the reality is not always to the
taste of patients. For example, moving care out into the community may mean that patients needing multiple services find they have to visit multiple locations where before their appointments were all in the same hospital.

In terms of the influence of external organisations, the boundaries set by professional bodies do have to be respected, but the Department of Health is by far the most influential.
Understanding the interviewee organisation and context

The interviewee has responsibilities for collating and analysing information on the PCT’s workforce and planning ahead based on this. He sees a number of general challenges facing the Trust in the coming years with the new economic climate being first in the list. From a more pragmatic viewpoint, there is the challenge of ‘retirement bulges’ and replacing those skills and experience. The ‘new ways of working’ agenda is an issue – i.e. providing more person-centred care, allowing patients to produce care plans etc. These developments will require different skills and a different approach from clinicians. A more local issue (which has been a concern for a number of other Trusts we have interviewed) is attracting clinicians to the area which is quite rural.

Care of older people is a significant part of the Trust’s current planning. The challenge is to balance the “changing demand for the services against the changing workforce supply.”

Meeting the aspirations: Assessment of the current situation

The interviewee thought that there needed to be significant investment in workforce planning in the NHS. Older people are more likely to have co-morbidities and this is the major workforce challenge presented. Placing a greater emphasis on preventative healthcare might help to reduce the co-morbidities in older people in future years.

The interviewee recognised the aspirations; they are similar to the demands older service users present to his Trust. The strength of knowing such aspirations is that they provide focus. Their weakness is that they are not benchmarks. The interviewee thought that the aspirations may become less realistic to achieve as the NHS is faced with new economic constraints. In terms of meeting the aspirations, the interviewee thought that having staff with specific geriatric training and skills was important; generic care skills are not sufficient. The interviewee thought that “skills gaps have a greater chance of occurring when the workforce planning focuses too much on the supply of staff (i.e. numbers) and not enough on the demand for the services.”

Improving health services and priorities for action

The interviewee considers that silo thinking and a lack of communication between relevant stakeholders within the health and social care sectors are barriers to organisations meeting the aspirations of older people. The interviewee sees the Department of Health and Strategic Health Authorities as being the main policy drivers. Professional organisations have a key role in training and regulation of staff. Social care services and care homes also play an under estimated role in helping older people retain their independence for longer.
#31 - Director of Organisational Development and Human Resources
(Mental Health Partnership Trust)

Understanding the interviewee organisation and context

The interviewee leads on recruitment, workforce development, equality and diversity and workforce planning in a mental health trust which provides most of its services in the community, commissioned by the local primary care trust. He saw very few problems ahead for his workforce aside from the move to nursing becoming an all-graduate profession which may cause some problems with throughput from the universities for the first couple of years. The care of older people is a key concern for the Trust given that they represent a large proportion of their service users however it was not seen as a pressing issue for them, at this stage.

Meeting the aspirations: Assessment of the current situation

The aspirations tie in very closely to their strategy. They provide all of their care in community settings as it is so there is already a focus on meeting these aspirations. Much of their care is provided in the home as well. There is a general point to be made about Mental Health Trusts; the type of care they provide is very much based around person-centred principles (as mental health problems are well suited to this view of care provision) as well as a large emphasis on working in the community / care homes / homes. As a result, the interviewee thought “Mental health trusts are better placed to understand the issues of holistic care for an older person than other organisations. We tend to have a much longer running relationship with a person than, say, an acute trust”. This long-term engagement means clinicians begin to identify with service users as individuals.

Rather than individual job roles, the interviewee stressed the importance of thinking about the workforce as a multi-disciplinary team. In his organisation, members of this team include psychologists, healthcare assistants, nurses and psychiatrists. When recruiting and building a workforce, facets that are seen as important are “life skills ... we are more relaxed about the age range of recruits”. “We want people who have high levels of empathy and who see the role as more than a job”. Clinicians in mental health trusts face emotional challenges as the service users they work with will, in the majority of cases, have quite profound mental health issues. This requires an extra level of resilience which the interviewee wants evidence of before employing someone.

The only gap that the interviewee could foresee was when nursing moved to an all-graduate profession. Once this occurs there may be a gap for a new role to emerge in carrying out some of the more menial nursing duties which the better qualified nurses might not focus on.

Improving health services and priorities for action

The interviewee argued that a young workforce could act as a barrier to meeting the aspirations: “Young people do not like to see their own mortality”. In general, “It’s a working environment that is not for everyone”. For this interviewee, caring for older people had less to do with job roles and qualifications, and more to do with personality and vocation. There is an organisational aspect though. With particular reference to Mental Health Trusts, who provide care to service users who often cross the boundary between health and social care, there is a need for seamless links between local authority providers of social care and healthcare providers: “There isn’t one body that deals with older people and this is a major barrier to caring for older people, particularly in their home. The third sector, health, housing and social care are all involved but there is no one accountable group.” Commissioning arrangements are vital in achieving this level of coordination. PCTs, in particular, have the ability to prioritise certain types of care. Professional organisations such as the Royal Colleges are less influential and do not play a part in the day to day activities of clinicians.
Understanding the interviewee organisation and context

The interviewee is Director of HR and, as such, has a broad range of responsibilities but the main areas are workforce planning and recruitment. He outlined four key issues facing his Trust’s workforce:

- How to offer the same level of service when resources are being cut quite stringently. This is compounded by the fact that he argues “Mental health is always bottom of the pile when it comes to resourcing”.
- He thought there was a stigma attached to mental health linked to individuals who might be dangerously ill. There is a PR problem in informing the public that mental health problems are prevalent in mild forms throughout society.
- The demographic profile of the country means that it is likely his Trust will face an increase in service users suffering from dementia, thereby putting greater strain on resources.
- Coupled with what he saw as the inevitable cuts in the health sector, are the cuts to local authority budgets. He thought it likely that adult services within local authorities would suffer and that this would impact upon their ability to join-up care.

On the positive side, he thought that an ageing workforce was a bonus as it meant more experience and therefore a higher quality service.

Meeting the aspirations: Assessment of the current situation

The interviewee questioned why healthcare organisations should split adults’ services from older people’s services: “Why draw an arbitrary line at 65? Care needs operate on a continuum.” He thought that the aspirations were very similar to what he understood as the main needs of older people. His Trust is working towards meeting the aspirations in all areas and he gave a number of examples of this. The organisation offers single sex wards which he thought was the key element to privacy in the acute setting. The level to which care is joined-up between health and social care departments is varied. This variation is related to a recent restructuring of local government in his county which means that some of the new local authorities are good to work with, and some quite poor. In terms of meeting the aspiration on ‘face to face, personalised appointments’, he thought that a key gap here was in the administration staff who do not fully appreciate the importance of organising outpatient appointments to meet the needs of older people. In general, though, he thought his organisation were “there or thereabouts” and were certainly moving towards the aspirations.

The interviewee highlighted a small number of roles he thought were most important to older people. In the acute setting, the ward manager/modern matron role is vital i.e. “the individual with the quality oversight”. He thought that they were responsible for identifying where aspirations are not being met or poor practice is taking place and that they have the remit to address this. Managers in general are important: “If you want systems to improve, you need to employ more managers (including clinical managers). Clinicians spend a relatively small amount of time with patients”. Other workers, not necessarily clinicians, who work on the ‘frontline’, are important. Roles mentioned here include: gardeners, porters, domestics – “these people can make a real difference”.

He thought that a possible weakness in meeting these aspirations was at the rehabilitation stage. The reason for this is “Once a service user is getting better, some workers are less interested”. He couldn’t identify any particular skills gaps. As mentioned, he thought they were on their way to meeting the aspirations and the workers are a key part of this. The only area that could improve is management skills, particularly in roles such as the modern matron however this is more related to the importance of the job than its incumbents’ deficiencies.

There is a difficulty with the apparatus available for recruitment though. The Agenda for Change format is the “wrong way round. It asks: ‘Is this person a good team member?’ but it should ask: ‘Can this person be part of a team that can provide person-centred care?’” Agenda for Change does not describe the skills required for person-centred care well enough.

Improving health services and priorities for action

In terms of recruitment practices there were a couple of changes which could be beneficial to meeting the aspirations. Firstly, it is important to change the person specifications slightly so that “they start with different assumptions i.e. person-centred care is the be all and end all of most health sector jobs”. Secondly, Agenda for Change means “some jobs and careers have become ossified and this limits talented people”. It is difficult for workers to collect skills and experience across professional areas and this would improve the level of care. A means of achieving this would be to further increase the subsidiarity of the health sector, allowing local areas to innovate more with their workforce management so that they can meet the needs of their own
areas.
In terms of creating change within Trusts the interviewee thought that “increasingly, initiatives are clinically-led therefore it’s the clinical directors and not the management (be it Board level or organisation level) who lead on projects.”
#33 - Senior Manager in the Adult and Older People’s Transformation Directorate (Primary Care Trust)

Understanding the interviewee organisation and context

This interview was conducted with the Change Programme Project Manager who is leading an innovative programme in the PCT area to integrate the health and social care teams in order to improve the care given to older people.

She thought that the major challenges facing the PCT in the next few years are:

- Caring for people who have had strokes is a key area of development in the coming years. The challenge will be to educate the whole workforce about this rather than restricting the expertise to a small number of expert stroke nurses.
- The move towards using pre-reg workers such as healthcare assistants at the expense of / in addition to clinicians is something which is quite controversial. The interviewee thought this may lead to a reduction in care standards however it is a nationally-driven policy.

The ageing population is a key driver behind the project to integrate the health and social care teams.

Meeting the aspirations: Assessment of the current situation

Looking at the aspirations, the interviewee believed that the project she was leading would contribute directly to meeting a number of them (particularly joined up care and retaining control over the home).

The interviewee thought that community-based workers and those that go into the homes of older people every day were most important for meeting the aspirations. District nurses were raised as most important with a range of allied health professions in the second tier (including podiatrists and occupational therapists). There are also a number of key relationships, for example, between social workers and district nurses (on the day to day care of service users) and local authority and PCT commissioners (on more managerial issues).

At the professional level the most important new skill required is an ability to think more holistically about service users. In the context of the personalisation agenda (where service users are in receipt of personal health budgets), clinicians need to develop skills in developing care plans in collaboration with service users. Added to this, clinicians require imagination in recommending care options which may not be traditional but are effective to the individual: “Clinicians need to think outside the professional service-led brain”.

As well as this attitudinal change, there is a more pragmatic requirement: health professionals need to know about what sort of services are available in their local area. The key workforce groups for these changes are district nurses and community matrons. Contact with social care professionals helps this skill to develop as health staff work continue to work alongside social care staff in the integrated team that is developing in Milton Keynes.

The interviewee believed that the skills gaps described are most obvious when comparing social care staff (who are much closer to meeting the aspirations) and health care staff: “Social care staff are used to responding to need whereas health staff are used to responding to diagnosis”. Health staff have traditionally focused immediately on the main problem a service user is facing whereas social care staff view the whole person. However the gaps are closing as health staff work continue to work alongside social care staff in the integrated team that is developing in Milton Keynes.

The interviewee would not commit to particular workforce groups who are better or worse at meeting the aspirations. Instead, they thought that “There are people who get it and people who don’t”.

**Good practice:** In the PCT area, they are piloting an approach in two of the twenty eight practice sites which aims to formalise the more joined up care they are attempting to provide. The two sites hold weekly meetings attended by GP, Practice Manager, District Nurse, Community Matron, Community Psychiatric Nurse, Telehealth and Care providers (assistive technologies), Pharmacists and the voluntary sector (Age Concern in this case). At these meetings, a multi-disciplinary group discuss vulnerable adults in the area and there is obviously a specific focus on older people. Achievements so far from these meetings include medication errors being resolved.

Improving health services and priorities for action

The interviewee thought that the key tool for addressing the identified gaps and moving towards a service which fully meets the aspirations of older people is to develop joint workforce development plans across health and social care teams. This would address the gap in understanding between health and social care. They also thought that new roles would emerge in the next few years. In particular, a low level support role would emerge. This role would encompass low level skills in nursing, occupational therapy, physiotherapy and phlebotomy and would take place, primarily, in the home.
In order to address the inevitable financial barriers to fully integrating health and social care services, a 'Section 75 agreement' has been drawn up between the two service areas which merges the two budgets but also clearly delineates areas of responsibility. As funds are merged, some responsibilities transfer (e.g. safeguarding has moved from social care to health) and these have to be written up in the contract.
#34 - Discharge Coordinator (Independent sector hospital)

**Understanding the interviewee organisation and context**

The interviewee has responsibility for the discharge of every patient in the hospital. As a result she is expert in assessing whether a patient is ready for moving into community care and reducing readmission rates (which is a key goal outlined in the Darzi report and reiterated by the coalition government). The discharge nurse needs to be especially skilled at looking at all aspects of an older person’s health and wellbeing e.g. what are the care arrangements once they leave hospital; are they going to contribute to a rapid readmission?

The concerns of the ageing population are very important to her organisation; it is seen as their most important concern going forward.

**Meeting the aspirations: Assessment of the current situation**

The interviewee focussed on the nursing workforce as the key area for older people. In particular, the discharge nurse (as they play a massive role in reducing readmissions) and the tissue viability nurse (as they deal with conditions that can lead to readmission) should be focussed on. The physiotherapy and occupational therapy workforce are important too.

According to the interviewee, her organisation is “meeting the aspirations 100%”. She justified this by describing a situation where all service users have single rooms, the organisation’s leadership is committed to patient dignity (“it’s part of the ethos”). As well as senior leadership, the interviewee thought there needed to be clinical leaders throughout the organisation (e.g. a nurse / doctor / physiotherapist who is passionate about caring for older people who can act as an example).

In reference to the wider health sector, the interviewee identified a number of workforce areas where the aspirations are not being met. The medical profession has a number of gaps both in knowledge and the type of care it provides. There are particular gaps in knowledge about procedures for people with dementia. Many doctors who have specialised into quite a small area are not prepared for service users suffering from co-morbidities (or “a conglomerate of little ailments”). Similarly, some doctors are not prepared for poly-pharmacy patients (i.e. those service users taking a number of types of medication). With regard to nursing, the interviewee thought that nurses coming through the training system in recent years, and going forward, are less likely to specialise in nursing older people: “It’s too much like hard work ... not sexy ... not like E.R”.

These trainee nurses are more likely to be interested in intensive care work and surgery. The older people’s nursing workforce is older itself and this will obviously have to be replaced once retirement takes place.

The interviewee noted a number of skills gaps that she thought existed across the sector. There is a general lack of clinical leadership in health organisations. She thought it was “absolutely imperative that there is clinical representation – particularly nurses – at the Board level” in order that issues such as dignity are given proper consideration. There is a lack of knowledge in preventing dehydration among older patients.

Healthcare workers often do not treat this as one of the most important part of an older person’s care.

**Good practice:** Nurses at the interviewee’s organisation often check up on their patients after they have left the hospital setting. While this is not (and nor should it be) a realistic aspiration from workers across the sector, it is indicative of the importance of the period after an older person leaves the acute setting and moves into a community setting, particularly if they do not have access to informal care (such as family members).

Another example is that the hospital, in recognition of the importance of quality food, has convened a nutritional working party in which the catering department is involved.

**Improving health services and priorities for action**

The interviewee works for an independent sector hospital which is able to offer service users a level of care (such as single rooms for all) which is financially unviable in the NHS. Nursing colleagues in her hospital sometimes follow up patients as they go into the community care sector. This is another service that is less realistic in the NHS simply because of the far higher number of patients per nurse. The interviewee does not think that the staff are better, or more ‘older person-centred’ in the independent sector, but rather that they have certain financial and organisational advantages over NHS provision. She did argue that clinical and Board-level leadership in the NHS was a key facilitator of change.

Royal Colleges and other professional organisations are important in improving care services. In the area of nursing, the Royal College of Nursing is favoured, particularly for the standard of its research. The Nursing and Midwifery Council is thought to have improved its standing in recent years. One of its major tools in influencing the workforce is their ethical guidelines that all registrants have to sign up to.
Understanding the interviewee organisation and context
The interviewee is “effectively the HR manager for the medical workforce”. As such her key roles are recruitment and ensuring new entrants are fit for purpose. The major challenges facing her Trust’s workforce over the coming years are the uncertainty deriving from the political and financial situation. She thought that, politically, doctors were subject to change more than other professions within the sector. She gave Modernising Medical Careers as an example of a policy change pushed through without the consent of the major workforce bodies.

The Trust has five wards for ‘Medicine for the elderly’. Each morning they meet to discuss the patients that have come in during the past 24 hours. Older people (they consider this to be over 65) will go on the Medicine for the Elderly ward, unless they have an overriding clinical condition which means they should go onto a different ward.

Meeting the aspirations: Assessment of the current situation
The interviewee thought that between them, the nursing and medical workforces were the most important care providers for older people: “Nurses to provide the TLC and doctors to look after the clinical needs.” Nevertheless, she thought that, on the whole, the medical workforce was meeting the aspirations quite well.

Improving health services and priorities for action
The importance of expert geriatric skills was highlighted. They have quite a large proportion of geriatricians (both within the medical and nursing workforce). Their specific skills are a vital contribution to the care process. They are particularly valuable in assessing when a patient should be discharged. This is one of the key risk points in a care pathway. Good geriatrician skills recognise if the risk of discharge is too high and if not, to organise suitable care services once they have gone back to the community.
Understanding the interviewee organisation and context

The interviewee is a senior workforce manager for the provider arm of a primary care trust and is also Associate HR Director for the commissioning arm. She has a wide range of responsibilities: to manage HR and development provision to ensure that there is occupational health provision in place; to manage staffing systems and recruitment; to manage communications; and to lead the modernisation and transition programme.

The challenges for the workforce are different for different groups of staff within the organisation. They have taken on the Darzi agenda of moving provision and decisions about healthcare closer to patients and into the community. This has been their agenda for some time, and requires working closely with colleagues in acute care at the hospitals ("widening the interface" between the two sets of staff).

The ageing population is extremely important to the Trust, especially in terms of treating the long-term conditions experienced by many older people. "The prevention aspects of this are absolutely key."

Meeting the aspirations: Assessment of the current situation

Older people are not treated as a distinct group with its own needs, but their needs are more prominent as they are more likely to have long-term conditions, and to need treatment far more regularly.

When asked about the aspirations, the interviewee responded "I think they're our aspirations, completely." The interviewee was very positive about the relevance of the aspirations, commenting on how each of them fits into their agenda on healthcare in the community. She emphasised in particular their aspiration (and their ongoing work) to maximise face to face contact. She also highlighted the 'respect agenda' as central to modernising the workforce. They are currently running pilot schemes to find the best way to gain consistent feedback from patients.

They coordinate with an organisation called LINKS (she could not remember the full name) that represents patients, attending board meetings and meeting with senior staff in an attempt to bring in and take account of patient views.

Older people specifically are taken into account through the adult services (as opposed to children's services) arm of the organisation. This is for all adults, but tends to focus on older people as they are the most common service users. Similarly, she feels the aspirations are general but more applicable to older people because of their closer relationship with the health sector.

The interviewee picked out nursing (district and community) as experiencing some skills gaps, particularly in terms of the age of the workforce and the difficulties of attracting new, younger staff. Attracting younger nurses will require making jobs in the community more specialised. It should be remembered that the older nurses have a lot of experience, which is very important, but they have found it quite difficult to move to computerised systems. There are also higher sickness levels in older staff due to tiredness or developing long-term conditions themselves.

Therapists are another key group of staff in terms of older people, and they are much more forward-thinking and inclined to change. They are generally younger and more adaptable. On being asked how the learning might be transferred from one group of staff to the other, the interviewee referred to the care pathways model, with its much more integrated workforce, that will allow ideas and enthusiasm to 'pull together' and transfer between groups. "It does make a difference, actually, it's quite interesting. It motivates, and that's the thing." Differences can already be seen from the changes that have been made.

Good practice: The podiatry service they provide has proven very successful. The Trust manages podiatry services for the acute hospital care in the area, allowing for "seamless" care. Otherwise healthy people can be easy disabled by problems with feet, and so they invested a lot in improving the service. They have their own foot surgeon and have simplified the process, and have also coordinated with other organisations e.g. Age Concern does their toenail cutting.

Improving health services and priorities for action

One of the key factors in implementing change is motivating staff. "It's about them talking to their patients, and then them saying, 'This is what I think we can do', with the organisation, corporately, assisting that change to happen. And that is what we're trying to do." Motivation is achieved through their modernisation programme, which is encouraging staff to generate their own ideas about what can be improved.

Some of the barriers are practical – use of IT, and communication issues. But there are also cultural issues, in that staff are used to doing things a certain way, and it's difficult to get them to change their habits. Financial issues are secondary. "If people gradually do things differently, it frees up money to use in different ways...I honestly believe a lot of it can become self-funding"
#37 - Medical Director (Acute Foundation Trust)

Understanding the interviewee organisation and context

With this Trust, our enquiry was passed on to the Medical Director for the hospital. It was felt by the HR Department, that he would be best placed to discuss the workforce as a whole (with a focus on the medical area) as well as some of the clinical needs of older people. His responsibilities were wide-ranging and included maintaining the standards of the medical workforce, conducting clinical effectiveness audits, providing medical advice to the Board, dealing with National Institute for Clinical Excellence guidance, and dealing with the European Working Time directive for Doctors.

The key challenges for his Trust’s workforce over the next five years are to keep sufficient staff numbers as finances are cut. His Trust aims to save £18 million this year and 60% of expenditure is on staff therefore there will be a great deal of pressure here. The second challenge facing the Trust’s workforce is to provide sufficient care to an ageing society. This is a prescient issue in his Trust’s area as 60% of the captive population is retired. He also noted the specific issue of an increase in the “old old” which he defined as those with frailties, often in their eighties or above.

Meeting the aspirations: Assessment of the current situation

The interviewee was of the opinion that: “all clinicians deal with older people. This includes paediatricians and midwives who may deal with grandparents.” It is important for all clinicians and support staff therefore to possess the skills and competencies capable of meeting the aspirations of older people. However, he thought that specialist geriatricians were needed throughout the workforce. The importance of these individuals is in their clinical knowledge: they are specialists in stroke care, movement disorders, orthopaedic geriatrics, and infection control. They also act as clinical leaders in the provision of good quality care of older people and, according to the interviewee are more likely to meet their aspirations as well.

While this interview covered a discussion of whether the aspirations were being met, there was a clinical focus as well, given that the interviewee was responsible for the medical workforce. He saw the nursing workforce as underpinning the care of all patients but especially older people. Providing round the clock care, one of their core roles is “accurate observation and being able to recognise illness”. They also play a key part in preventing falls and looking after continence needs which link into a number of the aspirations.

The interviewee thought that the Trust was doing “quite well in meeting the aspirations”. He outlined a number of initiatives in place which he felt were contributing to this work.

- In order to provide ‘face to face, personalised and flexible appointments’ the Trust is implementing evening clinics as well as providing a mobile clinic service (the Trust has a large rural hinterland).
- ‘Respect for preferences and belongings’ is a very difficult aspiration to achieve. They provide a single sex clinical environment and staff are supported by management to provide personal touches but “it’s a constant battle to achieve this one”.
- The same could be said for the staff’s ability to provide ‘company and the opportunity to be listened to’. The Trust has recognised this aspiration and is taking part in the productive ward project which is a scheme aimed at increasing efficiency so that clinicians can spend more time on caring duties such as providing company for patients.
- In terms of providing privacy on the wards, the Trust is quite limited in what it can do by the fact that they inhabit quite an old building. The interviewee also thought that there had to be a balance between “privacy and observation” i.e. wards / clinical environments have to retain a certain level of openness so that clinicians can observe in case of accident. Even so, he thought that eventually the NHS would reach a stage where they were at single rooms for most patients.

Overall the interviewee felt that, “Hospital systems are so complicated that the personal touch can be lost.”

Old age psychiatry and mental health care in general is a gap in the opinion of the interviewee. Only recently has psychiatric care become available for over-65s. Before this, the NHS was breaking the very first standard of the national service framework for older people: that of providing equal services regardless of age. Old age psychiatry is still a niche area with a small number of practitioners and needs development in numbers and recognition.

Good practice: While the vast majority of Trusts now have specialist wards for older people (according to the

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67 On this note, the interviewee made an important point: while the government is committed to protecting the health budget in real terms, ‘real terms’ does not really apply in the health sector. This is because inflation is much higher in the health sector (mainly caused by the inflated price of drugs and other treatments). As a result most Trusts will be aiming to reduce costs over the next couple of years (and this has been shown in other interviews).
interviewee), this Trust focuses on ensuring that geriatricians are integrated throughout the hospital. A key mechanism to achieve this is that at the morning meeting of senior clinicians where the needs of each service user are discussed, it is hospital policy for a geriatrician to be present.

As referenced in the section above, this Trust aims to provide for quite a large rural hinterland by providing clinics in the community in order to ensure care is available closer to service users’ homes. Importantly, just about every speciality goes out to these clinics.

**Improving health services and priorities for action**

The interviewee argued that greater specialisation among clinicians was a positive development driving forward the standard of care. However he acknowledged that these specialised skills need to be blended into multi-disciplinary teams. Geriatricians are key members of this team combining, as they do, specialist knowledge of the way in which illness affects older people as well as quite generalist skills about the care expectations of older people.

In order to address the identified gap of providing sufficient psychiatric care for older people, the interviewee thought that ‘liaison psychiatry’ was vital. This role (‘Liaison psychiatrist’), which is not present in all Trusts is for a psychiatrist whose role is to refer service users on to other medical / health disciplines to ensure their care needs are being met. An example is of a patient with dementia being treated by the psychiatrist who can recognise another health problem being faced and refer them onto another clinician or worker (who may be in the health or social care setting) so as to get this condition / circumstance sorted.

The interviewee discussed the range of external organisations that influence his Trust’s workforce. He thought that the Strategic Health Authority was quite separated from them as they have Foundation status. This means that they report to Monitor who are the independent regulators of Foundation Trusts; nevertheless, “it's good to remain friends with the SHA as they commission the education”. The Royal Colleges produce a lot of research, much of which is valuable to the different professions however “none of it is binding”. Similarly with the more specialist societies such as the British Geriatrics Society. Their work is thought to be very useful if that is what you are interested in.
#38 - Acting Director of Nursing (Hospital Foundation Trust)

Understanding the interviewee organisation and context

The interviewee has responsibility for nursing staff across all surgical areas. She also has a wider corporate responsibility for all nursing staff with regard to workforce development activities, such as: working with universities on training activities; staff induction; training beyond registration (CPD); and ensuring that nurses are meeting NMC requirements and acting in accordance with professional standards. One element of this includes responsibility for managing complaints made by patients. This insight provided the interviewee with a clear perspective on the tenor of the Age UK aspirations.

One of the key challenges facing the Trust’s workforce – and nursing staff in particular – is managing what the interviewee saw as a shifting set of priorities in health over recent years in which the primary focus for her service (in surgical teams) is on acuity and optimising patient length of stay. This can mean that “we are less involved in the fundamentals of nursing care – unruished, well-communicated [patient engagement]”. This is felt to be a particular issue with regard to older people who may have longer recovery time (“people need their own time to heal”), which is something that is not necessarily recognised in the guidelines they work with (e.g. NICE guidance on observations in the acutely ill).

Meeting the aspirations: Assessment of the current situation

The aspirations are “perfectly reasonable”. The interviewee found it “almost sad that we’ve got to the point where these [aspirations] have to be spelled out”. The subtext was that the Age UK aspirations are not only an effective benchmark but should be a given in terms of how health professionals deal with patients.

The interviewee painted a picture of a Trust that has the systems (training etc) in place to ensure that there is sufficient support for staff development to meet the aspirations, but in which the financial/performance framework for day-to-day nursing mitigates against effectively delivering on the aspirations: “When I started nursing in the late-80s it was much less rushed”, but some of what the interviewee called the ‘quality’ priorities (“sitting down with patients”) is almost “frowned upon” and certainly subjugated to the needs of an efficient system.

In terms of how the needs of older people are considered as part of workforce design and development, the argument is that because older people form the large majority of service users in the interviewee’s area then they are core to all aspects of the service. The reality is though, according to the interviewee, that their specific needs can be lost. “We don’t have a care for the elderly service”, so there is no effective champion of their needs.

The interviewee was also worried that the organisation pays “lip service” to the notion of consultation with service users. The patient’s voice – especially that of vulnerable patients - may not therefore easily find its way into the system. Having said that, the interviewee did feel that the defined responsibilities for commissioners and the impact of the Darzi review were creating new expectations ensuring that patient needs are centre-stage.

The main weakness in terms of meeting the aspirations relates to having joined up care. “We’re not good at joined up care between primary and secondary services – people get lost in the system”. The interviewee gave the example of orthopaedics, where the hospital has two small wards predominantly populated with older people recovering from hip fractures. They have a ‘best practice pathway’, which they follow, but the reality is that they ‘struggle’ with domiciliary services and being able to great effective treatment in the community which would enable them to send patients home to recover. Partly, this was about a lack of resource – and whether there are sufficient non-acute physiotherapists and occupational therapists in the community (these are “Cinderella services”) but it was also about organisation (the interface between services) and recruitment (it is not easy to fill the posts that are there).

Improving health services and priorities for action

Pre-registration training (not just in nursing) now has so much content and information packed into it that some of the important competence development work gets passed over, even though it is core to healthcare roles. The interviewee agrees with the move to professionalise the nursing role to making it a degree-level role, but wondered whether it risked losing something of the apprenticeship-type development on the wards that would previously have been a larger part of initial training – and would have perhaps better-encompassed developing the broad communications-type competences related to the aspirations of older people (which are developed “at the bedside”).

Post-registration training also needs to “change radically” (as does pre and post employment training for unregulated healthcare assistants). They have the training and education strategy (“the opportunities are there”) - but lack sufficient content and struggle with delivery mechanisms. What is needed in terms of content are powerful patient testimonies. “Older people are too ubiquitous – we need to see the world through different eyes”. Some of that insight is lost within a CPD focus on the primacy of patient safety (how to prevent...
the spread of c diff. "It's more than customer care – it's about understanding how individuals respond". Day-to-day life on the ward can be so busy that they lack the "headroom" to stay in touch with these fundamental elements of care ("it's almost a behavioural model"). The related point is delivery mechanisms – “the training agenda often takes staff away from the ward environment – and that puts extra pressure on colleagues” (and reduces the likelihood of meeting patient expectations).

As part of her role, the interviewee signs off on complaints from patients about their treatment and a significant amount of it relates to simple communications: “I think that health professionals now are nervous about sitting down and talking to people”. More specifically, the interviewee felt that the “generation gap between my young nurses is greater than when I was 18 or 19”.

In relation to improved joined-up care, there is a long way to go. The Trust does a lot of work on internal teams and how they co-operate – but even here the focus tends to be on minimising the time spent dealing with patients rather than looking at whether the right carer is dealing with the right patient. Also, all professions in the hospital are guilty of talking a different language (“we can’t even talk to and understand each other...how is the patient meant to understand?”). There is therefore a gap in relation to co-ordination and communication. It is, though, important that responses here are bottom up: “there’s a lot said about working in collaboration, but when things come out (national policy etc) it sounds like you’re (the health professional) doing it wrong”. That’s not a helpful or entirely accurate message. It is much more effective to work at grassroots level (within an SHA area, within a Trust) to make the patient experience more seamless.
#39 - Assistant Director, Out of Hospital Care (Primary Care Trust)

Understanding the interviewee organisation and context

The interviewee is responsible for changing the shape of services within the Trust in light of its 5-year strategic plan. She works on the strategic and redesign element of commissioning with respect to long-term illness, old age and out-of-hospital care, with the exception of services for people with mental health problems or learning difficulties. The emphasis is therefore on community services. The trust is a commissioning organisation.

The major challenges facing the Trust’s workforce (which she defined broadly as including the provider organisations commissioned by the Trust, community organisations and third sector organisations) are:

- The ageing workforce. The organisation has found it is difficult to attract ‘new blood’ to work in the region.
- Partly due to the age demographic of the workforce, there is resistance to the rapid pace of technological change. There is a good deal of potential for technology to improve the services they provide, but “we need to think about what we can do to make our workforce more technology-savvy”.
- “It’s about the competencies of the workforce to deliver the new agenda” For example, personalisation of patient care means clinicians need to adapt to make decisions with patients rather than for them.

The ageing population is of particular concern for this PCT. Mobility and access is a regional issue as many inhabitants live in dispersed rural settings, with poor public transport. There are also significant numbers of care homes.

Meeting the aspirations: Assessment of the current situation

The trust recognises the need to take action and is already taking a number of steps to address the issues around older people’s care.

- Efforts are being made to coordinate with services outside of clinical care and even outside of the NHS, such as social care services and third sector organisations, and the county council.
- A large-scale public consultation took place with older people within the past few years. It yielded a large number of recommendations and an action plan. An older person’s partnership has been set up to for ongoing consultation on how the action plan is being carried out.
- Trials have also been ongoing for new methods to improve the lifestyle of frail and elderly people, such as telecare and teleshopping equipment, and a ‘Personal Health Advisor’, someone who is there to help guide older people through the process of receiving treatment and making decisions about their own care. These trials aim to reduce the number of unnecessary hospital admissions.
- A joint strategy with the county council – ‘Living Longer, Living Well’ – is looking at more preventative measures for older people’s care.

The interviewee fully recognised the aspirations – “they are all what I would see as very important for older people” – and picked up on ‘retaining control’ (which she translated into ‘healthcare in the community’) and ‘joined up care’ as having particular importance in her experience. She later went on to say that they should refer to all patients, not just older patients.

Through the trial that has been ongoing in the region, she believes there are core elements to their findings that link in well to the aspirations:

- Within the community, older people require an integrated care team of clinicians who talk to each other and know the people who are at risk.
- They also found that people wanted advocacy, advice and support. This is where the ‘Personal Health Advisor’ comes in, who can help not just with decisions relating to health care but also (for example) by suggesting power of attorney, or navigating the benefits system. This would map onto ‘joined-up care’ in an even broader sense than that expressed by the aspiration.

The interviewee picked up on the idea of face-to-face contact as particularly problematic for their region. Working under the new policy agenda, which includes heavy emphasis on reducing their carbon footprint, there are difficulties in visiting all people in need of care when they are so widely dispersed. She believes that there is a future in using technology to facilitate ‘face-to-face’ contact which is not necessarily in-person i.e. via some form of videoconferencing.

The interviewee did not feel able to comment on different strengths or weaknesses within the workforce itself, (“I would be doing them a disservice if I tried to say that group of people are better than that”) and largely spoke about it as a whole. The one example she provided was of community nursing staff “needing to be more aware of how to empower people”. The only general deficiency she identified was a widespread lack of awareness of the early signs of dementia.
Improving health services and priorities for action

Overall the interviewee felt there is a positive direction of travel, asserting that steps are being taken to fill the skills gaps in the workforce. The implication was that in implementing the strategy with the needs of older people in mind, as they are doing, the workforce would respond to new methods of delivering care.

Recognising these aspirations fully, however, will involve “a huge cultural change”. This process is already taking place, as the ongoing work “is a hook to hang something on”. This will need to occur both in terms of how NHS staff operate the system and treat their patients (i.e. in being more prepared to consult with the patients) and in terms of patients becoming accustomed to the idea of being more in control of their own care. In many cases older patients have been found not to want responsibility for making decisions about their own treatment.

She identified two improvements that need to be made to help bring this about:

- More needs to be done to measure output, in order to establish whether people’s aspirations are in fact being met. They already use a tool that monitors aspirations at the outset of a patient’s care and at the end of the process, which incorporates some aspects of Age UK’s aspirations. She suggested that these could be modified to incorporate the Age UK aspirations, and MI fed back to Age UK itself to help with the national monitoring of care for the ageing population.
- They need to work more closely with other organisations and align philosophies across them, “to work from a collective set of principles”.

Apart from data protection proving problematic for achieving ‘joined-up care’ in some cases, the interviewee asserted that there are no real barriers or inhibitors to achieving the aspirations apart from time. Despite commenting earlier on the difficulties of the economic situation, she did not feel that finances were an issue, as it is a case of just “moving resources around”.


#40 - Nurse Manager (Community Healthcare Provider)

Understanding the interviewee organisation and context

The interviewee is currently on secondment at the SHA, where she project manages a strokes programme. She works directly with colleagues at the SHA to coordinate the cardiovascular network, which links providers and focuses on service development. She will return in May to a management role within a community setting, with responsibility for a team of occupational therapists and physiotherapists.

The interviewee considers the major challenge facing both the SHA and PCTs to be “prioritising where resources are put given that the income to health and social care is not increasing whereas the older population is increasing rapidly”. She felt that there was “a lot of goodwill in terms of developing services for older people but a lack of commitment of resources”. For example, in the area of strokes, while there has been investment in admission and treatment, there have been limited resources invested in community settings and developing the skills of people working in those settings to be able to effectively meet the needs of older people. This results in patchy delivery of services to older people.

Another key challenge facing the workforce is the need to shift from a reactive approach to a “proactive, preventative approach”. The interviewee discussed three main issues related to this shift to prevention rather than treatment:

h. The older population is more prone to multiple risks such as poor mental health, incontinence and social isolation. The workforce needs to be able to identify potential risk and then be trained to address it.

i. A preventative approach requires reaching those who do not necessarily have medical problems and therefore will not ask for support from health services, but who may still be at risk. Identifying and accessing these people is very difficult.

j. Because of the difficulties of access and the increasing numbers of older people, more staff are required.

Meeting the aspirations: Assessment of the current situation

The needs of older people are considered through a systematic analysis and audit of data relating to KPIs such as acute admissions and numbers of bed days. Older people are more likely to become acutely unwell and by analysing the reasons for admission they can develop strategic plans about how to target resources for prevention activity. For example, their data shows that older people are most likely to be admitted to acute settings as a result of urinary tract infections, falls or exacerbation of long term conditions such as diabetes and therefore there has been a focus on these areas. Data analysis also highlights problem in particular geographic areas.

The interviewee described Age UK’s aspirations as “great – there’s nothing that’s a surprise here or anything new”. She reported that “we have been aiming to work toward this type of aspiration for some time”.

She felt that the aspiration for ‘face to face, personalised, flexible appointments’ was the one that is currently least well met by community settings. This is mainly due to limited resources to offer face to face visits to all housebound patients. She considered that as budgets are cut, there will be a greater move to providing support over the telephone. In terms of retaining control in the home, she feels that community healthcare settings have a clear focus on maintaining patients’ lives at home. Respect for preferences is an underpinning principle of patient owned care plans and the interviewee felt that most community healthcare staff have the skills to develop care plans collaboratively and to respect patient choice and preference.

The interviewee considers that an effective workforce that has the right skills to meet the aspirations of older people, will comprise a high proportion of nursing staff and allied health professionals in bands 3, 4 and 5. This is largely an issue of staff volume and cost effectiveness: staff qualified to higher levels e.g. bands 6 and above are more costly and therefore fewer can be employed, resulting in inadequate capacity to support demand for healthcare. While it is relatively easy to recruit nursing staff at these bands, there is a lack of occupational therapists and physiotherapists at these bands, because they tend to work to bands 6 or above. Therefore, although there is recognition that “a multi-professional workforce is the way forward, the workforce is still nursing dominated”.

In terms of the key roles, the interviewee highlighted the importance of patients being assessed by someone with a strong skill set who is able to assess need holistically, considering a range of clinical, physical and social needs, ranging from abuse, to risk of falls and need for socialising. A community matron would be an example of somebody undertaking this role. The interviewee would then expect nurses, physiotherapists and occupational therapists at bands 3 and 4 to form the “core workforce”. They would have core skills that include taking blood, taking blood pressure, assessing sitting to stand, assessing mobility issues, identifying the need for social activities, and washing and eating issues. As well as this knowledge, communication was seen as a core generic competency that is vital to building a good relationship with patients.

The interviewee felt that communication and interpersonal skills are generally good in community healthcare and that “going into people’s homes and having dedicated time to see patients helps this”. She felt that communication in acute and care home setting was less good and pointed to a specific gap in staff’s ability to
"undertake more complex communications, for example, with people who have dementia".

A major gap in skills and knowledge of community staff is the ability to recognise minor mental health problems, including anxiety and mild depression and to know how to support those patients for whom referrals to mental health professionals might not be necessary or appropriate.

The interviewee commented that skills within care homes are hugely variable and that "it is a workforce that has been ignored". Because they are largely private providers, the SHA has limited control and influence over them.

According to the interviewee, there have been positive developments in addressing skills gaps in recent years. For example, the "drive for training on dignity and working with vulnerable adults" has led to greater awareness of these issues and an increase in skills. Clinical leadership in the workforce (i.e. someone who can be responsible for ensuring that the needs of patients are met effectively by managing professional teams) has also improved significantly over the last two years since the introduction of community matrons.

Band 4 community health professionals are required to have completed a foundation degree in health and social care. The interviewee felt that this qualification equipped band 4 with excellent generic skills to support older people.

**Good practice:** Community Innovation Teams (CIT) were highlighted as an example of good practice. A CIT involves a social worker and a highly skilled nurse working together to deliver a proactive and preventative healthcare service. The model has been successful at "picking up people who don’t meet the criteria for social care" but who still have significant needs. Each team has a responsibility for around 200 people, which means that they gain detailed knowledge of the communities and populations with which they are working.

**Improving health services and priorities for action**

The interviewee felt that to affect a change in the workforce so that it is better at meeting the aspirations of older people, "there needs to be a change in attitude and mindset so we are not simply reactive but more proactive".

She highlighted incompatible IT systems as a barrier to effective joint working across health and social care, which means that, for example, social care assessments cannot be shared with health colleagues resulting in duplication of effort with assessments having to be re-done. Aside from data sharing issues, the interviewee considered that "health and social care work quite well together" when it comes to complex cases but that those who may be at risk but have less severe existing problems "are missed out because of lack of capacity". Therefore, reforming systems and improving compatibility should be a priority action.

Developing the skills of private sector health professionals should also be a priority. This is challenging because private sector staff are unlikely to leave the workplace for training and so more innovative solutions such as e-learning are required.

Another barrier faced by organisations is that "some older people don’t necessarily want support and may not feel that they have a need". The interviewee highlighted the tension between respecting a patient’s choice to be left alone and the need to avoid a crisis that results in admission to an acute setting and “their choice being taken away” inadvertently. She considered the voluntary sector to play an important role in addressing this issue because people may "have less of a concern about invasion of privacy" and may be more willing to accept services from the voluntary sector. Befriending services, for example, are effective at reaching isolated older people.

In order for real change to the workforce, there needs to be a clear national strategy set out by the new government, which will provide the structures and frameworks for local action. In the current context, GPs will mainly be responsible for local level implementation, and ensuring that services commissioned are delivered by staff with appropriate skills.

The audits undertaken by the Royal College of Physicians are considered to be “powerful” because they are detailed and ‘name and shame’ organisations. The interviewee felt that it was unlikely that busy operational managers would have time to access resources and support provided by Skills for Health and that, therefore, in most settings Skills for Health would be likely to work with learning and development managers within trusts.

NHS Education South Central (NESC) is a key stakeholder in workforce development in the South East. NESC has a service level agreement with the SHA to lead on training and education working on behalf of and in partnership with trusts and PCTs and funds pre-registration and postgraduate courses.
Annex 2 Relevance of job roles to older people

**Key:**

<table>
<thead>
<tr>
<th>Key</th>
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<tbody>
<tr>
<td>Specialist focus on older people</td>
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<tr>
<td>All age focus with older people a likely prevalent service user group</td>
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<tr>
<td>All age focus</td>
</tr>
<tr>
<td>Minimal engagement with older people / Non-service user-facing role</td>
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### Ambulance service professionals

<table>
<thead>
<tr>
<th>Ambulance Service Professions - 32,284</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified ambulance staff = 17,922; support to ambulance staff = 14,362</td>
</tr>
<tr>
<td>Ambulance care assistant</td>
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<tr>
<td>Ambulance technician</td>
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<tr>
<td>Call handler</td>
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<tr>
<td>Emergency care assistant</td>
</tr>
<tr>
<td>Emergency care practitioner</td>
</tr>
<tr>
<td>Emergency medical dispatcher</td>
</tr>
<tr>
<td>Paramedic</td>
</tr>
<tr>
<td>Patient transport services (PTS) controller</td>
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</table>

### Allied health professions

<table>
<thead>
<tr>
<th>Allied Health Professions</th>
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<tbody>
<tr>
<td>Arts, Music and Drama Therapists</td>
</tr>
<tr>
<td>Chiropodist / Podiatrist</td>
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<tr>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>Counselling psychologist</td>
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<tr>
<td>Diagnostic radiographer</td>
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<tr>
<td>Dietician</td>
</tr>
<tr>
<td>Forensic psychologist</td>
</tr>
<tr>
<td>Health psychologist</td>
</tr>
<tr>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Operating Department Practitioner</td>
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<tr>
<td>Orthoptist</td>
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<tr>
<td>Orthotist</td>
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<tr>
<td>Physiotherapist</td>
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<tr>
<td>Prosthetist</td>
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<tr>
<td>Speech and language therapist</td>
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<tr>
<td>Therapeutic radiographer</td>
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### Dental care professions

<p>| Dental Hygienist                          |
| Dental Nurse                              |
| Dental Technician / Technologist          |
| Dental Therapist                          |
| Dentist                                   |
| Maxillo-facial prosthetists               |
| Orthodontic Therapist                     |</p>
<table>
<thead>
<tr>
<th>Specialty</th>
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<td>Allergy medicine</td>
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<td>Audiological medicine</td>
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<td>Cardiology</td>
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<tr>
<td>Clinical Genetics</td>
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<tr>
<td>Clinical neurophysiology</td>
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<td>Clinical Pharmacology and Therapeutics</td>
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<td>Dermatology</td>
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<tr>
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<td>Gastroenterology</td>
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<tr>
<td>General (internal) medicine</td>
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<tr>
<td>Genito-urinary medicine</td>
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<tr>
<td>Geriatric medicine (aka gerontology)</td>
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<td>Infectious diseases</td>
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<td>Medical Oncology</td>
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<td>Medical Ophthalmology</td>
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<tr>
<td>Neurology</td>
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<tr>
<td><strong>Other</strong></td>
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<td>Palliative medicine</td>
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<tr>
<td>Renal Medicine (nephrology)</td>
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<tr>
<td>Cardiothoracic surgery</td>
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<td>General Surgery</td>
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<td>Neurosurgery</td>
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<tr>
<td>Opthalmology</td>
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<td>Otolaryngology</td>
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<td>Paediatric</td>
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<td>Plastic surgery</td>
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<td>Trauma and orthopaedic surgery</td>
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<td>Urology</td>
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<td><strong>Public health and community health medicine</strong></td>
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<td><strong>Psychiatry</strong></td>
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<td>Forensic psychiatry</td>
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<td>General psychiatry</td>
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<td>Learning disability</td>
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<td>Old age psychiatry</td>
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<td>Psychotherapy (can be provided by a number of different professionals)</td>
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<td><strong>Paediatrics and child health</strong></td>
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<tr>
<td>Paediatrician</td>
<td>7,620</td>
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<tr>
<td>Paediatric cardiology</td>
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</table>
### Obstetrics and Gynaecology – 5,440
- Gynaecologist
- Obstetrician

### Pathology – 4,252
- Chemical pathology – 240
- Clinical cytogenetics and molecular genetics – 18
- Haematology – 1,462
- Histopathology – 1,710
- Immunology – 105
- Medical microbiology and virology – 717

### Radiology – 3,580
- Clinical Radiologist – 3,497
- Nuclear medicine – 83

### Clinical Oncology – 1,107
- Clinical Oncology – 1,107

### Anaesthetics – 11,330
- Anaesthetist – 11,330

### Dental Group – 2,791
- Additional dental medicine specialties – 255
  - Oral and maxillofacial surgery – 1,231
  - Oral surgery – 286
  - Orthodontics – 550
  - Paediatric dentistry – 94
  - Periodontics – 22
  - Prosthodontics – 13
  - Restorative surgery – 313
  - Surgical dentistry – 27

### Accident and Emergency Medicine – 4,962
- A&E Doctor – 4,962

### General Practice – 40,269
- GP – 40,269

## Healthcare Science

**Healthcare Science**

<table>
<thead>
<tr>
<th>Life Science and Pathology</th>
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</thead>
<tbody>
<tr>
<td>Anatomical pathology technician</td>
</tr>
<tr>
<td>Biomedical scientist</td>
</tr>
<tr>
<td>Cervical cytology screener</td>
</tr>
<tr>
<td>Clinical biochemist</td>
</tr>
<tr>
<td>Clinical cytogeneticist</td>
</tr>
<tr>
<td>Clinical embryologist</td>
</tr>
<tr>
<td>Clinical haematologist</td>
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<tr>
<td>Clinical immunologist</td>
</tr>
<tr>
<td>Clinical microbiologist</td>
</tr>
<tr>
<td>Clinical scientist in haemostasis and thrombosis</td>
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</tbody>
</table>
**Clinical scientist in histocompatibility and immunogenetics**
- Community pharmacist
- Community pharmacy technician
- Hospital pharmacist
- Hospital pharmacy technician
- Molecular geneticist
- Primary care pharmacist

**Physiological sciences**
- Audiological scientist
- Audiologist
- Cardiographer
- Cardiological technician / Cardiac physiologist
- Clinical gastrointestinal physiologist
- Clinical neurophysiologist
- Clinical respiratory physiologist
- Critical care technologist
- Hearing therapist
- Optometrist / ophthalmic optician
- Perfusionist
- Physiological scientist

**Clinical engineering and physical sciences**
- Clinical / medical technologist
- Clinical engineer
- Medical Illustrator
- Medical physicist

**Health informatics**

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</thead>
<tbody>
<tr>
<td>Application analyst</td>
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<tr>
<td>Application and system developer</td>
</tr>
<tr>
<td>Computer support analyst / support desk engineer</td>
</tr>
<tr>
<td>Helpdesk adviser</td>
</tr>
<tr>
<td>IT training manager</td>
</tr>
<tr>
<td>Network Manager</td>
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<tr>
<td>Telecommunication manager</td>
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<thead>
<tr>
<th>Information management staff</th>
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</thead>
<tbody>
<tr>
<td>Auditor</td>
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<tr>
<td>Clinical coder</td>
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<tr>
<td>Clinical coding tutor</td>
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<tr>
<td>Information analyst</td>
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<tr>
<td>Information governance manager</td>
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<tr>
<td>Planning and performance manager</td>
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<table>
<thead>
<tr>
<th>Libraries and knowledge management staff</th>
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<tbody>
<tr>
<td>Head of archives and museums</td>
</tr>
<tr>
<td>Information assistant</td>
</tr>
<tr>
<td>Knowledge and information manager</td>
</tr>
<tr>
<td>Librarian</td>
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</tbody>
</table>
### Clinical infomatics staff
- Clinical infomation manager
- Patient archiving communication system (PACS) manager
- Pathology links manager

### Management

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<tr>
<th>Management</th>
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<tbody>
<tr>
<td>Clinical managers</td>
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<tr>
<td>Estates and facilities managers</td>
</tr>
<tr>
<td>Financial managers</td>
</tr>
<tr>
<td>General managers</td>
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<tr>
<td>HR/Personnel managers</td>
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<tr>
<td>Information managers</td>
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<tr>
<td>Practice managers</td>
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</table>

### Nursing and midwifery

<table>
<thead>
<tr>
<th>Nursing &amp; Midwifery – 417,164</th>
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</thead>
<tbody>
<tr>
<td>Midwifery</td>
</tr>
<tr>
<td>Consultant midwife</td>
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<tr>
<td>Midwife</td>
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<table>
<thead>
<tr>
<th>Nursing</th>
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<tbody>
<tr>
<td>Adult nurses</td>
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<tr>
<td>Children's nurses</td>
</tr>
<tr>
<td>Community matron</td>
</tr>
<tr>
<td>District nursing</td>
</tr>
<tr>
<td>Learning disability nurses</td>
</tr>
<tr>
<td>Mental health nurses</td>
</tr>
<tr>
<td>Neonatal nurse</td>
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<tr>
<td>NHS direct nurse</td>
</tr>
<tr>
<td>Nurse consultant</td>
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<tr>
<td>Occupational health nurse</td>
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<tr>
<td>Practice nurse – 21935</td>
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<tr>
<td>Prison nurse</td>
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<tr>
<td>School nurse</td>
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## Wider healthcare team

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<tr>
<th><strong>Administration</strong></th>
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</thead>
<tbody>
<tr>
<td>Admissions clerk</td>
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<tr>
<td>Clerks</td>
</tr>
<tr>
<td>Clinic clerk</td>
</tr>
<tr>
<td>Clinical record officer</td>
</tr>
<tr>
<td>Medical record clerk</td>
</tr>
<tr>
<td>Medical secretary</td>
</tr>
<tr>
<td>Personal assistant</td>
</tr>
<tr>
<td>Receptionist</td>
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<tr>
<td>Secretary</td>
</tr>
<tr>
<td>Telephonist / switchboard operator</td>
</tr>
<tr>
<td>Typist</td>
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<tr>
<td>Ward clerk</td>
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<table>
<thead>
<tr>
<th><strong>Domestic services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Catering manager/assistant catering manager/catering assistant</td>
</tr>
<tr>
<td>Chefs/head chefs/assistant head chefs</td>
</tr>
<tr>
<td>Domestic services manager/domestic services supervisors/domestic assistants</td>
</tr>
<tr>
<td>Housekeeper</td>
</tr>
<tr>
<td>Laundry managers/assistants</td>
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<table>
<thead>
<tr>
<th><strong>Corporate services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Architects</td>
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<tr>
<td>Chaplains</td>
</tr>
<tr>
<td>Engineers</td>
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<tr>
<td>Finance</td>
</tr>
<tr>
<td>Health Education/health promotion specialist</td>
</tr>
<tr>
<td>Hospital play staff</td>
</tr>
<tr>
<td>Human Resources</td>
</tr>
<tr>
<td>Librarians</td>
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<tr>
<td>Surveyors</td>
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<tr>
<th><strong>Estate Services</strong></th>
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<tbody>
<tr>
<td>Building workers</td>
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<tr>
<td>Caretakers</td>
</tr>
<tr>
<td>Electrician</td>
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<tr>
<td>Estates managers</td>
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<tr>
<td>Estates technicians</td>
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<td>Gardeners/grounds staff</td>
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<td>Plumbers</td>
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<td>Window cleaners</td>
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<th><strong>Support services</strong></th>
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<tr>
<td>Audiovisual technician</td>
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<td>Drivers</td>
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<td>Fire safety officer</td>
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<td>Messengers</td>
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<td>Porters</td>
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<td>Sterile services</td>
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<td>Storekeeper</td>
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<td>Clinical support staff</td>
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<tr>
<td>Arts therapy assistant</td>
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<td>Assistant dietician</td>
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<td>Assistant technical officers</td>
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<td>Counsellor</td>
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<td>Donor carer</td>
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<td>Healthcare assistant</td>
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<td>High intensity therapist</td>
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<td>Occupational therapy assistant</td>
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<td>Prosthetic technician</td>
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<tr>
<td>Psychological wellbeing practitioner</td>
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<tr>
<td>Radiography assistant</td>
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<tr>
<td>Speech and language therapy assistant</td>
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<td>Support, time and recovery worker</td>
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Annex 3 Interview topic guides

Stakeholder topic guide

**Background and context for interviewers:**
The aims of the interviews are as follows:

1. To understand how effectively the health sector workforce is meeting the needs and aspirations of older people;
2. To assess the nature of any gaps in terms of the knowledge, skills and competencies of the workforce;
3. To explore stakeholder views on the most effective levers and mechanisms for ensuring that the health sector workforce meets the aspirations of older people going forward.

Prior to the interview, interviewees will be sent a copy of the aspirations as background to the discussion.

Given the variety of organisations included in the stakeholder consultation and the complexity of the research subject area, the topic guide is structured in terms of a number of high-level discussion areas.

Interviews are confidential and specific comments will not be attributed to individuals / organisations in the report.

**Section 1: Understanding the interviewee organisation / context**

The purpose of this section is to gain a thorough understanding of the individual and their organisation, as well as establishing the links they and their organisation have with older people and workforce development.

1a) Confirm and explore the following (as necessary)

- Interviewee’s role and main responsibilities
- The organisation’s interest in, or role in relation to, workforce development in the health sector (Does the organisation have specific responsibility for workforce development? If so, what is the scope of this responsibility?)
- Any specific responsibility or interest in older service users

**Section 2: Assessment of current situation**

The purpose of this section is to assess how well older peoples’ aspirations are being met by the health sector workforce, to understand the nature of any gaps and why they exist.

Age UK has undertaken research into how the health sector is responding to the needs of older people and has defined a number of aspirations of older people. Introduce the nine aspirations (as necessary), acknowledging their broad nature. Age UK has suggested that at least six of the aspirations (*) relate fairly directly to the health workforce.
The aspirations for older people: Healthcare in the community: 1* Face-to-face, personalised, flexible appointments; 2* To retain control over their home; 3* Respect for preferences and belongings; 4* Company and the opportunity to be listened to; 5* Proactive healthcare and support; Healthcare in hospital: 6* Choice and control over daily routines; 7 A ‘connected’ relationship between staff and patients; 8 Maintenance of privacy in hospital; Healthcare across all settings: 9 Joined-up care

2a) What are your initial reactions to these aspirations?

Prompts:
- Are they meaningful, comprehensive and logical?
- When you hear these aspirations, do they resonate in terms of your understanding of the needs of older people?
- Do you agree that there is a significant workforce component to meeting these aspirations? (What is the interplay between workforce and other factors in meeting these aspirations? How significant is the workforce element overall here?)

2b) What is your perspective on the key considerations and most critical elements in terms of health services meeting the needs of older people?

Explore:
- The extent to which older people, as a broad group, have needs that are specific and differ from other service users (What are the common needs and expectations of users and where are the differences?)
- Understanding and perspective on specific needs of different groups within the older people category – e.g. frail older people; older people in specific contexts or with key specific characteristics; older people with co-morbidities (What are the key factors or characteristics of individuals that define need and expectations? To what extent is it meaningful to look at older people as a category of service user?)

2c) What are the key parts of the health sector workforce for delivering on and meeting the aspirations?

Prompt using our findings from Task 2 to test assumptions about the priority areas for action in terms of the workforce.

Explore:
- What is the more appropriate way of thinking about and making sense of the large and complex health sector workforce in terms of service provision for older people (e.g. within the NHS careers framework; distinguishing between different healthcare settings – community, hospital etc; distinguishing between areas of health activity – health promotion, treatment, care etc; distinguishing between types of service provider or service area)
- Also explore, if possible, the specific skills and competencies required across key parts of the workforce in this context

2d) To what extent is the health sector (and the health sector workforce specifically) meeting the aspirations of older people (as defined above)?

Prompts:
- Where are the gaps, how significant are the gaps and what are the implications of the gaps? Explore in terms of specific occupations and areas of health service provision.
- Is there a direction of travel in terms of whether these gaps are growing or narrowing? Are there other factors informing the aspirations of older people (and other users) over time (i.e. are the aspirations themselves changing?)

2e) What is the nature of any identified gaps?

Prompts:
- Why do these gaps exist? How widespread are they / how variable is practice? How confident can we be that they are (or are not) widespread? Explore again the interplay between workforce and other dimensions in contributing to gaps in meeting the aspirations of older people.
- What is the impact of these gaps in terms of the service experienced by older people and impact on level of care / outcomes?
- Specifically, how important are commissioners for shaping the experience of older people in the health sector? How well do you think they are meeting these aspirations? What should they be doing differently?

Section 3: Improving health services and priorities for action

The purpose of this section is to assess what levers and mechanisms the health sector has to affect change in its workforce to meet the aspirations of older people.

3a) What are the main barriers / challenges faced by organisations and clinicians in meeting the aspirations of older people?

Prompts:
- Financial barriers and resourcing
- Structural barriers (e.g. the boundary between health and social care) and cultural barriers (the organisational principles and established practises underpinning service delivery)
- Workforce barriers (recruitment practices; ensuring skills, knowledge and competency; the practicalities of planning, managing and delivering CPD)
- The degree of alignment or disjuncture between health policy (i.e. the role and influence of DH, SHAs, etc) and what is expected by older people (the interplay between the key current health policy drivers and the aspirations of older people). Discuss with reference to health policy developments such as the focus on: personalisation; preventative (as opposed to restorative) care; increased emphasis on community provision; providing care in the home.

3b) What kind of changes or interventions do you think would help to meet the aspirations of older people? Who needs to do what to ensure that these aspirations become or remain a reality?

Explore in terms of:
- Policy developments: at what level (e.g. Trust / Regional / National)?
- Organisational or service delivery changes (e.g. care provision shifted to community locations)
- Workforce redesign:
  - New roles
  - Greater specialisation / generalisation among key workers
  - Upskilling / reskilling key groups
- Ensuring effective support for workforce development and consistency of approach to workforce development (across service areas, occupations and organisations)

3c) How effectively does the workforce planning infrastructure in the health sector operate?

Prompt:
- Are changes in national / regional strategies reflected accurately with changes to the workforce?
- How well are older people’s needs represented in the prevailing workforce strategies? If there is a gap here, why?
  What are most effective levers for supporting workforce development ‘on the ground’ and how does that vary across the sector?

3d) For those with an overview of workforce strategy: Which organisations are most influential in relation to workforce improvement?

- Are the SHA / Trust workforce strategies influential?
- Are the professional bodies influential on particular parts of the workforce?
- Which organisations do you pay most attention to when making decisions about your workforce?

3e) What is your understanding of the work of Help the Aged/Age Concern/Age UK? Where and how can it most effectively influence this agenda?

Finally, are there any other areas that we have not covered that you feel are important in terms of understanding how the health sector workforce meets the needs of older people
Practitioner topic guide

Background and context for interviewers:
The aims of the interviews are as follows:

1. To understand how effectively the health sector workforce is meeting the needs and aspirations of older people;
2. To assess the nature of any gaps in terms of the knowledge, skills and competencies of the workforce;
3. To explore views on the most effective levers and mechanisms for ensuring that the health sector workforce meets the aspirations of older people going forward.

Prior to the interview, interviewees will be sent a copy of the aspirations as background to the discussion.

The aim of the interviews is to provide a more detailed understanding of current practice in relation to workforce development and how organisations within the health sector consider and respond to the needs of older people.

Begin by explaining that:

GHK has been commissioned by Age UK to conduct a research study into how well the aspirations of older people are being met by the health sector workforce.

Interviews are confidential and specific comments will not be attributed to individuals / organisations in the report.

Section 1: Understanding the interviewee organisation / context
The purpose of this section is to gain a thorough understanding of the individual and their organisation as well as establishing the links they and their organisation have with older people and workforce development.

1a) Confirm and explore the following (as necessary)
   - Interviewee’s role and main responsibilities
   - Type of organisation.

1b) What are the major challenges facing your Trust’s workforce in the next five years?

1c) How important is the ageing population to your Trust’s strategic decisions and workforce strategy in the next five years?
   - Why? What is the nature of the challenge here (Financial / workforce / organisational / cultural)?

Section 2: How is the health sector workforce meeting the aspirations of older people?
The purpose of this section is to gain an understanding, at a more localised level, of what the Trust is doing to meet the aspirations of older people.

2a) How, if at all, are the needs of older people (as service users) considered when thinking about workforce design and development?
- Is there a systematic approach? Does it fall within a generic set of skills, knowledge and competencies? Is it an issue for particular parts of the organisation (which and why?)

Age UK has undertaken research into how the health sector is responding to the needs of older people and has defined a number of aspirations of older people. Introduce the nine aspirations (as necessary), acknowledging their broad nature. Age UK has suggested that at least six of the aspirations (*) relate fairly directly to the health workforce.

The aspirations for older people: Healthcare in the community: 1* Face-to-face, personalised, flexible appointments; 2* To retain control over their home; 3* Respect for preferences and belongings; 4* Company and the opportunity to be listened to; 5* Proactive healthcare and support; Healthcare in hospital: 6* Choice and control over daily routines; 7 A ‘connected’ relationship between staff and patients; 8 Maintenance of privacy in hospital; Healthcare across all settings: 9 Joined-up care

2b) Do you recognise these aspirations? Are they a logical and coherent way of thinking about what an effective benchmark for the health workforce should be in relation to older service users?

2c) To what extent is your organisation meeting the aspirations of older people (as defined above)?
- Explore the rationale and evidence for the response here.

2d) Looking across the workforce, where is the greatest need and what are the most significant areas (occupations; roles; service areas) for ensuring that the aspirations of older people are met?
- To what extent are skills gaps generic (i.e. present across the workforce) or specific?

2e) What evidence do you look for to ensure sufficiency / appropriateness of any generic skills and competencies (re. communications, interpersonal etc)?
- Who manages this – is it down to specific occupations / service areas (e.g. in terms of the due emphasis placed on these skills and competencies)?
- How does it inform staff development and how does that vary (CPD etc) across occupations and service areas?

2f) What would you consider to be the 2-3 main staff groups (as defined by the interviewee) that are least prepared in terms of meeting the aspirations?
- How significant are the gaps here and what are the implications of the gaps? What is the impact of these gaps in terms of the service experienced by older people and impact on level of care / outcomes?
- Is there a direction of travel in terms of whether these gaps are growing or narrowing? Are there other factors informing the aspirations of older people (and other users) over time (i.e. are the aspirations themselves changing?)

2g) Why do these gaps exist and how are they changing over time?
- What is the interplay between workforce and other dimensions in contributing to gaps in meeting the aspirations of older people?

2h) In relation to the groups identified under 2d and 2f, how do the aspirations for older people translate into (or map across to) the specific skills, competencies and knowledge that you expect in relation to these groups / roles?
- Discuss, as feasible / appropriate, in the context of: defined job roles; person specifications; ensuring occupational competence; workforce development activities
- Explore also if there are any gaps relating to professional requirements and occupational standards
- What skills and competencies do you consider to be the most important in meeting the needs of older people?

2i) What does good practice in relation to the provision of health care for older people look like?
- Can you provide any examples of good practice in provision of services for older people? What makes these examples notable, and how replicable are they in practice?

Section 3: Improving health services and priorities for action
The purpose of this section is to assess what levers and mechanisms the health sector has to affect change in its workforce to meet the aspirations of older people.

3a) What, in your view, needs to be done in order to address the identified gaps in relation to meeting the needs of older people? Discuss in relation to the following:
- i) Understanding of the needs of older people (within the organisation)
- ii) Understanding of how older people interact with the organisation
- iii) Ensuring that there are the appropriate building blocks for effective workforce development (e.g. workforce strategy; professional requirements; cross-cutting training activities and CPD)
- iv) Ensuring occupational and professional competence across the workforce in practice

3b) What are the main barriers / challenges faced by organisations and clinicians in meeting the aspirations of older people?
Prompts:
- Financial barriers and resourcing
- Structural barriers (e.g. the boundary between health and social care) and cultural barriers (the organisational principles and established practises underpinning service delivery)
- Workforce barriers (recruitment practices; ensuring skills, knowledge and competency; the practicalities of planning, managing and delivering CPD)
- The degree of alignment or disjuncture between health policy (i.e. the role and influence of DH, SHAs, etc) and what is expected by older people (the interplay between the key current health policy drivers and the aspirations of older people). Discuss with reference to health policy developments such as the focus on: personalisation; preventative (as opposed to restorative) care; increased emphasis on community provision; providing care in the home.

3c) Internally, who needs to do what within the organisation in order to support workforce improvement in line with the aspirations of older people?

3d) Which are the most influential external organisations and strategies influencing workforce development in this context?
- Professional organisations / Royal Colleges; National / regional policy makers (DH; SHA); other skills-related organisations (e.g. Skills for Health) etc.
- What roles do these organisations play in practice and how do you engage with them in the context of workforce development

Finally, are there any other areas that we have not covered that you feel are important in terms of understanding how the health sector workforce meets the needs of older people
Annex 4 Analytical framework

Below we outline the analytical framework used for the scoping review elements of the assessment of Healthcare Workforce Skills and Competencies for an Ageing Workforce.

The framework provided a mechanism for understanding and organising the diverse information and intelligence base to be incorporated in the literature review (Task 2). It also provided an entry point for relating this information to the more detailed skills and competency mapping (Task 3).

The framework is organised as a series of levels of analysis shaped around the six main aspirations of older people. The levels of analysis are as follows:

- The 'top down' drivers influencing current practice, primarily policy-related.
- Current practice – understood in terms of a map of the healthcare workforce and its importance in terms of engagement with older people and alignment with the six aspirations (this provides the basis for understanding gaps and priorities for action).
- The levers available for influencing future practice, focusing on the workforce elements but acknowledging that these are mediated by various organisational factors.

The framework outlines some of the key research questions relating to each level and traces this back to our research tasks. The framework also outlines a series of cross-cutting questions that ran, as a thread, throughout the research.
<table>
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<tr>
<th>LEVELS OF ANALYSIS</th>
<th>THE ASPIRATIONS OF OLDER PEOPLE</th>
<th>KEY RESEARCH QUESTIONS</th>
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<td>Cross-cutting</td>
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The aspirations of older people are categorized into levels of analysis as follows:

**Face-to-face, personalized and flexible**
- Retaining control over the home environment
- Respect for home life and belongings
- Company and the opportunity to be listened to
- Proactive healthcare and support
- Choice and control over daily routines

**Key Research Questions**

*NB: We use the term 'aspiration' below as a shorthand relating to meeting the specific needs of older people*

Relevance of policy by aspiration (Task 2)
- How policy supports or acts as a potential barrier to each aspiration (Task 2)

**Cross-cutting research questions**

1) Understanding the workforce influence on the six aspirations:
- Interplay between workforce factors and other factors

2) Significance of the aspirations across the workforce:
- Identifying the older-person specific elements of generic ambitions and goals

3) Making the links between the workforce and the six aspirations:
- The actual workforce translation (in terms of skills, competencies, and knowledge) of the aspirations of older people.

**Key Drivers Influencing Current Practice**

Policy drivers
- Outline of key national policy drivers (white papers/green papers)
- Outline of sub-national or sub-sectoral workforce policy drivers (strategies etc)
- Other drivers (e.g. demographics, patient demand, financial constraints in the health sector)

**Identification of Need / Assessment of the Current Landscape**

Disaggregation of the health workforce by career grouping:
- Allied Health Professionals; Ambulance service professions; Dental care professions; Doctors; Healthcare science; Health informatics; Management; Midwifery; Nursing; Wider healthcare team

Disaggregation of the workforce by job role and clusters of job role
- Workforce size by job role
- Availability and use of professional standards and requirements by job role
- Skills and competencies by job role

Disaggregation of the workforce by Standard Industrial Classification (SIC) code

Disaggregation of the workforce by level (1 – 9)

**Key Research Questions**

- Workforce map of engagement with older people (Tasks 2/3, verified through Task 5). Classification of engagement:
  - Specialist focus on older people;
  - All age focus with older people as a likely prevalent service user group;
  - All age focus;
  - Minimal engagement with older people / Non-service user-facing role

- Identifying key job roles/occupations (Tasks 2/3)
- Links between skills and competencies and the six aspirations, plus the identification of gaps (Tasks 3, 4 and 5)

**Lever for Change**

Organisational and cultural influence:
- Organisational typologies: NHS (different types of NHS Trust, SHAs); independent; third sector
- Structure of local service delivery
- Do workforce strategies influence at the organisational level?
- How to affect workforce changes in the health sector (using Planning and developing the NHS workforce: the National Framework as the start point).

**Key Research Questions**

- Variability in existing practice across organisations (Tasks 4/5)
- Nature of this influences – how and whether it supports or acts as a barrier to meeting the aspirations (Task 5)

Workforce levers:
- Professional regulation
- Qualifications and other training and skills development programmes
- Decision-making regarding service design and organisation
- Role redesign (by competence)

**Key Research Questions**

- How to address identified gaps and current direction of travel (Tasks 4/5)
- How the meeting of the six aspirations is influenced by external (non-workforce) factors (Task 5)
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