Enhanced Care for Older People (EnCOP)

Competency **D**evelopment **F**acilitator Guide

Acknowledgements

The EnCOP team are thankful to James Wade and Sue Tiplady, Northumbria University, for sharing their expert knowledge about learning, development and practice assessment which has contributed to the development of this guide.

Purpose and Background of EnCOP:

The main aims of EnCOP are:

- **To support the delivery of high-quality care**

EnCOP is based on the latest evidence and best practice guidance and therefore reflects the knowledge, skills and behaviours that are required in order to deliver high quality care

- **To support us to be able to be able to work together to deliver timely, responsive care**

A key focus of EnCOP is to support and promote effective interprofessional and inter-organisational care. Defined competencies are outlined in relation to this

- **To recognise older people's care as a specialism in its own right**

Many people underestimate the levels of knowledge, skill and experience that are required to meet the care needs of the older population, particularly those living with more advanced levels of frailty. This framework aims to outline all that is required, and provide a framework for professional development

- **To ensure consistency across the system**

Organisations can use EnCOP as a benchmark for good practice, to promote high quality care for older people wherever they are being cared for. The ambition is to implement EnCOP across different providers, including the NHS., Social care, and in the private sector e.g., care homes and domiciliary care providers to improve care for all

The framework has 4 keys areas:

Each of these areas has 1 or more domains within it, with the bulk of the framework focussing on section D: Knowledge and Skills for Care Delivery. There are **15 domains** in total which are broken down into performance indicators to support assessment in practice and competency achievement. Each domain is separated into 3 levels: essential, specialist and advanced.

Although not prescriptive, the following gives an indication of what might be expected at each level:

Essential – Awareness, understanding and some application in practice

Specialist – Role model, comprehensive knowledge, applies evidence base in practice, some analysis and some evaluation

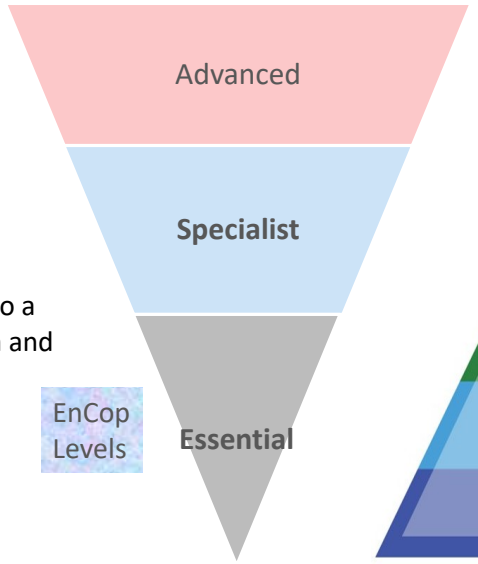
Advanced – Expert in field, designing, monitoring and evaluation are key components in role, engaged with research type activity

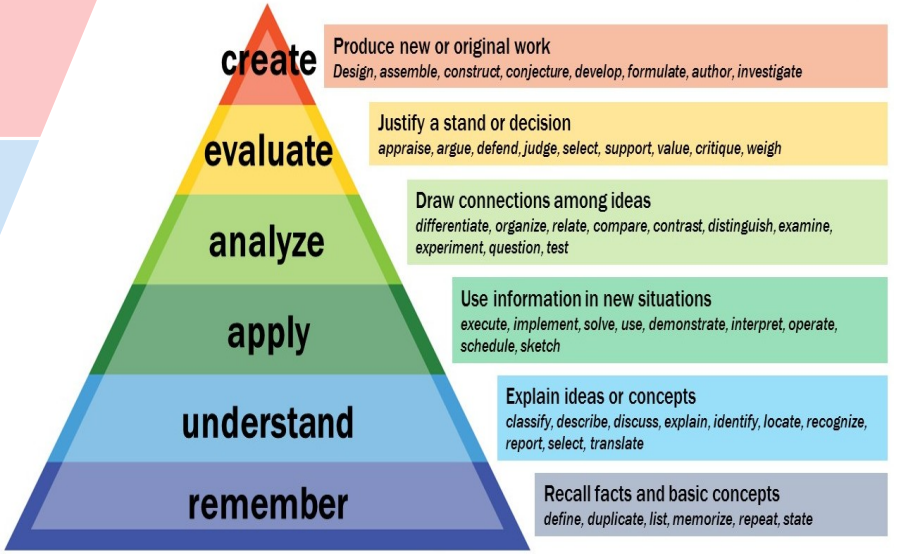
Performance Indicators (PI's)

The performance indicators within the EnCOP domains are based on Blooms Taxonomy (1956), a recognised hierarchical educational model which supports the acquisition of knowledge. e.g. thinking, learning and understanding.

Objective assessment using PI's

- This knowledge acquisition reflects the expanding and cumulative level of knowledge and its application to practice at each EnCOP progressive level
- PI's offer a set of objective measures of achievement for each domain
- They are broad enough for them to be applied to a range of roles and across a wide range of health and social care settings
- There may be some overlap between the levels, however
- this is useful in identifying progression towards the next level





EnCOP Key Principles:

- Everyone should aim to achieve all competencies within the 'essential' level
- Some individuals may have competencies from more than one level, relevant to their knowledge, skills and behaviours
- Through the cycle of competency assessment and review, areas for development can be identified. On an individual basis, this knowledge can support personal development and career progression

Adult Learning Theory

The delivery of EnCop is based upon the principles of adult learning theory. That is adult learners:

- Need to know why they need to learn something
- Must control what, when, and how they learn
- Need to learn through their experiences

Therefore, outlining the aims and objectives of EnCOP are important to ensure staff understand how it's use is of benefit to them, and their professional development. Staff should be encouraged to direct the process of competency review and work with facilitators to identify potential learning opportunities, as required.

Learning Styles, According to Honey and Mumford, (1986) there are four distinct learning styles,

1) Activists: enthusiastic optimistic people who like to get stuck in and learn by doing- typically 'act now think later'
2) Reflectors: prefer to observe and think about things before doing anything. Look at the wider picture
3) Theorists: analytical people who like doing things methodically to try and reach a deeper understanding
4) Pragmatists: practical people who look for the quickest way to solve problems

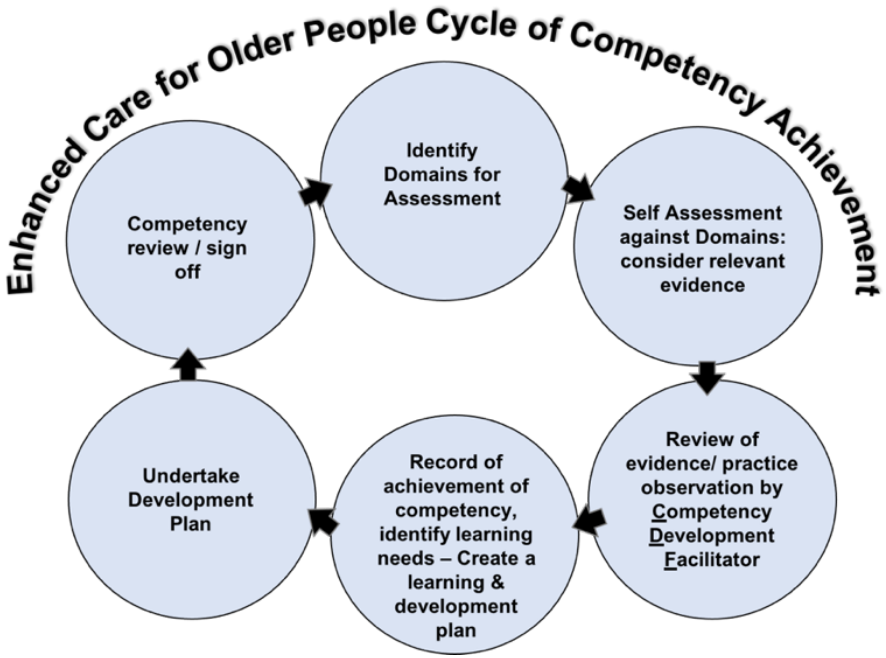
Key characteristics	Potential Drawbacks
Activists	
✓ Philosophy: enjoy the 'here and now' ✓ Enjoy getting stuck in! ✓ Optimistic about anything new ✓ Less likely to resist change	➢ Prone to take unnecessary risks ➢ Tendency to do too much themselves rather than delegate ➢ Can often get bored with 'implementation and follow through'
Reflectors	
✓ Philosophy is to be cautions, careful and methodical ✓ Thoughtful people, often take a backstage in meetings ✓ Often hold a low profile / distant	➢ Tend to refrain from direct participation ➢ Slow to make a decision ➢ Tendency to be over cautious – not willing to take risks ➢ Not necessarily assertive
Theorists	
✓ Philosophy – 'if it's not logical it's not good' ✓ Often tend to be perfectionists, needing things to 'fit' to be rational ✓ Can be detached and dedicated to 'objectivity' rather than ambiguous subjectivity ✓ Good at asking probing questions	➢ Restricted in lateral thinking ➢ Little tolerance for uncertainty and ambiguity ➢ Distrustful of anything subjective or intuitive ➢ Full of 'should, ought's and musts'
Pragmatists	
✓ Philosophy 'there is always a better way' ✓ Like to just get on, acting quickly and confidently	➢ Can often be impatient and prone to ruminating over open-ended discussions ➢ Not very interested in theory or basic principals ➢ Impatient with indecision ➢ More task than people orientated

Most people have strong preference for one of these but can draw on all elements to learn. It is important to consider your learning style as a facilitator, as well as the learning styles of the people you support, in order to have mutual respect and to guide them to the right learning opportunities and experiences.

<u>Competency, Practice Assessment & Competency achievement</u>.

The assessment, review and sign-off of EnCOP competencies should be completed using a collaborative, partnership approach between the staff member (assessee) and the **C**ompetency **D**evelopment **F**acilitator [CDF]. **Workforce competency** is defined within EnCOP as *"the ability to apply knowledge and skills in an appropriate manner, underpinned by appropriate attitudes / values, to achieve an occupational function"*.

The EnCOP Cycle of Competency Achievement is an iterative process and should be followed continuously throughout the assessment process



EnCOP Criteria for assessment

EnCOP is not role specific but generally speaking ……

LEVEL	DESCRIPTOR
Essential	**Applies to all staff within adult health and social care or other sectors who provide care to older people in all care settings**
Specialist	**Staff who work with a high degree of autonomy and have specialist knowledge relating to the care of older people**
Advanced	**Experts and leaders in the care of older people who influence change and improve service provision for older people**

Effective implementation of EnCOP is underpinned by the principles of sound assessment which require the process to demonstrate:		
VALIDITY	**RELIABILITY**	**PRACTICALITY**
Opportunities for assessment and methods / evidence used relate to the performance indicators within the assessment framework	There is consistency of approach to assessment by CDF'S with the relevant knowledge and competence in the care of older people and practice assessment	Both the performance indicators, assessment tools and modes of EnCOP assessment are relevant to practice and easy to apply

Assessment is something you do 'with' someone rather than 'to' them

For effective practice assessment think about:

- ✓ Who are you assessing?
- ✓ What are you assessing?
- ✓ What evidence of learning is required?
- ✓ How will learning be assessed

Top Tip - Be consistent in your methods of assessment whilst flexing and adapting to your learners (assessee) style. Think of your role as a supporter and encourage the assessee to take ownership of their own learning

Skills for Self-Assessment

Person-Centered Care:

Self-assessment is a natural and essential starting point when using the EnCOP framework. It makes us think about what we do at work, how we do it and how our health and social care colleagues, and most importantly, the older people we work with (and their families) see us. **As health and social care staff, studies tell us that we need to feel valued as individuals, to deliver high-quality person-centered care to older people**

Preparing yourself for self – assessment against EnCOP

- Becoming familiar and comfortable with the EnCOP assessment framework is crucial to be able to support others with competency achievement
- Begin with becoming acquainted with the EnCOP domains and sub-domains and the key components associated with EnCop levels. **Self – assessment is the best starting point to help you feel at ease with EnCOP**
- Avoid overkill or feeling overwhelmed, by starting with one domain. EnCOP is about individual learning and development so select a domain you feel most confident and comfortable with
- Remember as you begin to review yourself and your evidence, it may become clear that you have evidence that applies to more than one domain

ASK YOURSELF

- Are there any obvious areas of learning and development?
- Which EnCOP domain am I reviewing / mapping myself against?
- What are the essential performance indicators?
- What evidence do I have of achievement?

Consider: 'How do I do that? 'Why do I do it that way?'

Always try to be open and honest with yourself!

Key points about self – assessment

- It can be difficult to do initially
- As humans we can tend to under or over rate ourselves
- How we see ourselves may not always be how other people see us
- The more you do it, the easier it gets!

REFLECTIVE PRACTICE

Reflective practice is critical and deliberate inquiry into practice in order to gain a deeper understanding of oneself, others and the meaning that is shared among individuals (Peters 1991, Schon 1983)

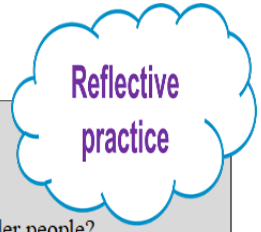
When do we reflect?

- ✓ During Practice
- ✓ After the fact
- ✓ Alone or with others

Adapted from Gibbs' Reflective Cycle, (1988)

Using a reflective model, either formally or informally, can support the process of learning through experience, for example after a positive experience or outcome, critical incident, complaint or complex interaction

Using EnCOP to support reflective learning



Using the EnCOP domains and performance indicators

Think about:

- What do I do within my job that makes a positive impact for older people?
- Do I apply the right evidence, knowledge and experience to my day to day practice?
- Do I recognize my own feelings and assumptions when I am working with a variety older people and their families OR in interactions with my own team or other colleagues?
- How can I use incidents and mistakes to learn and improve the care I deliver to older people?
- What are my development needs in relation to EnCOP and are there opportunities to progress across the EnCOP levels?

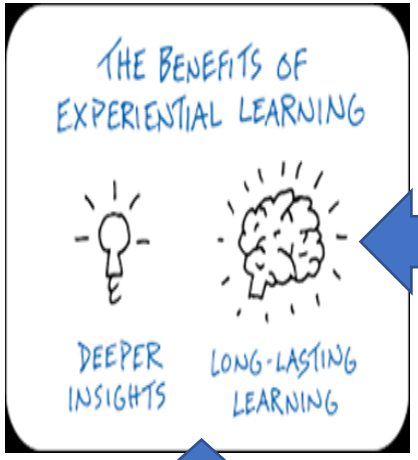
TOP TIPS for reflective learning

- Some people find it useful to keep a reflective diary or journal of experiences. This could support EnCOP assessment and review
- Consider writing up reflections and analysis of situations which have triggered reflection, do this as soon as you can
- Use actual dialogue wherever possible to capture the situation accurately and realistically
- **Always balance problematic experiences with good experiences** - celebrate the positive impact you make**,** reflection is not just about learning from mistakes
- Use EnCOP as a tool to challenge yourself about something that you normally do without thought or take for granted – this keeps you up to date with evidence- based care for older people and can stimulate great ideas for improving care

Evidence for EnCOP Competency Achievement

Collecting evidence:

- *Working with older people across a variety of health and social care settings is valuable, rewarding, and attractive but also very often demanding, fast -paced and challenging therefore collecting evidence for EnCOP should not be onerous and burdensome*
- *There will be lots of work products and examples of feedback and scenarios found within your day-to-day work that you can either use to demonstrate competency or as the basis of reflection with your EnCOP assessor*



Consider:

Do you recognise learning in practice?

Do you make time for reflection?

Examples:

On the job experience

Case-based discussion

Shadowing others

Self-assessment

Peer review

Client feedback

Teamwork- feedback from others (multisource)

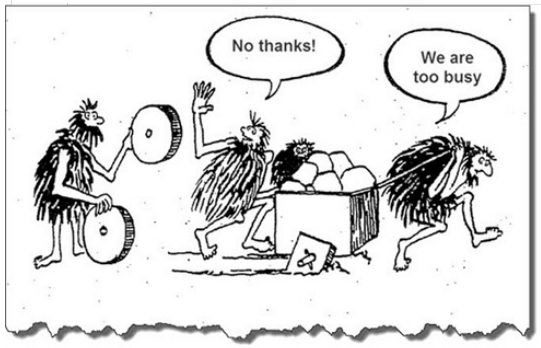
Appraisals

Work products

Direct observation of practice

Reflection on training into practice

CROSS REFERENCING EXISTING EVIDENCE



- *EnCOP is not about re-inventing your knowledge & experience …it's about **applying it to the needs of older people***
- ***You will** have **examples of prior learning or development** activities that you have undertaken or participated in that can be used or adapted to review against EnCOP*

Checkpoint:

Is my evidence contemporary? Is it relevant to EnCOP?

Examples:

Appraisals/ PDP's

Care Certificate / NVQ

Prior Practice Assessor / Practice Supervision

Preceptorship

Professional Supervision Sessions

Continuous Professional Development (CPD)

Nursing & Midwifery Re-Validation

HCPC Audit

Advanced Clinical Practice Award

Professional & Academic Portfolio's

Leadership Awards

Formal and Informal Qualifications

Some assessment techniques can make us feel apprehensive and even a little uncomfortable. However, with supportive preparation and skilled facilitation, they have great potential to provide effective and comprehensive feedback, as exampled below:

SEEKING FEEDBACK FROM OTHERS: *It is human nature to welcome positive feedback about ourselves and our work, and most of us appreciate it, more so if it is well thought out and genuine rather than just flattery. The first step to seeking feedback is to decide what you want it for and who can provide the most useful feedback*

Ask yourself:

- **What exactly do you need feedback on & how will you use it?**
  The performance indicators within EnCOP and your own learning & development plan should help to guide this

- **What specific questions should you ask to get the most focused and useful answers?**
  E.g., How would you describe my contribution within the MDT meeting? What specifically am I doing well when I communicate with older people and what would be even better?

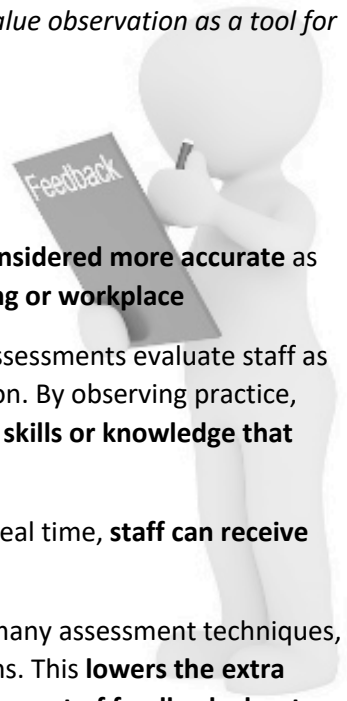
- **Are you seeking feedback from the right sources?**
  Who will be most honest? Who will have the most insight? Who is the most trustworthy? Do they understand why I need feedback?

Top Tip:

Don't forget to seek upward, peer and lower-level feedback *(360-degree feedback is a particularly useful tool to do this)*

DIRECT OBSERVATION OF PRACTICE (DOP)

Observational assessment within health and social care settings can provide several specific benefits. Encouraging staff to value observation as a tool for improving practice is a good thing to do.



The advantages of this method of assessment include:

1.Reliability: Observational assessments are **considered more accurate** as they take place in the **context of the care setting or workplace**

2.Direct Practice of an Action: Observational assessments evaluate staff as they are immersed in the actual work in question. By observing practice, **CDF's can support identification of any gaps in skills or knowledge that need to be filled.**

3.Results: Since the assessment takes place in real time, **staff can receive immediate feedback and respond accordingly**.

4.Assessments Take Place on the Job: Unlike many assessment techniques, DOP occurs in the workplace, often within teams. This **lowers the extra demands on time for CDF's and increases the impact of feedback about the individuals' strengths**

5. Ideal for Assessing Teamwork: EnCOP recognises teamwork and collaborative ability as essential for good care. DOP is **especially well-suited to evaluating teamwork and collaborative skills**

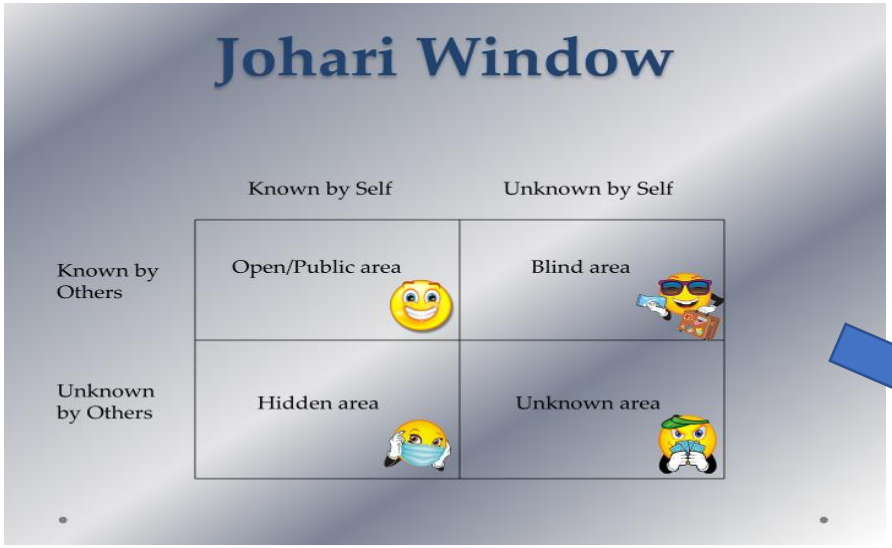
Reflect:

- ✓ On both the positive and developmental areas of the feedback
- ✓ What feedback was expected and what came as a surprise? This helps to link feedback to what you know already and in what areas you need to become more self-aware
- ✓ By increasing your self awareness, feedback sessions become easier & more productive

When giving feedback we assume people 'must know' the strengths and weaknesses that sit in their blind spot. When we receive feedback, if the feedback is not specific and real, we might fail to see areas that fall in our blind spot.

The **Johari Window** is a useful model to **increase self-awareness** and your **understanding of how you interact** with others and can also be a **useful tool to provide productive feedback to others.**

'Exercise' Using the model, list adjectives that describe you and ask your assessor to do the same. These adjectives are then mapped onto a grid as below and can be used to either guide self-reflection or frame feedback.



Luft, J. and Ingham, H. (1955)

Open

Represents what is known by you about you, which others also know about you e.g. I know I speak quickly, and others notice that too

Blind spot

Represents things you are not aware of about yourself, although these things are apparent to others e.g. You know I am good at putting people at ease, but I didn't realise that about myself

Hidden

Refers to things you know about yourself which you do not reveal to others e.g. I used to provide training to others in my old team and wish I could teach others more in this role

Unknown

This represents things about a person that are unknown both to themselves and to others. This area is normally left to professional mediators to deal with because neither party are aware of why the issue has happened and it may often need professional analysis

Reviewing your own Johari Window

Blind spot: Is there a mismatch between the view you have of yourself and how others see you?

Hidden: Would more disclosure improve trust and relationships? Are there any hidden or undeveloped talents or potential?

Approaches to consider when supporting assessee's within the EnCOP Cycle of competency achievement

Coaching

What is coaching?

- It is essentially a non-directive form of development
- It focuses on improving performance and developing individuals' skills
- Personal issues *may* be discussed but the emphasis is on performance at work
- Coaching activities have both organisational and individual goals
- It provides people with feedback on both their strengths and their weaknesses
- Usually coaching would be for the short term

6 Principles of coaching

- ✓ Coachee has the ability to resolve their own situation
- ✓ Coach's role is not to give advice
- ✓ The Coachee sets the agenda
- ✓ Coaching is designed to bring out the best in already effective people
- ✓ Coaching is confidential where agreed
- ✓ People are capable of infinitely more than they believe

Active listening is a core skill to be an effective coach. How would someone know that you are *really* listening to them?

Active listening involves paying attention to what the other person is saying. To acknowledge that you are engaged in the conversation you can nod your head, make 'mmm' sounds and use encouraging words such as 'yes' and 'I see'. (Skills for Care, 2018).

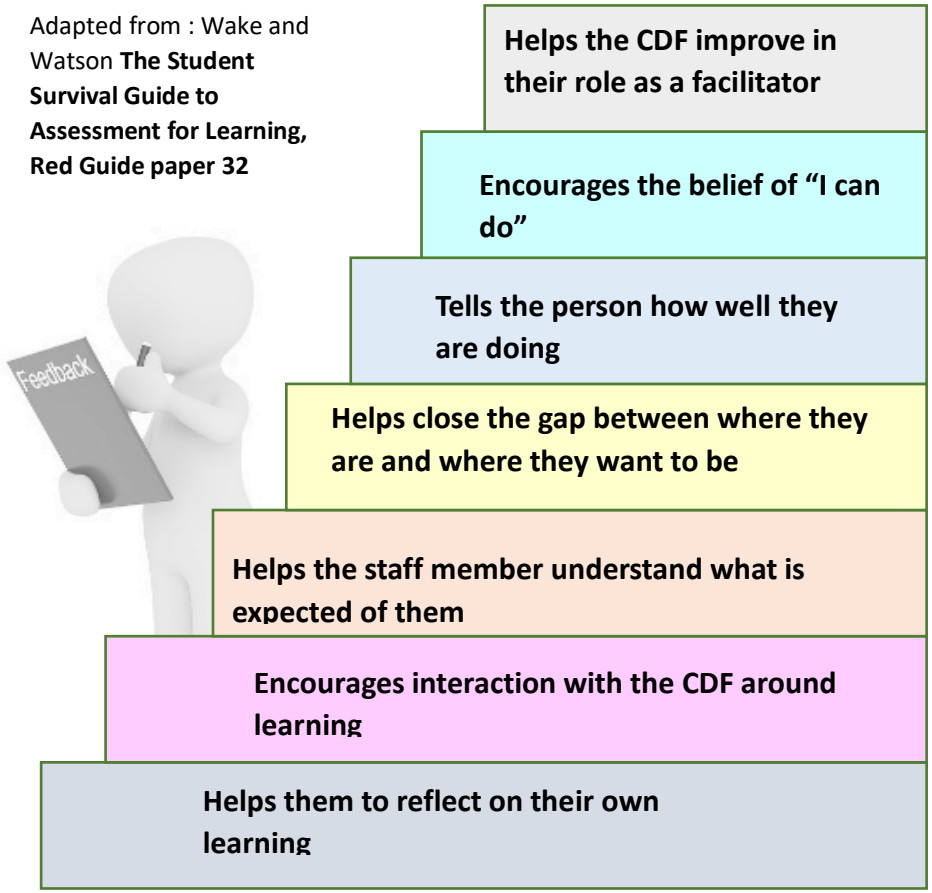
Active listening skills - Non-verbal behaviour	Active listening skills - Verbal behaviour
Open alert posture	Encouraging words
Good eye contact	Clarifying
Encouraging gestures	Paraphrasing
Mirroring and pacing	Summarising
Suspend judgement	Reflections
Distinguish facts/feelings	Questions
Whole message not part	Silence

As a CDF you may want to consider:

- ✓ The need for self-awareness for you as a Competency Development Facilitator and your own skills in giving feedback
- ✓ When and where to give feedback
- ✓ How you will give constructive feedback
- ✓ Is the feedback you are giving motivational
- ✓ Is the feedback based on agreed assessment criteria within EnCOP?
- ✓ Does feedback highlight strengths of the work?
- ✓ Do you balance positive and negative comments?
- ✓ Do you provide specific ways to improve?
- ✓ Do you pose questions that encourage reflection?
- ✓ Do you explain all of your comments?

Revisiting Feedback – Why effective feedback is useful

Adapted from : Wake and Watson **The Student Survival Guide to Assessment for Learning, Red Guide paper 32**



Caring Conversations

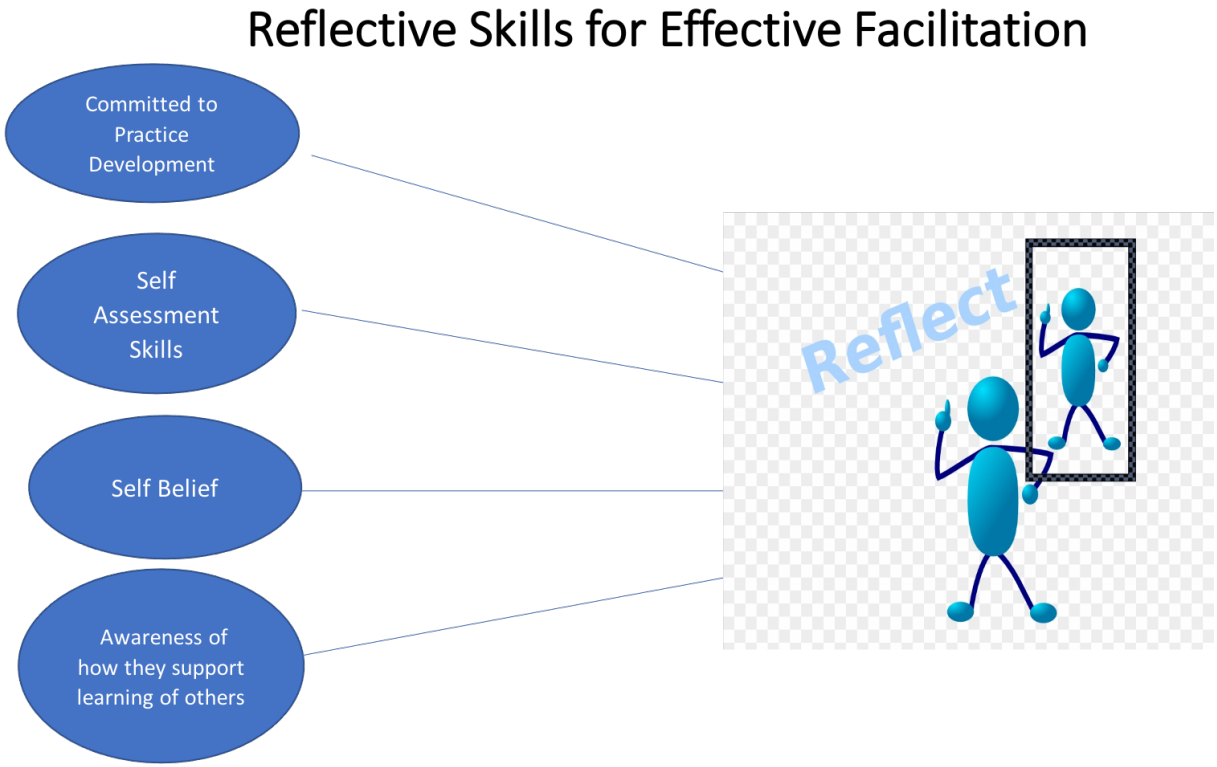
As outlined within this guide, being an effective Competency Development Facilitator is about adequately supporting the staff member through the EnCOP process and ensuring opportunity is given to progress and develop towards competency achievement wherever possible.

Caring conversations as outlined on page 13 can help to make this a positive development experience when used to support the assessee throughout the process of competency achievement.

The Caring Conversations Framework, Dewar & MacBride, (2017).

Key attribute	Dimensions	Key questions to ask others
Being Courageous	Courage to ask questions and hear responses. Feeling brave to take a risk. Persevering. Having courage to stand up for things.	What matters? Help me to understand what has happened? What would happen if we gave this a go?
Being Celebratory	Making a point of noticing what works well. Explicitly saying what works well and asking questions that get at 'the why'. Continually striving to reframe language to the affirmative.	What worked well here? Why did it work well? How can we help this to happen more of the time? If we had everything we needed, what would be the ideal way to do this? What are our strengths in being able to achieve this? What is currently happening that we can draw on? I like when you.....
Connecting emotionally	Using 'windows of opportunity' to create openings for people to discuss emotional and personal issues in the context of ordinary conversations. Inviting people to share how they are feeling. Noticing how you are feeling and sharing this.	How did this make you feel? How would you like to feel?
Being Curious	Asking curious questions about even the smallest of happenings. Wondering in the moment about what you see, hear and feel. Using micro-noticing practices by being attentive and open to what is happening. Questioning, weighing up this or that, hunting for meaning. Looking for the other side of something that's said, checking it out. Being receptive to be changed by what you hear.	What strikes you about this? Help me to understand what is happening here? What prompted you to act in this way? What helped this to happen? What stopped you acting in the way you would have wanted to?
Considering other perspectives	Creating space to hear about another perspective. Recognising that we are not necessarily the expert. Checking out assumptions. Being open to hearing perspectives, recognising that they may not be the same as your own and feeling comfortable to discuss this in an open way. To enlarge and expand my point of view.	Help me to understand where you are coming from? What do others think? What matters to you? What is real and possible? What would it look like if we did nothing?
Being Collaborative	Talking together, involving people in decisions, bringing people on board, and developing a shared responsibility for actions. Looking for the good in others to encourage participation and collaboration. Finding out about what we care about – our shared aspirations. Making connections and realising the relevance of these to help make choices.	How can we work together to make this happen? What do you need to help to make this happen? How would you like to be involved? How would you like me to be involved? What would the success look like for you? What can each of us do to make this better?
Compromise	Being open and real about expectations Working hard to suspend judgment and working with the idea of neutrality. Helping the person to articulate what they need and want and share what is possible. Talking together about ways in which we can get the best experience for all.	What matters most to you? What is real and possible? What could we let go of? How would we feel about letting go?

Point to note - Facilitators with adept learning strategies that engage learners with problem-based learning are more likely to be reflective



- **Self-assessment is defined as the ability to discover and assess the strengths and weaknesses about oneself after experiencing an event**

- **Self-assessment therefore enables CDF's to be reflective of what they are teaching and their relationships with EnCOP assessee's**

- **Self-belief will have a significant relationship with how you perceive yourselves in relation to the colleagues you will be assessing and your ability to support their learning and development**

- **Using reflective practices within your daily work and your CDF role will result in increased self-awareness, which will in turn encourage self-assessment and self-evaluation.**

Adapted from Chee Choy, S., Sau-Ching Yim, J. and Leong Tan, P. (2017)

All of these processes can support you to feel motivated, proficient, and effective in your Competency Development Facilitator role.

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Domain & Cycle of Competency Achievement Guidance – Introduction to Crib Sheets

The following Crib sheets are provided for your reference and use throughout the cycle of competency achievement with your assessee's. They are intended as a guide only and are in no way prescriptive. There are blank sections for your own local considerations - you may want to add any notes, questions, evidence examples or general comments to these to support you in your ongoing role as a Competency Development Facilitator.

Domain: **A**	**Values, Attitudes & Ethics**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask
Essential	**DOP:** observe interactions **WP:** MCA assessments safeguarding incidents, clinical notes, patient reports, meeting minutes, supervision records **CBD:** complex cases regarding capacity, working with patients from different cultures/ backgrounds **R:** clinical quandary around working with people from other backgrounds, complex capacity or safeguarding issues, reflection on training **FB/ WT:** compliments/ comments from others	**Consider:** • How they consider the feelings of the person in interactions and ensure dignity at all times, e.g. explaining what they are doing/ why they are doing it/ ensuring privacy, etc. • Ability to always give adequate time to interactions • Understanding of the main principles of mental capacity act and how to apply it • Ability to recognise safeguarding issues and act on these accordingly • Understanding of, and adherence to professional boundaries **Ask:** • Can they explain how an older person may feel if their dignity is compromised? • Can they give examples of how they involve family and friends in care and interactions? Have they received any positive feedback in relation to this? • Can they describe what is meant by unconscious bias? Can they describe any situations where this be may have impacted on care delivery e.g. making assumptions? • Can they give examples of when they have worked with someone from a different culture or marginalised group? Did this make them think about things differently or act in a different way? • Can they give an example of when they may have challenged a negative stereotype in relation to older people? • Can they describe the principles of confidentiality at work? Consider using clinical quandary • Have they ever been involved in whistleblowing or raised concerns at work? If not, can they explain when this might be required and how this might do this? • Can they describe the difference between best interest day-to-day decisions and decisions that may require a formal DOL's application? Can they outline their role in relation to this? • Can they describe the most common types of abuse older people may be vulnerable to? (e.g physical, financial, psychological, neglect, domestic) • Can they describe the local safeguarding policy and referral routes? • Can they describe what is meant by the term 'ethical dilemma' and give an example of when they have experienced this in practice? • What strategies do they use to manage stress? Where do they access support at work to help with the emotional challenges of caring for others?

Domain A: Values attitudes & Ethics Continued		
Specialist	**WP:** Evidence of teaching and supporting other's, e.g. supervision/ 1:1's/ mentoring, providing constructive feedback, training **WP/ R:** Evidence of collaborative service development/ delivery, audit **FB;** service user, carers**,** training evaluations, 360 feedback **WP:** Evidence from audit/ revalidation for professional registration	**Consider:** • Specialist knowledge and understanding of the importance of values and attitudes on care delivery • Their position as a role model and the strategies they use to support staff in relation to values and attitudes, e,g, supervision, mentorship • Ability to give constructive feedback • Their role in supporting staff resilience and wellbeing • Evidence for registration with professional body (if applicable). **Ask:** Can they name key legislation/ principles relating to equality and diversity? ➢ Equality Act 2010 ➢ Health & Social Care Act 2012 ➢ Care Act 2014 ➢ Mental Capacity Act 2005 ➢ Human Rights Act 1998 • Can they give an example of where they have seen dignity or care as compromised? What did they do? What were the outcomes? • Can they outline when or how they would apply the MCA to formally assess capacity? What processes would they follow? Who would they involve? (Case example may be useful) • Can they describe what is involved in advocating for older people? When might they refer on and what are the local routes for independent advocacy e.g. IMCA • Can they explain the best interest decision making/ DOLS process, when and how it might be used? E.g. medication, not free to leave, need for continuous supervision • Can they describe a situation where they or a staff member raised a safeguarding concern? How was this addressed/ dealt with? How would they support others to highlight potential safeguarding issues?
Advanced	**WP:** Minutes from meetings, policies/ procedures, reports **CBD/ R:** Complex case notes/ discussion	**Consider:** • What systems have they set up/ managed/ utilised to ensure the patient voice is heard in relation to their rights and choices? • What systems have they developed or contributed to, to ensure effective safeguarding of both staff and service users? How do they involve service users in this? • How do they promote/ support the effective use of MCA legislation within their organisation and wider afield? **Ask:** • Can they give an example of when they have carried out a high-risk capacity assessment? • Can they give an example of when they have used advanced skills to make a make a complex best interest decision?

Domain: **B1**	Inter-professional and inter-organisational working and communication	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth
Level	Suggested modes of competency assessment	Points to consider / ask / review										
Essential	**Oth -** Service outline, Job Description and specification, Mandatory Training, Information Governance, Confidentiality, safeguarding training. **R –** Reflection on practice situations when teamwork has been good or not so good. Use reflection to make sense of these and draw out points for learning. **FB/ WT –** any feedback from colleagues, service users regarding working together and / or communication **WP –** Handover tools e.g. SBARD, Anonymised referral forms, Templates	**Consider:** • Awareness of their own role and the service they work within • Communication skills and the importance of clarity in information sharing (range of methods e.g. record keeping, verbal, digital solutions) • Understanding of transfer points in care and the significance of these for older people • Teamwork in general, relationships within teams, empathy, respect, seeking to understand each other's role and perspective, conflict. • Recognises and involves patient, family and friends as part of the care team • Responsibility, Accountability, Autonomous working, limitations of role – when to refer on / seek help. **Ask:** • Who / what are the key services they interact with in the course of their work? • How do they make sure they are proactive in both seeking and providing (clarity of) information when needed? • Can they outline the key principles of the Data Protection Act and General Data Protection Regulation UK? • How do they ensure everyone involved in the persons care is clear about treatment and care decisions? • What do you consider before sharing patient / client information and data? • Do they understand what transfer points in care are? And why these can be detrimental to older people? • What is your understanding of responsibility and accountability? • Can you give an example of when you needed to involve someone else in a person's care rather than you manage on your own? • Do you feel comfortable giving feedback on effectiveness within your team / working with other teams? Referral systems? How do you make sure you give this feedback in a timely way? Do you know who to give this feedback to? Why is it important to flag things up? • If problems arise when accessing support from others, how would you deal with this? • What do you understand about your role & responsibilities in information governance & confidentiality?									

Domain B1: Inter-professional and inter-organisational working and communication continued		
Specialist	**FQ –** Leadership, Graduate or post graduate study **Oth –** Minutes of meetings (attendance at cross organisational forums, meetings, case reviews, MDT meetings) **FB/ WT –** any feedback from colleagues, service users regarding working together and / or communication **R-** To make sense of challenging situations that may have arisen	**Consider:** • Their position as a role model and both motivating and supporting others • Specialist experience, skills and knowledge in older persons care, • Comprehensive knowledge of health and social care system and services / pathway of care for older people • Advanced communication skills – range of methods. Self and supporting others. • Key specialist role in MDT • Safe delegation including consideration of accountability and responsibility, safety and quality (might be cross organisational) • Key role in shared decision making. • Problem solving and responding to concerns, flagged issues etc (older person, family and friends, colleagues, team, other teams, cross organisational, interagency) • Ability to facilitate effective information exchange to ensure safe and timely care? Example? • Do they engage and motivate others in order to ensure teams that are appropriate to each care situation? **Ask:** • How do they advise and support other staff in caring for older people? • Can they give examples of how they include all relevant parties in shared decision making? • How do you collaborate with others to both deliver and improve care? • How do you ensure the care you give to older people is holistic in nature? • Can you explain the strategies you use to break down barriers when accessing support across teams? • How do you ensure yourself and others adhere to information governance and confidentiality during information exchange both internal and external to their own organisation? • What is your understanding of the challenges of multiple organisations working together delivering care to older people? (e.g. staff competence, delegation, different policies and procedures)
Advanced	**FQ –** Leadership and management, Professional qualification, relevant post graduate study.	**Consider:** • Advanced clinical skills and leadership • Advanced staff, operational and service development leadership • Complex care situations - ability to lead, support others, influence and manage these • Interagency collaboration and working • Teamwork strategy built upon best evidence • Organisational compliance - Data Protection / GDPR UK, Information Governance, Organisational risk and accountability

Domain B1: Inter-professional and inter-organisational working and communication continued		
	Oth – Reports, minutes of meetings, Policy they've written or contributed to, Attendance at interagency planning sessions, Professional roles, chair of meetings, forums.	**Ask:** • Do they promote multi agency and partner involvement? – how? Who is their network? • How do you develop maintain and grow your network? • What do they have in place to aid IG adherence? Any breaches in information governance? How did they manage this? • How do you ensure all staff feel valued and able to contribute about complex care situations? • Can you describe your role in ensuring learning and change takes place across the organisation and system e.g. serious case reviews, • safeguarding and root cause analysis? Example? • How do you manage disagreements and conflict within teams about values, roles, goals and actions that arise among professions and organisations, in a constructive, positive, diplomatic manner? • Can you give an example of a time when you used advanced negotiation skills in conflict resolution? • How do you use evidence and research to inform effective teamwork?
Local Considerations:		

Domain: **B2**	Teaching, learning, and supporting competence development	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**R -** On areas they would like to develop. **FQ-**review these and impact on role / care delivery **Oth-** Record of learning and development. **WP** -teaching evaluations, evidence of impact on patient care	**Consider:** • Compliance with professional regulation standards if appropriate • Ability to reflect on own strengths and learning needs • Role and experience in teaching and learning. **Ask:** • Why is appraisal important? • What is their understanding of feedback? • Can they give examples of when they have received and when they have provided feedback? • What are their experiences of learning and development opportunities specifically related to the care of older people? • How does they learn best ? example on the job (experiential) online, face to face in big groups, one to one. • Do they feel that they are able to access learning and development opportunities? – discuss further if they do not for example what are the barriers for opportunities. • What are their aspirations for development? • Are there any competencies within the EnCOP Framework where they feel they could be at or working towards within essential or specialist level if so, what would enable them to get there?
Specialist	On areas they would like to develop. **FQ-**review these and impact on role / care delivery	**Consider:** • Formal Qualification or specialist experience in teaching and learning (at specialist level these may differ depending on role and working environment). • Experience of facilitating or delivering teaching and learning initiatives **Ask:** • Can they articulate their understanding of coaching? • What is their experience of supervising and assessing other staff ? **e.g.** – involvement in staff appraisals, personal development plans (PDP),

Domain B2: Teaching, learning, and supporting competence development continued		
	Oth- Record of learning and development. SWOT analysis **DOP-** observe an education session	• What is their experience of receiving and giving feedback? have they reflected upon this? • Have they ever had 360- degree feedback? How did they find this process/experience? How did they use this? • Have they carried out staff training needs analysis ? Examples of these? • Do they self-reflect on their own learning and development needs? • Have they done their own SWOT analysis? What resulted from this? • Have they facilitated any training / development? Examples? PROMPTS- who were the staff group, topic, content, what was the feedback, impact upon care for older people. • What do they feel are any challenges and enablers for their own and other staff members learning and development opportunities? • Are there any competencies within the EnCOP Framework where they feel they could be at or working towards in specialist or advanced level if so, what would enable them to get there? • What are their future aspirations?
Advanced	**FB** – from seniors, peers, managers, workforce, service users **R -** On areas they would like to develop. **FQ-**review these and impact on role / care delivery / workforce **Oth-** Record of learning and development. SWOT analysis	**Consider:** • Experience of leading or contributing workforce development / strategy • Further academic study e.g. PGCE, MSc PhD which could include a Professional Doctorate • Are they compliant with professional regulations? • Have they self-reflected upon their own development needs and completed their own SWOT analysis related to this? **Ask:** • If the assessee is responsible for supervising and assessing other staff if so, explore with them their experiences of this prompts could be – involvement in staff appraisals, personal development plans (PDP), • Have they ever had 360- degree feedback? How did they find this process/experience? How did they use this? • Can they describe any creative, innovative, flexible coaching, teaching, and learning strategies that they have developed/used and what the impact that this had on participants and on care for older people? • What influence have they had on workforce development locally, regionally, or nationally? • Can they give examples of cross sector working with regards to the development of the workforce for older people, e.g. what was their experience? who did they collaborate with? what was the outcome for staff and for care for older people? • How do they feel they contribute to raising the profile of working in services for older people? • How do they lead and motivate people to want to work in older people's care? What are the barriers and facilitators of this? • Are there any competencies within the EnCOP Framework where they feel that they are not at advanced level if so, what would enable them to get there? • What are their future aspirations?
Local Considerations		

Domain: C1	Leading, organising and managing care	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask
Essential	**R** On Practice. On Core Skills Training & application **DOP** Observation of usual care delivery **WT / FB** Manager / Senior colleagues E.g., Appraisal, thank you letters, e-mails **CBD** Clinical Quandaries or case examples re: compromised care situation **WP** e.g., Community Nurse Diary, Board Round Log, Clinic Schedule	**Consider:** • Can they evidence good time management of care delivery, appropriate prioritisation, and safe, effective delegation? • Do they demonstrate person-centeredness as opposed to task orientated approaches to the care of older people? • Is the use of care plan, care standards and evidence-based guidelines & tools evident? • Is their approach to health and safety in relation to care delivery safe, effective, and compliant? **Ask:** • How do they access local, team and organisational clinical/ operational policies, practice / policy guidance or protocols, care standards? • Understanding of relevance and how these are monitored internally and externally? E.g., CQC Standards • Can they describe or give examples of how costs need to be considered when delivering high quality care for older people? • Can they name the relevant health, safety and risk regulations, policies, and guidance? Can they example how this applies to their role, their team, and the safe care of older people? E.g., Pressure area care, Falls Management, Control of Substances Hazardous to Health (COSHH) • Who do they contact with concerns or questions regarding older persons' care and support?
Specialist	**R** on practice or on training/application to practice E.g., Interviewing experience, conference presentations	**Consider:** • Is leadership demonstrated in practice? E.g., Transformational leadership qualities and techniques, change management approaches, team management • Is evidence- based care of older people evident in their day-to-day care delivery or management within role? Do they influence others within role? E.g., Use of evidence- based tools and resources • Whole local system awareness regarding older persons care? E.g., health and social care services & pathways, VCSE provision, peer support • Do they act as a role model in supporting system navigation and advocacy for older people? E.g., Inward, and outward referral processes, promoting staff awareness / understanding and promotion of whole system awareness and approach

Domain C1: Leading, organising and managing care continued		
Specialist	**DOP** Leadership e.g., whilst leading team or service, planning caseloads, influencing others as lone advanced practitioner **FB/ WT** from senior or junior colleagues referencing leadership style. From older people / families re: advocacy, care navigation **D** Re: Older persons pathways – successes & challenges **FQ** Leadership e.g., ACP, LEO, BSc, MSc **WP** E.g., Root Cause Analysis, Clinical Audits, PDSA, Care Standards **CBD** E.g., Complex case management, complex discharge planning, dealing with complaints	• How do they demonstrate, promote, and foster in others a whole systems approach to care for older people? E.g., Political, cultural, and contextual awareness • Do they play an active role if the monitoring and evaluation of care standards, policies, and practices? E.g., Clinical audits, service user surveys, staff surveys, PDSA cycles, Root Cause Analysis • Do they demonstrate effective resource (human and non-human) management in their day-to-day practice? E.g., This may include rostering staff, ordering stock, managing clinics or home visits, managing own diary and others Ask: • How do they manage complaints and /or conflict? • Can they describe the current local, regional, and national agenda steering the safe effective care of older people and frailty care? E.g., NHS Plan, NENC Ageing Well Strategy, Getting It Right First Time (GIRFT) • Can they describe locally used tools for safe staffing/ measuring patient acuity? • Can they articulate what good leadership looks like? E.g., Transformational, Emotionally Intelligent, Coaching styles, Positive Change Management • How do they ensure safe governance within their role, service, team for older people, family & friends, and staff / colleagues? E.g., Local system / organisational tools / resources • How do they contribute to promoting 'working with older people 'as a key specialist focus or element of their role or service? E.g., role recruitment campaigns, through staff appraisal or PDP, staff line management • What strategies do they use to ensure effective resource management to ensure fair and proportionate distribution that meets the needs of all older people? E.g., Continence products, medication, staff skill mix • Can they describe the local processes and considerations for accessing funding for older people? E.g., CHC and Care Placement, benefits, social care assessments, social prescribing and VCSE sectors
Advanced	**R** On system working and/or local, regional, national networking **WT** From colleagues / network links/ service user groups across system **FB** From colleagues / network links/ service user groups across system. Appraisal/ PDP	Consider: • Past and present roles and experience pertaining to business and resource management and transferability and relevance to current role and leadership within older people's care provisions • Involvement or contribution to the development, implementation, monitoring and evaluation of evidence-based and compliant policies, protocols, and pathways, E.g., Local Frailty systems boards, cross-organisational groups, VCSE networks and service user groups • Are they considered as a local leader and expert in the care of older people and in the scoping, development, delivery, and evaluation of services which support good care for older people? • Do they evidence established network links with key roles and leaders across the care system related to older people's care? • Do they demonstrate highly evolved leadership qualities in influencing and shaping how funding, staff and non- staff resources are deployed effectively across the local care system? E.g., Implementation and evaluation of projects, use of Quality Improvement methodology, effective use of project management principles

Domain C1: Leading, organising and managing care continued		
	D E.g., Population Health Modelling, Local & Regional Frailty Pathways, Health Inequalities, Market Forces **FQ** E.g., MBA, MSc, Project Management Qual **WP** E.g., Business Case, Evaluation Report, Options Appraisals	• Are they active in utilising and/ or establishing service user networks / groups aimed at gathering feedback on services, care provision and gaps? • Do they apply expert knowledge of key legislation, regulations and inspections which support the monitoring and evaluation of services for older people? Ask: • Can they describe whole system workforce requirements current and predicted and system pressures regarding care provision for older people? • Can they describe and apply national guidance and models of co-productions and service user involvement in the design and delivery of services for older people?
Local Considerations		

Domain: C2	Improving Care	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**R:** involvement in service improvement **CBD:** ideas based on patient care **WP:** patient notes, involvement in audit, evaluation **FB:** role in improving care/ embracing change	**Consider:** • Engagement in improving care. How open are they to change? • Ability to undertake effective record keeping **Ask:** • What service improvements have they contributed to/ made suggestions about, or are aware of? • Can they name the organisations vision and values and show how they support these vision and values? • Do they understand the reasons for keeping comprehensive records/ notes. • What ideas do they have for change/ improving services? Do they know how to share their ideas? • Do they understand what is meant by the term 'audit'?. Are they aware of any audits, improvements or research that are completed within their team/ service? • Can they outline examples of care that they deliver that are underpinned by evidence? E.g moving and handling, nutrition & hydration, pressure care, falls management, etc • Can thy explain why change is important in care delivery?
Specialist	**WP:** reports, evaluations, meeting notes, outcome measures, evidence of seeking patient/ career views **FB:** colleagues/ peer/ manager/ 360	**Consider:** • Quality improvement programmes they have they lead/ been involved with • How they utilise/ lead/ support audits or other forms of evaluation. How has this influenced service provision? • How they involve older people and their families in improving care within their team/ service/ wider organisation • Involvement/ engagement with research? Can they describe the research process and how this could influence practice? e.g. ethics, sample sizes, validity, reliability **Ask:** • Can they give an example of how they have applied evidence to change or influence practice? • How do they stay up-to-date with evidence? • Can they describe an example of how they have been a role model for change?

Domain C2: Improving Care Continued		
		• Can they give an example of being creative or innovative to support service improvement? • Have they been involved in gathering/ using information and data to evaluate and/or improve services? E.g. surveys, focus groups
Advanced	**WP:** Service evaluation reports, data, high level strategy documents, publications/ conference presentations	**Consider:** • What service improvement initiatives have they led or been involved in, that create a culture of continuous improvement? • How do they evaluate service provision within their area/ organisation? • How do they work with other partners to contribute to improving care at an organisational, local or national level? Can they provide examples of this. • What mechanisms have they set up/ supported to ensure staff stay up-to-date with best evidence and apply this to their practice? • What research have they lead/ contributed to, that has had a positive outcome for older people? • Have they contributed or developed links that facilitate service user involvement in improving care? **Ask:** • Can they articulate how population health needs map and reflect current trends in the over 65 population, at a national, regional, and local level? How do they use this information within their role or sphere of influence to improve care? E.g. frailty mapping, health inequalities
Local Considerations		

Domain: D1	**Communication with older people, families, and friends**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**R:** On interactions in practice/ communication training application **DOP:** Communication style during usual care **WT/FB:** From senior colleagues, older people, family, or friends **CBD:** E.g., older people with communication difficulties, language barriers, pandemic PPE barriers **D:** E.g., Referral pathways, communication strategies & techniques **WP:** Relevant care & support plans, communication aids, referrals **FQ:** E.g., British Sign Language Qualifications	**Consider:** • Always introduce themself sensitively and initiate meaningful conversations with the older people, family, and friends • Good verbal and non-verbal communication techniques with older people, family, and friends. E.g., Use active listening skills, display appropriate responses to verbal and nonverbal cues, their tone of voice and language demonstrates interest, compassion, empathy, and appropriateness • Seek to rectify or compensate for simple barriers to effective communication during usual care e.g., Ensure spectacles worn and clean, ensure hearing aids worn and in working order, overcome barriers caused by the use of Personal Protective Equipment • Work within the limitations of their role, can recognise when extra support or assessment is needed and make or facilitate access to appropriate onward referrals E.g., SALT, Audiology, Optician **Ask:** • What are the common types and/or causes of communication difficulties experienced by older people? E.g., expressive, and receptive dysphasia (e.g., due to stroke /neurological conditions, mild cognitive impairment / dementia), sensory loss (e.g., hearing impairment, sight loss) • What do caring conversations involve? E.g., Being courageous, being collaborative, considering other perspectives • What strategies have they used or considered to enhance communication with older people experiencing communication difficulties? E.g., involving family and friends, use of pen / paper, talking mats, other technological aids • What would they consider when working with an older person, their family, and friends where English is not their first language or understanding of English is poor? E.g., Cultural competence, how to access translation services, issues around ensuring informed consent • How do they consider and overcome the impact that wearing PPE can have on communication for themselves and for the older person? I.e., Increased anxiety, increased frustration, impact on distressed behaviours for older people with dementia
	R: E, g., complex interactions /application of advanced communication skills training	**Consider:** • Frequently engages with and /or lead difficult conversations with older people, family, or friends where there are communications difficulties or barriers which hinder shared decision-making related to individualised care and support planning

Domain D1: Communicating with older people, families and friends continued		
Specialist	**DOP:** E.g., Supporting older people within CGA, leading MDT or Interagency meetings **WT/FB:** Interagency /MDT colleagues, older people, family, or friends **CBD:** E.g., Ethical issues, Advanced care planning for older people with severe communication difficulties **WP:** E.g., MDT minutes, EHCP, Consultation and Referral documents, CHC assessments, Clinical Records **FQ**: E.g., ACP, SAGE	• Utilise a range of approaches to ensure that older people, family, and friends can be actively involved with all aspects of assessment, goal setting and care and support planning. E.g. Accessing interpreters, involving specialist services • Support the learning and development of others, both formally and or informally, related to effective communication with older people, family, and friends E.g., Role modelling, coaching, facilitating access to or providing staff training **Ask:** • What is their understanding of difficult conversations related to older people, family, or friends? Can they give examples of when they have been involved in initiating difficult conversations? • Are they aware of or do they use any relevant communication frameworks? E.g., SPIKES (Setting, Perception, Invitation, Knowledge, Emotions, Summary), SAGE & THYME (Setting – Ask – Gather – Empathy – Talk – Help - You – Me – End) • Ask how their communication skills are adapted where face to face communication with older people family and friends is compounded? E.g., Remote consultations, long distance communication, pandemic social distancing restrictions • How do they use advanced communication skills when dealing with complex clinical situations or conflict? E.g., differing viewpoints, ethical dilemma, language barriers / cultural differences, complex advanced and emergency care planning
Advanced	**R:** Providing expertise to influence individual outcomes or care pathways **DOP:** E.g., Leading complex MDT meetings, system wide collaboration **CBD:** E.g., Leading MDT and/or inter agency advanced care planning for older people with severe communication difficulties **WP:** E.g., Consultation letters/care records, Business Cases, Clinical audits, Research outputs **FQ:** E.g., SLT Qualification	**Consider:** • Considered a local expert in intervening in care and support planning where communication and maintaining therapeutic relationships with and between older people and / or family and friends with health and social care professionals is deemed as complex E.g., Dispute regarding communication difficulties versus mental capacity, end of life decision-making where complex communication is present, risk versus benefit decision-making • How they lead or influence local, regional, or national care pathways, guidance, strategies, information services, clinical services, or evaluations that may impact or disadvantage older people with a range of communication difficulties E.g., Literacy levels, hearing and sight impairment, speech difficulties **Ask:** • When and how they have ensured that the 'older persons voice' has been heard in developing services, pathways, quality improvements or workforce development related to older people with communication difficult? • When and how have they provided clinical expertise in supporting older people with complex communication needs – what was their role, how did they respond, what was the outcome for the older person? • How have they led or influenced collaboration or engagement with VSCE or Service User groups representative of older people with communication difficulties within service design, implementation, or evaluation? E.g., Alzheimer's Society, Action on hearing loss, RNIB, Alzheimer's society, Stroke Association • How do they engage with research related to older people (family and friends) regarding evidence-based effective communication?

Domain: D2.1	Frailty: Understanding, identification and recognition	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth
Level	Suggested modes of competency assessment	Points to consider / ask / review										
Essential	**R –** thinking about their day to day job **CBD –** case example of a person living with frailty / deterioration / first presentation of frailty. **FQ –** Any accredited learning **WP –** frailty scales, anonymised records, guidance tools **Oth –** certificates of training	**Consider:** • There is a clear understanding that frailty is not an inevitable part of ageing, is a long-term condition, can vary in severity and is not static – can be made better or worse • Awareness that frailty is most common in older people but may also have earlier onset. E.g. Those living with long term conditions or learning disabilities, • There is awareness and sensitive management of introducing the term frailty where older people may be uncomfortable with the reference to living with frailty. E.g. common association of frailty with loss / vulnerability / dependency • Awareness of the range of marginalised population groups who are or may be living with frailty? e.g. people living with Learning Disabilities, homeless, travelers, harder to reach groups **Ask:** • Do they understand the process of normal ageing? • Can they describe what frailty is? / What do they know about frailty? • Why is it important to identify when a person is living with frailty? • Can they give an example of a an older person and describe their level of frailty using the CFS? • Can they give an example of when an older person was displaying one or more frailty syndromes and how they responded to this? • Why is it important to support healthy ageing? what are the things they can do in your role to support an older person with this? • How would they help an older person to understand frailty and what it may mean to them, particularly when the older person may not want to think of themselves as living with frailty? E.g. education, supportive conversations									
	FQ – Post graduate, Advanced practice, fellowships, Specialist interest	**Consider:** • Specialist knowledge of frailty and complexity / long term conditions. Different models of frailty, assessment scales and tools.										

D2.2: Frailty: Understanding, identification and recognition		
Specialist	**Oth -**teaching, promoting frailty awareness, membership & engagement/ active within professional interest group **WP –** QI or Practice development linked to frailty awareness and recognition	• Knowledge and understanding of the needs of varying ageing population groups when considering frailty identification and management e.g. people living with Learning disabilities, premature frailty, harder to reach marginalised groups, travelers, homeless • Evidence of knowing the difference between a care and support planning approach and CGA **Ask:** • Can they articulate what the phenotype and cumulative deficit models of frailty are? • Can they articulate benefits of proactively assessing for frailty and why it is always important to look for first presentation. • Can they give examples of how they have / would use evidence based tools in practice to identify and diagnose frailty. • Can they articulate the difference between frailty, other long-term conditions and disability? • Can they give an example(s) of recognising deterioration in an older person living with frailty? What is the significance of frailty syndromes?
Advanced	**WP/ Oth –**Reports, minutes of meetings, Policy or strategy they've written or contributed to, Attendance at interagency planning sessions, Professional roles, chair of meetings, forums.	**Consider** • How they demonstrate their role in leading the development, implementation and evaluation of frailty pathways, services and partnership working which enhance the care of older people living with frailty. • How do they engage with and influence the wider system, locally, regionally and nationally. **Ask:** • Can they give an example of an older person with complexity when their expertise was used to diagnose / manage the care and support of this individual? • Can they articulate the current evidence base regarding population-based approach to frailty identification? How does this reflect in their own services / practice? • How do they use data and research to enhance the care for older people living with frailty? • How do they ensure provision is inclusive and meets the needs of varying population groups? E.g. People living with Learning disabilities, harder to reach marginalised groups, travelers, homeless, (prison population if applicable) • What is their role in local, regional and / or national frailty strategy and policy – how do they ensure they are active in the role to influence and their voice is heard? • How to they actively raise awareness of frailty at a local, regional and national level? • How do they ensure they play a key role in cross boundary, interagency, systems-based developments for older people's care? • How do they evaluate the effectiveness and efficiency of services and care? Evidence of their advanced clinical skills, knowledge and experience

Domain: D2.2	Assessing, planning, implementing and evaluating care	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**DOP –** observing discussions and care delivery re the needs of the older person / carers **FB -**from others re involvement in CGA, approach to care **CBD -** case example of a person living with frailty and their care/support needs, document templates **WP-** risk screening tools,	**Consider:** • Awareness of CGA as the cornerstone of frailty care • Clear about the part they play in effective CGA, e.g., they understand their role & contribution • Their understanding that the wishes of the older person are what matter most in assessing, planning, implementing and evaluating care • They use the life story of the older person to ensure the best care delivery. • They understand that key legislation is important in older person's care e.g. The Care Act, Continuing Health Care Process • Always consider the needs of Informal carer's in care delivery / planning **Ask:** • Can they describe what CGA is and why it benefits older people living with frailty? • How do they Involve the older person and their family and friends to identify preferences and expectations, how do they do this & **really** get to know the person? E.g. talk to the person about background, what's important. Use continuous observation, day to day interactions with the person and families, collateral history • What is their understanding of risk and screening tools? E.g., assessment, prevention, risk management etc. What tools do they commonly use in their role? Do they feel confident in there use and how to manage the information gathered? • How do they use their knowledge of the older person and their family and friends, to contribute to the formulation of plans of care? • What is their understanding of continuing healthcare assessments for individuals they are caring for? What is their role in this process? • Can they give an example when they recognised an older person had a deterioration in their condition? How did they manage this? • Can they describe how they decide who / how to access urgent and emergency care when necessary for a person in their care? • How do they consider the needs of informal carers ? (key point that carers are entitled to an assessment of their needs: The Care Act)

Domain 2.2: Assessing, planning, implementing and evaluating care continued		
Specialist	**DOP –** demonstrating their role in shared decision making, **FQ –** frailty / older persons care / assessment skills **Oth –** training and education delivered, evaluations, **R -** reflection on own performance in these	**Consider:** • How they involve the individual, family and friends in Identifying the older people's needs, goals and problems • Understand that shared decision making is a process that occurs between the older person and health and social care staff, utilises this approach in assessing and planning care in partnership with the older person • Understanding that all parts of CGA are equal • Respectful parity of esteem between physical and mental health problems • Their understanding of the presentations of multiple pathology, and age-related epidemiology of disease and presentation of illness • Ability to formulate a management plan based on the possibilities of differential diagnoses • How they use a range of clinical care interventions & appropriate referrals e.g. appropriate hospital admission, to manage these changes/diagnoses **Ask:** • Can they articulate how they encompass holistic comprehensive assessment – what might they include in this ? (e.g. biographical information, physical and illness conditions, sensory, functional and cognitive abilities, mental capacity, environment, psychological and mental health, social needs, spiritual needs, family issues, safety and safeguarding, and ongoing support and treatment) How do they support others to do this? • Can they give an example of how they formulate a stratified problem list? • Can they undertake a range of clinical assessment and diagnostic tests, including those utilising digital technology? Examples? • Can they critically interpret assessment data? Example? • Can they articulate how they apply the Mental Capacity Act in practice – Capacity assessment / best interest decisions / Advocates to embed anticipatory care into practice?
Advanced	Oth – Job description and spec, service outlines, business cases, strategic plans **D-** re challenging	**Consider:** • Are they working to an advanced level clinically / strategically / both**?** **Ask:** • Can they articulate / discuss case examples from practice regarding D2.2Aa-d ? • What strategies do they use to influence service providers and planners? • Can they give an example of an innovation in clinical care that they have developed and used to influence wider guidelines? • What is their strategy to draw on and blend clinical expertise with the evidence base to evaluate and inform care / guidelines? • Can they articulate how they make their voice heard when challenging practice, systems and policies? An example?

Domain: **D2.3**	**Ageing well: promoting and supporting holistic health and wellbeing**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**CBD:** focusing on ageing well **R:** clinical quandary, training, local awareness **FB:** compliments/ comments **WP:** Assessment/ notes/ referrals	**Consider:** • Considers life story in interactions. • Knowledge of preventative interventions • Common preventative interventions that they promote routinely (opticians/ vaccinations/ podiatry, strength and balance, etc)? Are there any they could promote more widely? • Understanding of local provision and referral routes for preventative interventions and social needs **Ask:** • Can they describe what factors might influence why someone would develop frailty earlier? (area they live/deprivation/ gender/ education, occupation, family support etc) • Can they describe how they support older people to think about preventing development of frailty? E.g. advice on diet, supporting access to exercise, smoking cessation • Can they explain how social isolation/ loneliness can affect older people? What do they routinely promote (if anything) to support this?
Specialist	**In addition to those in essential:** **WP:** meeting notes, supervision records, evaluation reports, data **R/ FB**	**Consider:** • Their experience of using of life story in planning care to support ageing well. • Specialist knowledge of interventions that support ageing well. • How they provide or support access to preventative interventions e.g. podiatry, optician, strength & balance training. How do they support others to be able to do this? • Involvement in service improvements that support access to meaningful activity/ preventative opportunities • Engagement with community organisations to improve opportunities for older people **Ask:** • Can they give an example of when they have supported positive behaviour change e.g. lifestyle? Can they describe the strategies they used or would use to promote healthy living? • What strategies do they use to manage risk and acceptance of services?

Domain 2.3: Ageing well: promoting and supporting holistic health and wellbeing continued		
	FQ: Coaching/ motivational interviewing **WT:** voluntary sector	• What do they understand by a strength -based approach? How do they use this to inform practice? E.g. using what the older person can do well to support them to live well • How do they use a partnership approach and positive risk taking to support older people to live well?
Advanced	**In addition to those in essential & specialist**: **WP:** Service evaluation reports Research papers/ publications	**Consider:** • How do they promote a culture that is based on the importance of knowing the individual's life story? • How do they influence health improvement and prevention of frailty at a local level? • How do they influence at a local level to develop or enhance social, meaningful opportunities for older people as part of prevention?
Local Considerations:		

Domain: **D2.4**	**Ageing well: promoting and supporting independence and autonomy**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**DOP** **CBD/ R** **FB** from service users/ carers and colleagues **WP:** Completed assessments/ referrals	**Consider:** • How they promote choice on relevant decisions? e.g.clothing, when to get up, personal care, etc • Strategies they use to help older people to feel secure in their care (familiar items/ family/ routine/ choice ,etc) • Strategies they use to support older people's independence? • How they promote positive risk taking. Can they describe what this is? • Awareness and experience of using a range of equipment that can support older people to live well, e,g assistive equipment, technology • Awareness of how funding for care works e.g personal care budgets, financial assessments. **Ask:** • Can they give an example of when they have acted as an advocate for older people and their families? • Can they describe the difference between recovery, reablement and rehabilitation? • Who would they refer to, to enhance independence? E.g in feeding, function, mobility- can they give examples of doing this? • Can they describe risks that might be present in an older person's environment? Can they recall a time when they have adapted or changed the environment to minimise risk and/or enable better outcomes or quality of life for an older person? • Can they describe what is meant be advanced care planning and when it might be used? E.g to anticipate and plan for the future in respect of a progressive condition? • Are they aware that older people who need support may be eligible for benefits? (e.g attendance allowance)? Do they know how to support older people to access further support or advice?
	WP: advanced care planning documentation, meeting minutes, relevant service improvement	**Consider:** • How do they determine the goals of treatment/ intervention? • How they act as a role model to ensure others feel able to offer choice and promote independence • Their experience and knowledge of adapting care environments to facilitate independence. • Ability to use teaching skills when promoting self-care with older people and their families.

Domain 2.4: **Ageing well: promoting and supporting independence and autonomy**		
Specialist	**DOP/ R:** supporting positive risk taking and teaching patient **FB:** staff feedback	• Specialist knowledge and support for others in relation to determining opportunities and appropriateness of positive risk taking. **Ask:** • What outcome measures do they use to evaluate practice? • Can they give an example of when they have supported an older person, and their families in relation to finances, relevant to their care? E.g. referral to voluntary sector • Have the ever facilitated or used independent advocates? Would they know when and how to access these? • Have they been involved in, or facilitated advanced care planning? Can they give examples of when this should be considered e.g. progressive conditions
Advanced	**WP:** policies/ procedures, service reports & evaluation, data. **FB:** patient and other organisations	**Consider:** • What policies and developments have they influenced in relation to care environments and supporting independence? • How do they use outcome measures to inform service development? • How have they enhanced access to, and quality of, rehabilitation services? **Ask:** • Can they describe examples of when they have provided expert advice on advanced care planning? • What regional or national innovations are they aware of that support older people to access high quality advice in relation to their finances? Have they contributed to these in their role?
Local Considerations		

Domain: **D2.5**	**Physical Health in Frailty**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**R** on Practise re: physical health care provision or related frailty training and application in practice **DOP** Observation of usual care delivery e.g., supporting older people with physical health problems and making referrals **WT/FB** Manager / Senior colleagues / Older People & family or friends **CBD** Re: supporting physical health needs and associated issues, contributing to holistic or MDT assessments **WP** e.g., Anonymised care records / assessment tools	**Consider:** • They display confidence and understanding when supporting older people experiencing deterioration in their physical health either through ageing changes, morbidities, frailty, or acute illness? • They display understanding that physical health problems can impact on other aspects of the older persons well- being including decline in functional ability, increased reliance on others, impact on mood and anxiety levels and social interaction and show a compassionate and sensitive approach when delivering care and support? • They display a positive approach to care for older people with physical health difficulties and encourage the same with peers, informal carers, and older people themselves? • They ask older people (family and friends) relevant questions which can indicate whether their physical health and well-being is optimised, during simple assessments and episodes of care • They seek advice from or involve other health and social care colleagues in the most timely and appropriate way, when new physical health problems are suspected or there are signs that an existing physical health problem has deteriorated e.g., new symptoms, medication not working as expected, unexplained functional decline, non-specific signs such as lethargy, delirium signs **Ask:** • Can they describe a range of common physical health problems that older people frequently present with and how to recognise these? E.g., Pain, falls, incontinence, malnutrition, dehydration • Can they discuss how deteriorating physical health (both acute and chronic) can affect other aspects of the older persons quality of life? e.g., social isolation, embarrassment, loss of confidence, reduced motivation • Can they describe how to access advice and/or support, in the most appropriate way, regarding the physical health needs of older people E.g. appropriate use of urgent care services, GP access, referral for community nursing and therapy services, referral for specialist nurse assessment (e.g. Parkinson's Nurse, Respiratory Nurse, Older Persons Specialist Nurse, Bowel & Bladder Team

Domain 2.5: Physical Health in Frailty continued		
Specialist	**R** on practice – physical health assessment within CGA **DOP** Leading care delivery within CGA/formulating care and support planning / MDT Referrals **WT/ FB** From senior or junior colleagues referencing expertise in physical health assessment and management or supporting workforce development of others or older people, family and friends related to physical health **D** Re: Older persons care provision & referral pathways relating to physical heath **WP** E.g., Care and support plans, CGA, EHCP, referrals, consultation letters **CBD** E.g., Complex case management and ethical decision-making related to physical health e.g., poor concordance, **FQ** E.g., Advanced Clinical Practice, Independent prescribing	**Consider:** • They frequently encounter, assess, and address difficulties associated with the general physical health needs of older people E.g., Within specialist role or within a CGA type approach? • Others refer to them for specialist assessment or advice regarding the physical health of older people E.g., Family & friends, multi-disciplinary colleagues, receives referrals from social care or VCSE colleagues • Initiates/ facilitates evidence-based clinical management and referral pathways regarding optimal physical health E.g., Access to diagnostics, specialist advice (e.g., Specialist Nurses, Secondary Care Referrals), appropriate prescribing and deprescribing • Support the learning and development of others in relation to optimising physical health for older people? E.g., peers, colleagues, other health and social care workers, older people, family, and friends **Ask:** • They frequently encounter, assess, and address difficulties associated with the general physical health needs of older people E.g., Within specialist role or within a CGA type approach • Others refer to them for specialist assessment or advice regarding the physical health of older people E.g., Family & friends, multi-disciplinary colleagues, receives referrals from social care or VCSE colleagues • They initiate or facilitate evidence-based clinical management and utilise referral pathways regarding optimal physical health E.g., Access to diagnostics, specialist advice (e.g., Specialist Nurses, Secondary Care Referrals), appropriate prescribing and deprescribing • They formulate or contribute to anticipatory or emergency health care planning for older people using a shared decision-making approach, in collaboration with other health care professionals and show excellent information sharing regarding this • They support the learning and development of others in relation to optimising physical health for older people? E.g., peers, colleagues, other health and social care workers, older people, family, and friends

Domain 2.5: Physical health in frailty continued		
Advanced	**R** On experience and achievements related to older persons' care **DOP** Interagency working, leading service improvement **WT/FD** Interagency colleagues, System leaders **WP** Business Cases, Evaluation Reports, Conference Presentations, Clinical Audit **CBD** Complex emergency healthcare planning, serious incident review **FQ** Advanced Clinical Practice, MSC, MBA	**Consider:** • They are considered as experts in the care of older people within the local system E.g., Complex Care Planning, Risk versus Benefit decisions, Complex ethical decision making, Serious Incident Reviews, Readmission auditing • They lead or contribute to the design, development, monitoring or evaluation of physical health care pathways and services for older people E.g., Primary Care frailty pathways, Acute Care Frailty pathways, Intermediate Care Services, Care Home Support Services, Telemedicine • They are often involved in interagency local system planning involving healthcare needs of older people E.g., Housing services, public health services, urgent care pathways **Ask:** • Can they describe the current and predicted local, regional or national population health needs of the whole older people? population? • Can they articulate how they actively engage with research and development regarding the physical health needs of older people? • Can they describe how they impact on system wide physical health pathways for older people at a local, regional or national level ?
Local Considerations		

Domain: **D2.5.1**	**Management of physical health in frailty: Falls**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**DOP:** of initial assessment/ intervention **CBD:** on those at risk of falls **FB/ WT:** from patients and other colleagues/ professionals **R:** clinical quandary	**Consider:** • Use of falls screening and assessment tools • Awareness of local services and referral routes • Their experience in giving basic falls prevention advice e.g. footwear, eye test, med review, removing rugs, etc. Can they give examples of this? • Understanding that falls are *not* an inevitable part of ageing and that often there is something that can reduce the risk of falls **Ask:** • Can they describe some common causes of falls in older adults living with frailty? E.g. acute illness, deconditioning, medication, environment, sensory loss, medical conditions, etc. • Can they explain what is meant by 'multifactorial risk assessment'? • Can they describe why fear of falling is significant? E.g reduced activity-deconditioning-increased risk of falls
Specialist	**WP:** Example assessment/ case notes **WT** **WP:** Evidence of teaching/ supporting others	**Consider:** • Use of multifactorial risk assessment in practice • Experience of undertaking lying standing BP and interpreting a positive result. Do they know what to do with this? E.g. repeat/ onward referral/ seek advice **Ask:** • Can they detail all elements that should be included as part of a multifactorial risk assessment? These include Falls history, relevant medical history, medication, vision, hearing, feet ,footwear, environment, cognitive ability, mobility, nutrition, hydration, fear of falling. • Can they detail which of these elements should be addressed by them and when they should refer on? • Can they describe some of the common medical issues that can contribute to falls e.g hypotension, syncope, BPPV • Can they describe the common medications that can increase the risk of falls : antihypertensives, sedatives, beta-blockers, antipsychotics, anticholinergics • Do they consider fracture risk in the falls assessment? E.g FRAX • Are they aware of interventions to address fear of falling and how to access them? E.g. O.T/ CBT

Domain: D2.5.2	**Physical health in frailty: Promotion of continence and prevention and management of incontinence**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**DOP -** general questioning and discussion about continence in episodes of care **WP** - assessments, care plans, fluid balance charts, bladder bowel diaries, continence charts referrals).	**Consider:** • Always considers continence when caring for the older person appropriate questioning and discussion • Awareness that incontinence **is not** an inevitable part of ageing and that any incontinence should be assessed • Awareness of the importance of privacy and dignity when dealing with continence issues **Ask:** • Can they explain the different types and causes of incontinence (stress, urge, overflow, functional, faecal, and mixed)? • Can they give examples of strategies they have used to manage continence and how successful or not they have been for the older person? • Can they describe what the impact that unmanaged/poorly managed incontinence can have on an older person? e.g. quality of life, how bothersome it is, self-esteem, skin integrity • What is their understanding of the NICE guidance around urine dipstick testing in adults over 65 years old? • Have they has attended any training/education on continence care in older people and what was their learning from this?
Specialist	**WP**- assessments, care plans, referrals **R-** Any self-reflections, **FQ-** post grad study / modules	**Consider:** • Awareness of NICE guidance for Female and Male incontinence, • Knowledge of environmental factors which can impact on continence e.g. toilet proximity, cleanliness, any aids adaptations, **Ask:** • What is their knowledge of the causes and consequences of urine and faecal incontinence? e.g- potential risk factors and possible underlying causes, pathophysiology of renal and urinary system • What should be included as part of a comprehensive continence assessment? E.g. including complete medical, surgical, neurological, obstetric, mental health and social history

Domain 2.5.2: Physical health in frailty continued		
		• Can they identify medications that can affect continence? e.g. Diuretics, Alpha blockers/alpha-adrenergic receptor antagonists, Antidepressants, antipsychotics and narcotic analgesics, Angiotensin-converting enzyme inhibitors, Sedatives, hypnotics and sleeping pills, Anticholinergics and antimuscarinics, Antihistamines, Laxatives, • What is their understanding of evidence-based management of urinary and faecal incontinence? e.g. (pyscho-social, physiological, environmental) may include: pelvic floor, neuromuscular stimulation, behavioural programmes, time toileting regimes, medications, containment, • When would they refer for further investigations and specialist services? Examples? E.g. bowel and bladder services, urology, gynaecology, gastrology
Local Considerations		

Domain: **D2.5.3**	**Physical Health in Frailty: Risk assessment, prevention and management of malnutrition and dehydration**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask
Essential	**R** Practise or e.g., nutrition / hydration training and application in practice **DOP** Observation of usual care delivery – e.g., supporting eating / drinking / mouth care **WT / FB** Manager / Senior colleagues. Older people / family & friends **CBD** Examples of older people with compromised hydration/ nutrition, swallowing difficulties or use of Clinical Quandaries	**Consider:** • Good hydration and nutrition are a high priority within care and support planning with older people and a key element for good physical and mental health and daily functioning. E.g., Cooking / shopping ability, Dentition, Weight Loss/ Gain • Asks about food and fluid intake and mouthcare in routine assessment and/or routine care delivery. E.g., Oral intake amount, preferences, difficulty swallowing, oral pain • Pays attention to oral health during routine care. E.g., Offering toothbrush/paste, assisting with brushing teeth, denture care • Offers older people, family and friends accurate and evidence-based advice regarding daily dietary and fluid requirements. E.g., BAPEN Eatwell Plate, Minimum 1600mls RDA Fluids • Uses locally agreed evidence-based screening tools for nutrition, hydration, swallowing difficulty, mouthcare as recommended. E.g., MUST, Eat-10, Weight monitoring • Follows the older persons care plan effectively to support nutrition and hydrational changes and know who, when and how to report changes or concerns locally. E.g., Weight loss / Gain, Appetite Loss • Recognises and responds appropriately to signs of malnutrition/ dehydration/ swallowing difficulties? E.g., Increase or alter offer of food/ drink, increase assistance with feeding, support with positioning, set daily fluid target, adapted cutlery / crockery, document appropriately, monitor intake and chart appropriately, refer on appropriately i.e., raise concerns to team / senior staff and/ or appropriate MDT referral E.g., GP, Dietician, SALT? **Ask:** • Are they aware of the common oral health problems which older people may experience? E.g., Poor dentition, caries, oral abscess, oral thrush • Can they recognise the common signs and underlying causes of swallowing difficulties for older people? E.g., Choking or coughing when eating or drinking, reports difficulty with food, wet sounding voice, drooling, repeated chest infections •

Domain 2.5.3: Physical health in frailty continued		
	WP e.g., Anonymised care records / fluid & food charting / assessment tools	• Can they describe why older people are at increased risk of swallowing difficulties? E.g., frailty, ageing changes, neurological conditions i.e., stroke, Parkinson's Disease, dementia, muscular problems, obstructions, acute illness • Are they aware of common risk factors, signs & symptoms, and underlying causes for malnutrition? E.g., frailty, loss of appetite, dementia, low mood, altered taste / smell, poor dentition, swallowing difficulties, physical/mental health issues, polypharmacy, long term physical health conditions, reduced functional ability, increased dependency on others • Are they aware of common risk factors, signs & symptoms, and underlying causes for acute and chronic dehydration? E.g., Frailty, Long term physical health conditions, loss of thirst sensation, dementia, reduced functional ability, increased dependency on others, swallowing difficulties, medication, hot weather, environment • Can they describe the standard modified texture diet and fluid consistency scale (IDDSI) and how it can be applied safely and effectively in practice? E.g., Education of staff, family, and friends. good signage, making food and drinks look appealing
Specialist	**R** on practise or on training/application to practise E.g., Swallowing assessments, PEG Management, Prescribing ONS/ subcutaneous fluids / fluid thickener **DOP** Leading care delivery within CGA/formulating care and support planning re: nutrition/ hydration. Delivering training. Educating older people, family & friends in self-care **WT/FB** From senior or Older people, family and friends related to improving hydration / nutrition for older people	**Consider:** • **Whether they frequently encounter and effectively assess and address a range of multi-factorial hydration and nutritional difficulties, experienced by older people** E.g., Within specialist role or within CGA type assessment • **Other health and social care colleagues or older people, family and friends refer to them for advanced assessment or advice regarding oral health, hydration, nutrition, or swallowing difficulties** • **How they support the learning and development of others** (peers, colleagues, other HSC workers, older people, family, and friends) **in relation to hydration management, nutritional management, management of swallowing difficulties and/or oral care** • **How they approach shared decision- making regarding the maintenance and management of optimal hydration and nutrition with older people, family, and friends** **Ask:** • **Can they describe the local clinical management and referral pathways for the assessment and management of a range of oral health or swallowing difficulties? E.g.,** SALT, Dentistry, Gastro- enterology, Ear Nose and Throat specialists • **Can they offer comprehensive knowledge of the signs, symptoms, and common underlying causes of malnutrition?** E.g., frailty, reduced oral intake, dysphagia, sarcopenia, acute illness, new pathology • **Are they able to demonstrate broad knowledge of local clinical management and referral pathways for malnutrition?** E.g. initiating appropriate diagnostics, accessing specialist advice, appropriate prescribing of oral nutritional supplements • **Do they possess comprehensive knowledge and understanding of the signs, symptoms and common underlying causes of sub-optimal hydration and dehydration?** E.g., frailty, dysphagia, reduced oral intake, medication side effects, long term condition management

Domain 2.5.3: Physical health in frailty continued		
Specialist	**D** E.g., Older persons care provision & referral pathways re: hydration / nutrition complex needs e.g., PEG Feeds/ Artificial Hydration **WP** E.g., Care and support plans, CGA, EHCP, MDT Minutes / Reports / CHC assessments **CBD** E.g., Complex case management and ethical decision-making related to swallowing difficulties / introduction or withdrawal of artificial feeding or hydration **FQ** E.g., Swallowing assessment, Advanced Clinical Skills, Prescribing	• **Are they able to demonstrate robust understanding of appropriate local clinical management and referral pathways for hydration management?** E.g., initiating appropriate diagnostics, accessing specialist advice, appropriate prescribing of oral nutritional supplements, appropriate prescribing e.g., fluid thickeners, artificial hydration, appropriate de-prescribing
Local Considerations		

Domain: **D2.5.4**	**Physical health in frailty: Pain**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask / review
Essential	**D / CBD –** case examples, verbal and non-verbal signs of pain **WP-**pain assessment tools **DOP-** discussion and asking about pain	**Consider** • Awareness that pain is underrecognised and undertreated in older people, and may be subjective • Recognise they have a role in the management of pain • Recognition of the link between low mood and depression as both a cause and result of pain. **Ask:** • Can they give an example of acute pain and chronic pain? • Can they articulate or give an example of when it may be difficult to differentiate between acute and chronic pain? • Can they describe common verbal and non -verbal signs of pain? (changes in mood, facial expression, agitation, becoming withdrawn, reduced appetite, decreased function, complaints of pain, moaning, gasping or crying out, guarding an area on movement, being unusually short tempered) • Are they aware that there are a number of assessment tools and scales to determine the presence / intensity of pain including those which are useful when a person is living with cognitive impairment? Do they use any? Can they name any? • How can / do they support and educate an older person and their families and friends in managing pain? Can you give an example? • Can they describe the effects that living with pain can have on an older person, their families and friends? **Examples of assessment tools/scales:** Numeric rating scale Verbal descriptive rating scale Verbal numerical rating scale Pain Thermometer (For older people with moderate to severe cognitive / communication impairment) Abbey Pain Scale (For older people with severe cognitive / communication impairment)

Domain 2.5.4: Physical health in frailty continued		
Specialist	**FQ-** post graduate study / pain module **WP-** anonymised assessment / care documentation **CBD-** clinical quandaries / complex case exploration where pain has been problematic for the older person	**Consider:** • Their experience in assessment and management of pain within their role. • Awareness of the limitations of their role / when it is appropriate to refer on for specialist management **Ask:** • Can they describe a multidimensional approach to a detailed pain assessment? May include: ○ **Sensory dimension**: the nature, location and intensity of pain ○ **Affective dimension**: the emotional component and response to pain ○ **Cognitive dimension:** anticipation, cultural values, ○ **Also impact** on functioning, level and participation in activities of daily living (compared to usual) • How would they investigate pain from a physical health perspective? • Can they give a case example(s) where they have worked collaboratively with an older person, their families and friends to facilitate appropriate pain management strategies (would expect discussion of pharmacological and non-pharmacological approaches) Rationale? Evaluation strategies
Local Considerations		

D2.5.5	Physical Health in Frailty: Skin Health	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask
Essential	**R** on Practise or skin health / tissue viability training and application in practice **DOP** Observation of usual care delivery e.g., supporting personal care **WT/ FB** Manager / Senior colleagues **CBD** Re: skin assessment, pressure area care or wound care or use of Clinical Quandaries **WP** e.g., Anonymised care records / assessment tools	**Consider:** • Skin health as a high priority within care planning with older people, family and friends and a key element for good physical and mental health and daily functioning E.g., prevention and management of skin conditions, maintenance of tissue viability, optimal wound care • Demonstrate commitment to asking about skin health and skin conditions in routine assessment and/or routine care delivery. E.g., Dry skin, broken skin, rashes, discolouration, bruising, moles & blemishes • Provides older people, family, and friends with accurate and evidence-based advice regarding the maintenance of healthy skin, prevention of skin damage and how to access early advice / assessment of skin changes E.g., skin tears, discolouration, wounds, rashes and new or altered moles, use of emollients, advice re: posture and positioning, accessing Primary Care advice • Uses the care and support plan effectively to support evidence-based care, promotes prevention and reports changes in an appropriate and timely way E.g., good hygiene, posture, and positioning, use of emollients and prescribed medication • Use locally agreed evidence-based guidelines and screening and assessment tools for the prevention and management of pressure damage E.g., Waterlow Score, wound measurement tools • Recognises and responds appropriately to signs of compromised skin health or integrity in a timely way E.g., discolouration, inflammation/ reddening, necrosis, blanching, new rash or itch, bruising, new or altered moles, wounds, pressure ulcers, leg ulcers, oozing? • Knows the limitations of their role, when to report changes and refers on for specialist advice in an appropriate and timely way E.g., GP, Community Nurse, Tissue Viability Service **Ask:** • Are they aware of the common risk factors for the development of skin conditions, wounds, and pressure damage E.g., ageing changes (including chronic itch), increased skin dryness, sun damage, long term physical health conditions, poor nutrition / hydration, reduced mobility, poor posture and positioning, side effects of medication, urinary and faecal incontinence? • What is their role in the prevention and management of skin damage, pressure damage and wound care within local care pathways and protocols? E.g., Management of simple wounds, provision / ordering of pressure relieving equipment, referral pathways for specialist advice?

Domain 2.5.5: Physical health in frailty continued		
Specialist	**R** on practise or on skin health / tissue viability training and application to practise **DOP** Leading care delivery within CGA/formulating care and support planning re: skin health / tissue viability **WT/ FB** From senior or junior colleagues referencing management of skin health / tissue viability **D** Older persons care provision & referral pathways re: skin health / tissue viability **WP** E.g., Care and support plans, CGA, EHCP, Safeguarding records **CBD** E.g., Complex case management and ethical decision-making e.g., poor concordance with positioning advice, recurrent cellulitis, **FQ** E.g., Complex Woundcare, Advanced Clinical Skills, Prescribing	**Consider:** • Frequently encounter, assess, and address difficulties associated with optimal skin health for older people E.g., Within specialist role or within a CGA type approach • Others refer to them for specialist assessment or advice regarding skin health, skin integrity / pressure damage or wound care issues E.g., Family & friends, multi-disciplinary, colleagues • Initiates/ facilitates evidence-based clinical management and referral pathways regarding optimal skin health E.g., Access to diagnostics, specialist advice (e.g., vascular team, dermatology, Tissue Viability Nurse Specialist), appropriate prescribing and deprescribing • Appropriate use of incident reporting and safeguarding pathways regarding pressure damage occurrences within locally agreed evidence – based guidance and best practice to evaluate practice and inform service improvement E.g., Root Cause Analysis, incident reporting, clinical audits • Supports the learning and development of others in relation to skin health, tissue viability or other wound management? E.g., peers, colleagues, other health and social care workers, older people, family, and friends **Ask:** • Can they offer comprehensive knowledge regarding the pathophysiology of skin, ageing effects on skin and the common skin conditions and complications that affect older people? E.g., dry skin, pressure damage, skin tears, leg ulcers, eczema, psoriasis, pemphigoid, skin infections, skin cancer, medication side effects • Do they display comprehensive knowledge about the aetiology and evidence-based locally agreed assessment, grading, management and evaluation of pressure damage and wounds?

D2.6	Pharmacology	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth
Level	Suggested modes of competency assessment	Points to consider / ask										
Essential	**R** Practice or Medicines related training and application in practice **DOP** Usual Care – E.g., Medication administration rounds, home care visits, assessment older people, primary care clinic appointments **WT/FB** Senior colleagues, MDT Colleagues, older people, and carers **CBD** E.g., Older persons assessments, multi-disciplinary meetings, liaison with GP/pharmacists, complex care / referrals e.g., Covert medication decisions **FQ** E.g., NVQ, Medication administration or storage, FE course **WP** E.g., MAR Charts, written / electronic care records, referral forms	**Consider:** • Advises or supports older people, family and friends in the collection, administration, taking or handling of medication on a regular basis • Encourages and enables the older person to be as independent as possible. E.g., linking with GP or pharmacist re: prescription access schemes or medicine taking aids (e.g., monitored dosing system), referring to tele- care services for medication prompts • Accurately and thoroughly records and / or documents medication related information related to older people. E.g., this may include accurately recording lists of medication taken, recording medication or vaccine allergies, reporting, and recording side effects or adverse drug events or medication administration recording • Undertake safe and effective ordering, checking and storage of medication within the care setting or are able to advise older people, family, or friends regarding this. E.g., Timely ordering, avoiding 'stockpiling', expiry dates of 'as required' medication? • Arrange access to or promotes attendance at planned regular structured medication review via Primary Care services E.g., GP led, pharmacist led, practice nurse led, or other identified health care professional (e.g., Care Homes Liaison) • Recognises increased risks of medicine related harms and the importance of unplanned medication review at key events E.g., admission to or discharge from hospital /care home / caseload, change of care provider, acute illness, or presentation of frailty syndrome? • Contributes to medication review or ongoing monitoring by supplying relevant information regarding reaction, response, and concordance to relevant healthcare professional /prescriber. E.g., Recognition, response, and appropriate reaction to side effects / suspected adverse drug events, • Recognises, acts, and refers on (or can describe who, where and when to access guidance / advice) for wider multi-disciplinary or specialist advice/ support regarding medicines. E.g. poor concordance, safeguarding issues, confirmed or suspected diminished Mental Capacity, need for MDT best- interest assessment and decision making **Ask:** • Which groups of medication are commonly considered as critical / time specific medication and where incidents of omission are considered 'never-events'? E.g., Diabetic medication & insulins, Parkinson's Disease medication, some anti-coagulant medication?									

Domain D2.6: Management of pharmacology continued		
		• What are common age -related changes and increased risks of medication related harms associated with older people? E.g. changes to absorption of medication, changes in excretion of medication due to altered liver and kidney function, increased risk of interaction between both prescribed and over the counter medication • What are common groups of medication that may have increased risks of side effects for older people? E.g., blood pressure medication, water tablets, laxatives, painkillers, and sedatives • What are the common side effects that you should be vigilant for in older people? E.g., falls/ dizziness, drowsiness/ lethargy, constipation/ loose stools, altered cognition / delirium, nausea/ loss of appetite
Specialist	**R** Practice or Medicines related training and application in practice **DOP** E.g., Prescribing consultations, structured medication reviews **WT/ FB** Senior and junior colleagues, MDT Colleagues, older people, and carers **CBD** E.g., CGA, multi-disciplinary meetings, liaison, Covert medication decisions, safeguarding referrals **FQ** E.g., Prescribing. Advanced Clinical Skills **WP** E.g., Self – management plans, consultation records, use of PGD's, PACT Data audits	**Consider:** • Assessment and/ or review of medication management for older people is part of their role. E.g., Within specialist role or within CGA – type assessment • Uses evidence-based approaches to all aspects of medicines management for older people. E.g., medication assessment and review, consultation, and prescribing (within role), use of Patient Group Directives • Implements proactive risk management and advocacy for older people relating to safe and effective prescribing, ordering, storing and administration of medication. E.g., Optimising opportunities for self-care • Uses the principles of shared decision making through proactively offering choice and involving older people (and family and friend as appropriate) in what, how, and when to take medication. E.g., Telecare, rescue medication, education of older person, family & friends (e.g., PEG medication administration, insulin administration) • Supports safe, effective prescribing practice within the ethical and legal frameworks underpinning medicines management. e.g., Safe covert medication practice, the use of safe anticipatory prescribing, safe use of PGD's • Recognises opportunities for appropriate de-prescribing, including the use of deprescribing tools and guidance. E.g., Anticholinergic Burden Score (ACB) , STOPP/START, Sick Day Rules • Spots opportunities for learning and development of competence among health and social care colleagues. E.g., 121 shadowing opportunities, formal training programmes? • Contributes to development or evaluation of local policies, systems and governance in relation to medicines management for older people. E.g., Incident reporting / review, monitoring / review of prescribing data, clinical audit **Ask:** • What are the effects of ageing, frailty and multi-morbidity on the absorption, distribution, metabolism, and elimination of medication? E.g., increased levels / drug toxicity, reduced effectiveness, increased susceptibility to side effects • Describe in detail the range of medications available and prescribed to the older population which represent a 'higher risk' in old age? E.g., Falls risk medication, anti-cholinergic burden, sedating medication • What are the underlying cause and increased risks associated with polypharmacy, for older people? e.g., Adverse Drug Events, hospitalisation, falls • Can you describe the range of other risk factors associated with higher risk of medication harms? E.g., Acute illness, compromised hydration / nutrition, care transitions, altered care package, dependency on others

Domain D2.6: Management of pharmacology continued		
Advanced	**R** Practice complex decision making, leadership **DOP** E.g., Leading Complex MDT meeting **FB** Senior/ junior colleagues **CBD** Complex MDT leadership, safeguarding meetings **FQ** E.g., ACP **WP** E.g., Service evaluations, published peer reviewed research, audit reports	**Consider:** • Expert advisor in supporting other professionals or teams regarding complex assessment and decision -making in relation to medicines management for older people. E.g., Risk versus benefit decisions, minimising use of high-risk medication, complex polypharmacy, individual or institutional safeguarding concerns • Leads or contributes the development and review of evidence-based policies, guidelines and/ or development of care pathways and services which support the delivery of safe and effective medicines management for older people across the care system E.g., Medicine optimisation services, care home support teams • Leads the development or enhanced access to learning and development resources in relation to medicines management locally, regionally, or nationally which enhance the health and wellbeing of older people **Ask:** • How do they engage with research and remain critically aware of new and emerging pharmacological evidence in relation to older people? E.g., Local or Regional Forums / Groups, Wider Networks
Local Considerations		

Domain **D3**	**Management of Dementia**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth
Level	Suggested modes of competency assessment	Points to consider / ask										
Essential	**R** Practice or dementia training and application in practice **DOP** Usual care and support with **WT / FB** From senior colleagues / MDT colleagues. From older people, family, and friends. Dementia Champions / Dementia Friends achievements **CBD** E.g., Care of older person with cognitive impairment and/or dementia, referral for assessment, delirium superimposed on dementia, working under supervision / guidance specialist team **D** E.g., referral pathways, carer support networks, working within dementia environments (resilience) **FQ** E.g., Care Certificate, NVQ	**Consider:** • Delivery of care and/or support for older people with dementia is compassionate, individualised. Displays a positive attitude and calm manner • Attentive as to whether the environment is having a positive or negative impact. • Pays attention to whether the older person is offered or engaging in meaningful activity. Ensures activities are relevant or attuned to the older persons likes and dislikes. • Recognises the importance of meaningful relationships and uses strategies which promote relationship -centred care. E.g., Identifying and involving significant, supportive family & friends in assessment and care and support planning, using familiar objects and belongings (e.g., photographs) • Values the older persons life story to underpin positive strategies. E.g., Reminiscence, Sensory support • Asks about, recognises, and responds to carer stress and difficulties • Applies a proactive approach and positive attitude to distressed behaviours and systematic methods to identify unmet need. E.g., acute illness, pain, huger, thirst, anxiety, loneliness • Recognises signs and symptoms of delirium and uses assessment tools appropriately E.g., Soft Signs tools, Antecedent Behavioural Charts (ABC)? • Knows about and uses local dementia resources, services, and pathways to seek appropriate advice and support **Ask:** • What do they understand by the term dementia? What types of dementia are they aware of and how can they present differently? E.g., Alzheimer's Disease, Vascular Dementia, Frontal Lobe Dementia, Korsakoff's Dementia • What is their understanding of the range of common underlying causes of cognitive impairment aside from dementia E.g., Delirium, acute illness, undiagnosed physical health problem, depression, side effects of medication? • Can they describe when dementia should be suspected and how to refer for further advice, support, or assessment? • Do they recognise the common difficulties and impairments that older people with dementia experience? E.g., Memory problems, speech difficulties, word finding difficulties, disorientation, impaired mobility, continence issues, difficulty managing activities of daily living (ADL's) and Instrumental Activities of Daily Living (IADL's) • What local health and social care services and voluntary sector organisations / networks are available which offer specialist care and support for older people with dementia and their supportive family and friends? For example: - Community Mental Health Services, Mental Health Liaison Teams, Challenging Behaviour Teams, Alzheimer's Society, Carer Groups									

Domain D3: Management of Dementia continued		
Specialist	**R** Practice or dementia training and application in practice **DOP** Assessment and review of older people with cognitive impairment/ dementia; liaison with families; MDT meetings etc **WT / FB** From senior colleagues / MDT colleagues. From older people, family, and friends. **CBD** E.g., Assessment of cognition within CGA. Assessment of new or worsening confusion. **D** E.g., Diagnostic pathways, management and pathways for 'distressed behaviours', Delirium vs Dementia **FQ** L6/7 Dementia or Mental Health OP Module **WP** Anonymised … care records, Newcastle Model Assessment, EHCP, ACP, Referral & consultation letters	**Consider:** • Routinely incorporates a full assessment of mental health / psychological health within comprehensive assessment of the older person (parity of esteem). • Recognises and responds to potential signs of dementia effectively, establishing and eliminating other common potential causes for symptoms such as cognitive impairment, confusion, disorientation? E.g. Utilises evidence-based assessment tools, collects extended collateral history, initiates, or facilitates basic diagnostic investigations. • Advocate and role model in delivering relationship- centred care for older people living with dementia. E.g., Complex communication with family and friend, facilitates access to support and case management where appropriate, advanced, and anticipatory care planning • Provides advice, support, and assessment regarding more complex aspects of dementia management? E.g. Delirium superimposed on dementia, distressed behaviours • Supports the learning and development of others with regards to dementia care either formally or informally? E.g., Delivering dementia awareness training, providing clinical supervision, shadowing, **Ask:** • Do they possess comprehensive knowledge of the assessment of cognitive impairment? E.g., Typology, presentations and trajectories of the common dementia - type conditions • Do they have an extensive knowledge base of local access referral routes and management pathways for the assessment, diagnosis, post diagnosis care and support planning and end of life care for older people with dementia? E.g., Memory Protection Services, Community Mental Health services, Admiral Nurses, VSCE support services • Can they evidence extensive knowledge and understanding of the presentation, causes, assessment and management of 'distressed behaviours' (BPSD)? E.g., Anxiety, Fear, Pain, Loneliness/ social isolation, Physical Health Issue • How do they engage with the current and emerging evidence-base regarding dementia care? E.g., Forums, networks, conferences

Domain D3: Management of Dementia continued		
Advanced	**R** Practice, knowledge, experience **DOP** Clinics, Consultations	**Consider:** • Regularly provides or contributes to differential diagnosis of dementia for older people? • Expert practitioner (within their field) in providing specialist advice, support and/or input regarding the assessment, management and/ or review of dementia symptoms or management? E.g., Old Age Psychiatrist, Clinical Psychologist, Mental Health Nurse Consultant, Specialist OT
	WT / FB From colleagues. **CBD** Complex management / support for others **D** E.g., Development of pathways & services **FQ** HSC Mental Health Qualification **WP** Anonymised consultation letters/record, business cases	• Regularly involved or provides input into the development, implementation, or evaluation of dementia- friendly care environments, services, models, or innovations at a local, regional and/or national level **Ask:** • What knowledge and experience they have which constitutes advanced competency in the care and support provision for older people living with dementia? • How do they manage ongoing engagement with research and evidence-base to provide or support assurance regarding local care models and approaches?
Local Considerations		

D4	Management of Mental Health	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth

Level	Suggested modes of competency assessment	Points to consider / ask
Essential	**R** Practice or training applied in practice **DOP** Usual Care & communication **WT/FB** From senior colleagues, older people, family & friends **CBD** E.g., Older people with anxiety / low mood /psychosis **D** Apprehensions about dealing with older people's mental health symptoms, accessing support **WP** Anonymised care records, assessment tools	**Consider:** • Values the older persons psychological & mental health with equal importance as physical health • Asks about previous or known mental health conditions in routine assessments? E.g., depression, dysthymia, anxiety disorder, bi-polar disorder, schizophrenia, psychosis • Seeks to understand risk factors, triggers, symptoms, and behaviours which may indicate a 'flare-up 'of a known pre-existing mental health condition? E.g., hallucinations, delusions, low mood, apathy, anxiety • Offers opportunities for older people to express how they are feeling, including supporting those with known communication difficulties? E.g., sensory loss, cognitive impairment, apathy • Uses local sources of advice and support effectively, to support older people with new or existing mental health issues? E.g., General Practitioner, Community Mental Health Team, Talking Therapies **Ask:** • Can they describe factors which promotes mental health and well-being for older people? E.g., social inclusion, promotion of support networks, activity, exercise, healthy diet • Can they describe losses which may be experienced by older people and can result in grief reactions? E.g., loss …of spouse, sibling, home, independence, occupation, social groups • Can they describe the signs, symptoms and management of common mental health conditions affecting older people? E.g., anxiety, dysthymia, later life depression, mild cognitive impairment • Can they discuss how new mental health conditions and exacerbations of pre-existing mental health conditions can present as crisis and how this can impact on an older person's behaviour? E.g., functional decline, impact on physical health, physical health manifestations, increased use of /attendance at urgent care services • Can they identify local carer support networks and services for older people with mental health conditions? E.g., MIND, Age UK,
Specialist	**R** Practice or relevant training and applications **DOP** E.g., Assessment of older person with low mood	**Consider:** • Regularly undertakes comprehensive assessment of the psychological / mental health needs of older people? E.g., within specialist role, as part of CGA approach • Uses appropriate evidence-based screening and assessment tools relevant and validated with the older population? E.g., Geriatric Depression Score, 4AT Delirium Score • How do they promote or support older people's equity of access to mental health assessment, diagnosis and / or support? E.g., Community Mental Health Team, Talking Therapies

Domain D4: Management of Mental Health Continued		
	WT/FB Senior colleague e.g., appraisal, Training evaluations, thank you letter from older person/ family **CBD** E.g., Complex MH Needs, referral for MHA Assessment, Safeguarding issues **D** E.g., Referral pathways, support with resilience, positive conflict resolution solutions **FQ** E.g., L6/7 older persons mental health module **WP** Assessment / Care Plan / Assessment Tool / Referral Letter / Training Programme	• Promote shared decision-making with older people, family, and friends regarding mental health and well-being, E.g., Cognitive Behavioural Therapy (CBT) approaches, self-management plans • Assessment of family and friends within caring roles? E.g., accessing support services, referral for carers assessment • Support the learning and development of others regarding older people and mental health needs? E.g., awareness raising, shadowing opportunities **Ask:** • Do they display comprehensive knowledge of common mental health conditions affecting older people? I.e.., typical presentation, signs, symptoms, and evidence-based management and interventions • Are they aware of risks associated with older people with mental health conditions and indicators for crisis referral? E.g., signs of self-harm / suicide intention, risk to self and others • What is their knowledge about how and when to use local evidence-based pathways and services for older people with mental health needs? E.g., crisis Interventions, Talking Therapies, clinical psychology • What is their knowledge about how and when to access formal and informal support networks for older people with mental health needs and their carers?
Advanced	**R** Experiential learning **DOP** E.g., Specialist MH Assessment, AMPH Assessment Chairing MDT Meeting **CBD** E.g., Complex safeguarding / MHA assessment **FQ** Specialist MH Qualification Health or Social Care **WP** Business Case, Options Appraisal, Published Peer Reviewed Research	**Consider:** • Expert in leading or contributing to the assessment, diagnosis, and management of older people with mental health conditions, particularly where there is high risk or complex differential diagnosis or decision-making? E.g., Qualified Specialist Mental Health or Social Care professional • Leads or contributes to the development, monitoring or review of evidence- based care pathways or service provision for older people with mental health needs locally, regionally, or nationally? E.g., steering groups, multi-professional networks **Ask:** • What knowledge and experience they have which constitutes advanced competency in the care and support provision for older people living with mental health conditions? • How do they manage ongoing engagement with research and evidence-base to provide or support assurance regarding local care models and approaches?
Local Considerations		

D5	**End of life care**	Evidence Key	Type	Reflection	Direct observation of Practice	Witness testimony	Feedback	Case Based Discussion	Discussion	Formal Qualification	Work Product	Other
			Abbreviation	R	DOP	WT	FB	CBD	D	FQ	WP	Oth
Level	Suggested modes of competency assessment	Points to consider / ask / review										
Essential	**CBD-** use these to explore issues linked to end of life care including ethical issues which may arise **WT –** feedback from others, patient and family feedback can be very useful in end of life care **Oth –** training attended / certificates / gold standards framework **WP-** e.g. information leaflets, care pathways, referral forms	**Consider:** • Recognition that the end of life for an older person living with frailty and / or dementia can be different than in other end of life trajectories • How they ensure the wishes, choices and preferences of an older person, their families and friends for optimum end of life care • Role and experience of using Emergency Health Care Plans, Advanced Care Plans and legal declarations of wishes in end of life care • Recognition that delivering end of life care can be daunting, stressful, challenging and emotional for staff both pre and post death of the older person **Ask:** • Can you give an example of a time when you were involved with an older person who was coming to the end of their life? Did you have discussions about wishes and choices? What skills and knowledge did you use to help you with this? • What do you understand about 'deciding right' documentation and what this means for older person's care? • Thinking about end of life care, what is your role in this for older people and what skills do you have which you think are important to be prepared for this? (prompts.. contributing to and delivering a plan of care, dignity, respect, privacy, confidentiality, comfort, recognising symptoms and knowing how to manage or get help to manage these). • Can you give an example of a time when you recognised a person may be close to or in the dying phase? What knowledge and skills do you have which helped you manage this situation? What was your role and responsibilities ? • Do you have any experience of supporting bereaved friends and family after the death of the older person you are caring for? Are you aware of any support services for bereaved families? How would you involve these services? • If you have been involved with an older person at the end of their life, how did this make you feel? How do you make sure that you are thinking of your own needs and support in your role within end of life care for older people? How would you seek support if you felt that you needed it?									
	FQ – post graduate study / end of life module.	**Consider:** • The ability to act as a role model and support others in end of life care • Comprehensive knowledge and skills in proactive preparation for end of life in line with the wishes and preferences of the older person, family and friends										

Domain D5: End of life care continued		
Specialist	**R –** can result in very rich learning about strengths and development needs in end of life care **Oth –** clinical quandaries to explore complex choice, ethical considerations, mental capacity	• Broad knowledge of key legislation, (Mental Capacity Act, Palliative care guidelines, local, regional and national tools (e.g. Deciding right) **Ask:** • How do you ensure you facilitate or provide holistic care in supporting an older person with end of life care decisions? What needs to be considered? • How do you ensure you facilitate or provide holistic care for an older person at the end of their life / dying phase? What needs to be considered? • Deciding Right are key documents regionally for both planning for and managing care at the end of life, what is your role in advanced care planning, comprehensive assessment and care / goal planning for the end of life phase? • Can you give an example of a time when you recognised an person may be in the last 12 months of their life? What knowledge and skills do you have which helped you to manage this situation? What was your role and responsibilities? • When might the Mental Capacity Act and Mental Capacity Assessment need to be applied in end of life planning / care delivery? • What is your understanding of realistic medicine and how do you apply this knowledge in your role linked to end of life care? • Can you think of an ethical dilemma linked to end of life care for an older person? How would you manage this? • End of life care can be challenging for everyone involved, including after the death of the older person, how do you effectively manage your own needs, those of the deceased family and friends and those of other staff or service users?
Advanced	**WP** – e.g. meeting minutes, reports, service plans, strategic papers,	**Consider:** • How do they demonstrate their advanced / leadership role in end of life care whether this be clinical or strategic or both • Complex care situations - ability to lead, support others, influence and manage these • Workforce and community strategy for easily accessible emotional and psychological support built upon best evidence

Domain D5: End of life care continued		
	CBD – to explore clinical or other professional expertise and level of knowledge	**Ask:** • Can you articulate / discuss cases where you have had to act as a clinical expert in complex end of life care situation (s) (Prompting particularly ethical issues, advanced care planning, symptom management) • What is your role in developing models, pathways / systems of end-of-life care? Engaging with older people, family and friends to be involved in development? Effective evaluation? How do you ensure research and best evidence is used? • How are you involved in the development of national, local, regional best practice and quality standards related to end-of-life care? How do these influence your role in leading and managing services and service development? • How do you ensure the emotional and psychological wellbeing of the workforce and communities involved in end-of-life care for older people? (e.g. lead development of services, inclusivity and ease of access to support systems)
Local Considerations		

Your Notes & Clinical Quandaries – you may want to record some ideas of your own case-based discussion / clinical quandaries here for use in review meetings with assessee's. Consider any useful case examples or clinical quandaries which result from your own self-assessment and reflections that you would be willing to use. Remember to anonymise anything recorded to protect confidentiality of both patients, service users, staff and organisations.