NORTHUMBRIA UNIVERSITY

Workforce Competency Framework: Enhanced Care for Older People (EnCOP)

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1 Introduction

In the wake of an ageing population, there is an increasing demand on public and independent sector services to support growing numbers of people living with complex multi-morbidities and frailty (Salisbury, Johnson, Purdy, Valderas, & Montgomery, 2011; Barnett et al., 2012; Cornwell, 2012; European Commission, 2015). Health and social services are challenged to meet the care needs of this group, many of whom are highly dependent, have complex and unpredictable conditions including high levels of cognitive impairment, have limited functional reserve, and require end of life care. Providing high quality care for these older people requires an appropriately skilled and highly competent workforce.

2 Background to the Enhanced Care for Older People with Complex Needs (EnCOP) workforce competency framework

In the Gateshead locality, a care home programme has been in operation for five years and provides enhanced healthcare in care homes through multi-sector and multi-professional working. This integrated approach to service delivery involves the alignment of general practitioner (GP) practices to care homes, and alignment of older people nurse specialists (OPNSs) to care homes with nursing beds. These services have direct links to a multi-disciplinary community virtual ward, and the wider health and social care economy. There is local evidence that this multi-disciplinary approach to providing enhanced healthcare to care home residents is leading to improved quality of care, and reductions in avoidable hospital admissions. These positive outcomes have been recognised through a successful application for Gateshead Care Home programme to participate in the national Vanguard 'Enhanced Health in Care Homes' (EHCH) initiative.

The national Vanguard initiative is identifying and testing new care models with the aim of developing blueprints for the transformation of National Health Service (NHS) community and primary services in England (NHS, 2015). The driving principles of the EHCH initiative are to make health services for residents more accessible, cost effective, and appropriate to their needs, whilst improving resident outcomes and avoiding unnecessary admissions into hospital. The Gateshead project seeks to build on the existing multi-sector EHCH programme, and extend this to all older people's services and supported old age housing services (for example, intermediate care and home care). In addition to care provision the aim is to deliver an integrated community bed and home-based care service through a Provider Alliance Network (PAN) that cuts across traditional health and social care boundaries. Innovative

aspects of the proposed delivery model are the co-commissioning of all community-bed and home-based care, and a capitation-based payment system based on need with outcomes-based commissioning in place.

The proposed Gateshead Vanguard programme is aspirational in its reach as it focuses on transformation of the whole system for the delivery of older people's services. Achieving these ambitious plans requires both change in commissioning processes as well as developing new care pathways and systems/services for delivery. It is clear that a workforce capable of delivering the new care pathways will be needed, in order to ensure that staff are proficient and have competencies that are aligned with the new care model.

An initial qualitative study was commissioned by Newcastle Gateshead Clinical Commissioning Group in early 2016 (Cook, McNall, Thompson, & Hodgson, 2016). The aim of this study was to explore the experiences and competencies of the current Gateshead Care Home workforce team to inform workforce development for the delivery of the Gateshead Vanguard service model. Participants identified a wide range of core and extended competencies which are necessary to deliver the care model.

The study also highlighted that in order to deliver timely, responsive care, practitioners working with older people with complex needs (essential practice, specialist practice and advanced practice) and across all organisations and sectors, need to be competent at working together.

In order to move forward and address the workforce competency development need, a further four related studies were proposed utilising a collaborative action research approach. Action research is an appropriate methodology for designing, planning, implementing and evaluating workforce development initiatives and strategies, as it is designed specifically for bridging the espoused theory, research and practice gap, and offers a useful approach for those concerned with practical problems. The primary purpose of action research is to bring about change in specific situations, in local systems and real world environments, with the aim of solving real problems. Collaborative action research (CAR) brings together stakeholders who have insight into the issue of concern, and enables a wide range of perspectives to be considered and influence decision making (Koshy, Waterman, & Koshy, 2011) which reflects current UK health and social care policy through participation of those with insight to enable local decision making. Boog, Keune and Tromp (2003) observe that action research is an inherently cyclical process of researching, learning and putting what has been learned into practice, often on a localised or small scale. McNiff and Whitehead (2006) suggest that action research studies often involve lots of smaller spirals, which build upon each other to give a bigger picture.

Study 1: Developing a competency framework to reflect workforce competency requirements for essential level practice, specialist level practice and advanced level practice.

Study 2: Mapping the existing workforce against the identified competencies relevant to their level and undertake a gap analysis.

Study 3: Developing a workforce development strategy, to include co-production of:

- Accredited programmes/modules to meet identified need.
- Competency assessment strategy.
- Infrastructure to achieve practice based learning and assessment (mentors/ supervisors/assessors and practice educators).
- Blended learning packages and learning products to support practice based learning.

Study 4: Evaluate the impact of a workforce development approach on a range of agreed outcomes (person centred care, staff recruitment, retention and satisfaction, non-planned/unnecessary hospital admissions).

This report presents the workforce competency framework, and its development (study 1).

3 Definition and purpose of the EnCOP workforce competency framework

The study by Cook et al. (2016) demonstrated a need for:

> "A **standardised integrated competency framework,** specific to the needs of older people, covering the whole workforce from those providing essential care to specialist/advanced practice level".

The study defined the framework as a set of attitudes, behaviours, skills and knowledge required for health and social care staff to provide quality care for older people. The study proposed that the framework should encompass:

- The integration of physical, mental, social, emotional and spiritual.
- Align with, and incorporate, existing competency frameworks that have relevance to the provision of care for older people.
- Reflect the care pathways emerging from the Gateshead Vanguard programme.

The emphasis on competency rather than on role allows the framework to be both standardised and flexible, enabling it to encompass and support the development of all health and social care personnel who provide services for older people, regardless of role or employing organisation. The purpose of the framework is to provide a coherent approach to:

- Determining what competencies are required within the workforce that provides care for older people with complex needs.
- Identifying 'competency gaps'.
- Identifying, commissioning, developing and providing training and education programmes to support competency development.
- Agreeing and developing infrastructure to enable valid and reliable assessment of competency which is accepted across the whole system, regardless of employing organisation.
- Informing the future commissioning of older people's care services through explicit articulation of the competencies required of staff providing care and support.
- Workforce planning for delivery of integrated care.
- Formulating job descriptions for staff working providing care for older people.
- Developing clear career progression opportunities and pathways within and across organisations.
- Recognising gerontology nursing as a complex activity, and promoting care of older people as a specialised and attractive practice area.
- Informing service users and family members what competencies they should expect staff working with older people to have.

4 Development of the EnCOP workforce competency framework

The most effective competency frameworks are co-produced by practitioners and educationalists/academics (Anema & McCoy, 2010). The EnCOP framework was developed via a collaborative process involving academic staff from Northumbria University with expertise in the care of older people and workforce development, and practitioner stakeholders with expertise and experience in providing care for older people with complex needs. The study design consisted of two interrelated stages. Stage one involved the development of a draft workforce competency framework by Northumbria University staff and senior members of the Gateshead Vanguard 'Pathways of Care' team. Stage two involved a stakeholder workshop to disseminate the draft framework, and to provide an opportunity for participants to contribute their views on its further development.

Stage 1

The draft workforce competency framework developed by a team of educationalists/ academics from Northumbria University was informed by:

- Attendance of two team members at weekly Gateshead Vanguard 'Pathways of Care' work stream meetings to identify competencies required at each practice level (essential, specialist and advanced).
- Review of the existing workforce competency framework literature pertinent to the care of older people (already collated into an electronic library from the earlier study (Cook et al., 2016) appendix 1).
- Analysis, integration and consolidation of existing competency frameworks, occupational competencies, regulated qualification frameworks, policy directives and job descriptions that have relevance to the care of older people (appendix 2).

Members of the university team, together with senior members of the Vanguard 'Pathways of Care' work stream team reviewed and re-viewed the framework until consensus regarding design and content was achieved. A further level of rigour was inbuilt into the development process via discussing and reviewing the draft framework with workshop participants in stage two.

Stage 2

A workshop was held with the aim of providing an opportunity for other stakeholders to contribute their views on the development of the workforce competency framework for care homes. The workshop was held on 14 December 2016, and 65 participants attended.

Attendees represented a broad spectrum of stakeholder groups, professions and organisations from across the North East of England, including:

- NHS primary care managers and healthcare professionals
- NHS secondary care managers and healthcare professionals
- Managers, healthcare professionals and support staff from private and voluntary sector care homes
- NHS clinical educators
- Care home clinical educators
- Education and training providers and skills brokers
- Health Education England
- Academic Health Science Network

- Voluntary sector representatives
- Service user representatives
- Nursing students undertaking practice placements in older people's care settings

The involvement of individuals from a range of groups, professions and organisations ensured that diverse perspectives were brought to the discussions. This was deemed to be important, as older people's care services are often located at the intersection of health, social care and voluntary care services – locations where cross-organisational working and the enabling of seamless transitions across services is essential. As such, the development of the framework required input that reflected this core aspect.

5 Structure of the EnCOP workforce competency framework

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

A: Values and attitudes

B: Workforce collaboration, co-operation and support

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

B2: Teaching, learning, and supporting competence development

C: Leading, organising, managing and improving care

C1: Leading, organising and managing care

C2: Improving care

D: Knowledge and skills for care delivery

D1: Communication with older peoples, families and friends

D2: Care process

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

D2.2: Pharmacology and management of medicines

D3: Promoting health, wellbeing and independence

D3.1: Promoting and supporting independence and autonomy

D3.2: Promoting and supporting holistic health and wellbeing

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

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

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

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

Although all domains and competencies are inter-related, findings from the literature review and previous Vanguard study (Cook et al. 2016), and analysis of the discussions from the 'Pathways of Care' meetings highlighted that the ability of staff to deliver quality care very much depend upon a whole workforce ability to:

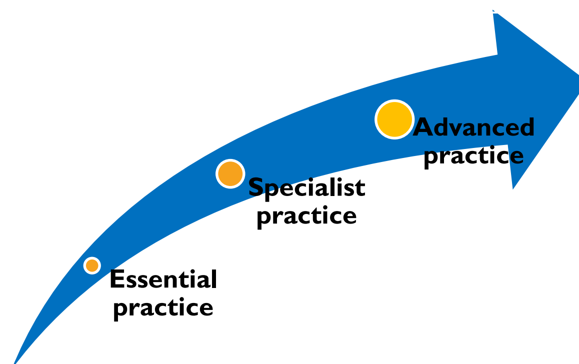
- Establish and maintain a culture of compassionate, relationship-centred values and attitudes.
- Work collaboratively, co-operatively and supportively.
- Lead, manage, organise and continuously improve systems of care, and sustain these improvements.

When developing the framework, the decision was made to emphasise these core workforce requirements by creating domains that comprise of competencies that specifically address these (domains A, B and C). While it is not intended that any domain should be prioritised over the others, domains A, B and C precede domain D the study findings suggest they are prerequisites for the development of knowledge and skills for care delivery, and quality, seamless care delivery practice.

The framework includes three competency levels: essential practice, specialist practice and advanced practice. During the workshop (stage two of the framework development), while attendees agreed these levels for domains B, C and D, the consensus was to collapse

specialist and advanced practice for domain A as attendees proposed that there is no difference between specialist and advanced practice for 'values and attitudes'.

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



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

A number of existing competency frameworks that are specific to professions, care settings or skill sets are relevant to the care of older people (summarised in appendix 2). Development of the EnCOP framework included integrating and consolidating aspects of existing frameworks that are applicable to the care of older people with complex needs. Each competency within this framework is linked to relevant sections of existing competency and knowledge/skills frameworks, and also to resources that offer useful information and education/training resources and opportunities. This linked information can be used by individuals to evidence and develop their EnCOP competencies.

6 Glossary of terms

Advance care planning

Advance care planning is the process of discussing and recording the treatment and care that a person wishes to receive in the event that they lose capacity to decide or are unable to express a preference. This might include their preferred place of care, and who they would want to be involved in making decisions on their behalf. Advanced care planning records a person's wishes, views, values, preferences and decisions, to ensure that care is planned and implemented in a way that meets their needs, and involves and meets the needs of the person's family and friends.

Further information:

- The Gold Standards Framework. (2016). *Advance care planning.* Retrieved from http://www.goldstandardsframework.org.uk/advance-care-planning

Best interest decisions

When a decision is made on behalf of a person who lacks capacity, it must be made in their best interests to ensure that their rights are respected, and the decision is the best one for them. When making a best interest decision, all relevant circumstances should be taken into account. This includes: what the person would have considered if they were able to make the decision themselves; encouraging the person to share their views where possible; deliberating whether the person will regain capacity, and if the decision can be delayed until then; the views of other people, such as family, friends, carers or persons holding power of attorney.

Further information:

- *Mental Capacity Act 2005.* Retrieved from http://www.legislation.gov.uk/ukpga/2005/9/contents
- Alzheimer's Society. (2015). *Mental Capacity Act 2005.* Retrieved from https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2646

Comprehensive geriatric assessment (CGA)

Comprehensive Geriatric Assessment (CGA) is a multidimensional, interdisciplinary assessment process of an older person's holistic needs. It identifies a list of needs and issues to address, and results in the formulation of an individualised care plan, tailored to an individual's needs, wants and priorities.

As CGA is multidimensional, it includes the following assessment areas: biographical information; physical and illness conditions; sensory, functional and cognitive abilities; mental

capacity, psychological and mental health; environment and availability of facilities, social support networks and social needs; spiritual needs; family issues; safety and safeguarding; ongoing support and treatment; views, preferences and expectations of current and future health and care.

Further information:

- British Geriatrics Society. (2014). *Comprehensive geriatric assessment.* Retrieved from http://www.bgs.org.uk/cga-managing/resources/campaigns/fit-for-frailty/frailty-cga

End of Life care

A person is approaching the end of life when they are likely to die within the next twelve months. This includes those patients whose death is expected within hours or days; those who have advanced, progressive incurable conditions; those with general frailty and co-existing conditions that mean they are expected to die within twelve months; those at risk of dying from a sudden acute crisis in an existing condition; and those with life-threatening acute conditions caused by sudden catastrophic events.

Further information:

- National Institute for Health and Care Excellence. (2011). *End of life care for adults.* Retrieved from https://www.nice.org.uk/guidance/QS13.
- Department of Health. (2008). *End of life care strategy.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf.

Frailty

Frailty is a health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of dramatic changes in their physical and mental wellbeing after seemingly minor challenges to their health, such as an infection or new medication.

It is important to distinguish between frailty syndrome and long term conditions, multi-morbidity or disability. People with long term conditions, multi-morbidity or disability may also have frailty which may be masked when the focus is on disease-based long term conditions. People with frailty syndrome but no disease-based long term conditions may not regularly use, or be known to, health services until they become immobile or delirious as a result of an apparently minor illness.

Further information:

- British Geriatrics Society. (2014). *What is frailty?* Retrieved from http://www.bgs.org.uk/frailty-explained/resources/campaigns/fit-for-frailty/frailty-what-is-it.

Integrated care

Integrated care enables the person to experience co-ordinated, continuous care across department, organisation or sector boundaries. Achieving integrated care requires that those involved with planning, financing and providing services across all health and social care systems have a shared vision, and work in collaboration to ensure that the person's perspective remains a central organising principle throughout.

Further information:

- Shaw, S., Rosen, R., & Rumbold, B. (2011). *What is integrated care?* London: Nuffield Trust.
- Department of Health. (2016). *Delivering better integrated care*. Retrieved from https://www.gov.uk/guidance/enabling-integrated-care-in-the-nhs#what-does-delivering-integrated-care-mean.

Mental capacity

Mental capacity is the ability of a person to make decisions autonomously. To have capacity a person must be able to: understand the information relevant to the decision; retain the information long enough to be able to make the decision; consider and use the information to arrive at a decision; communicate the decision.

The mental capacity of a person can vary or change over time. A person may have capacity to make some decisions but not others, as some decisions require understanding of complex information.

The Mental Capacity Act supports and protects people who lack capacity to make decisions. It is based on five key principles:

1. A person has the right to make their own decisions, and capacity must be assumed unless it has been shown otherwise.

2. All reasonable support should be given to assist a person to make and communicate their own decisions, before concluding they lack capacity.

3. A person has the right to make decisions that may seem unwise to others.

4. If a person lacks capacity, decisions taken on their behalf must be in their best interests.

5. If a person lacks capacity, any decisions taken on their behalf must be the option least restrictive to their rights and freedoms.

Further information:

- *Mental Capacity Act 2005.* Retrieved from http://www.legislation.gov.uk/ukpga/2005/9/contents
- Alzheimer's Society. (2015). *Mental Capacity Act 2005.* Retrieved from https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2646

Palliative care

Palliative care is the holistic care of a person with advanced, progressive, incurable illness. Palliative care, focuses on the management of pain and other symptoms, and the provision of psychological, social and spiritual support to a person and their family. Palliative care is not dependent on diagnosis or prognosis, and can be provided at any stage of a person's illness, including end of life. The aim is to support the person to live as well as possible until they die, and to die with dignity.

Further information:

- National Institute for Health and Care Excellence. (2011). *End of life care for adults.* Retrieved from https://www.nice.org.uk/guidance/QS13.
- Department of Health. (2008). *End of life care strategy.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf

Relationship-centred care

Relationship-centred care acknowledges and values positive relationships between older peoples, families, friends and staff, and also between communities, and health and social care provider organisations.

To foster a relationship-centred approach to practice Nolan et al. (2006) developed the Senses Framework. This framework proposes that an enriched environment of care, in which positive relationships can flourish, can be achieved by addressing key dimensions of care or 'senses' for older peoples, families and friends, and staff. Nolan et al. (2006) suggested that each of these groups need to feel:

- a sense of security

- a sense of continuity
- a sense of belonging
- a sense of purpose
- a sense of fulfilment
- a sense of significance

Further information:

- Nolan, M.R., Brown, J., Davies, S., Nolan, J., & Keady, J. (2006) *The Senses Framework: Improving care for older people through a relationship-centred approach*. Sheffield: University of Sheffield.

Shared philosophy of care

A shared philosophy of care is a framework of values and care aims that all members of the team involved in caring for older peoples share. This shared philosophy provides common ground for co-operation and collaboration to achieve shared aspirations and visions of care across the whole system.

Strengths-based approach

Strengths-based practice is a process whereby the person supported by services and those supporting them, work collaboratively to determine an outcome that draws on the person's strengths and assets. The term 'strength' refers to different elements that support or enable the person to meet their needs and wishes and achieve their desired outcomes. These elements include: their personal resources, abilities, skills, knowledge and potential; their social network and its resources, abilities, skills, knowledge and potential; community resources, also known as 'social capital' and/or 'universal resources'.

Further information:

- Social Care Institute for Excellence. (2016). *What is a strengths-based approach to care?* Retrieved from http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/strengths-based-approach/what-is-a-strengths-based-approach.asp

7 The EHCH workforce competency framework

A: Values, attitudes and behaviours		
	Values and attitudes are essential components of a workforce competency framework because they underpin and influence care practices and behaviours. Therefore, values and attitudes can impact positively or negatively on the quality of care older people, families and friends experience. Staff need to be aware of their own values and attitudes, but also acknowledge that older people and their families and friends will have their own sets of values and beliefs that influence their choices and decisions.	
	Essential practice	**Specialist/advanced practice**
	Behave with integrity, acting in an open, honest and ethical manner towards older people, families/friends and colleagues. Be compassionate and acknowledge, respect and value older people's personhood. Be relationship-centred in the approach to care, recognising the importance of positive relationships between older people, families, friends and staff. Understand that compassionate, relationship-centred care that values personhood consists of a number of attributes and values including sensitivity, empathy, kindness, 'knowing' the person, and responsiveness. Express to older people, families and friends 'I care about you, respect you and recognise you as an individual; and I understand	Act as a role model for honest, ethical practice that is compassionate, values personhood, and promotes and protects older people's dignity. Encourage and support staff to work in ways that demonstrates compassionate, relationship-centred care, values personhood, and maintains dignity for older people, so that a culture of care and dignity is achieved.

	what and who is important to you'. Understand that compassionate care that values personhood is integral to quality care and care outcomes. Promote, respect and protect older people's dignity. Understand that dignity is concerned with older people's personal feelings, thoughts, standards and behaviours in relation to how they value themselves, and link these with individual personal preferences. Understand factors that can affect older people's dignity, for example privacy and confidentiality, and the impact on older peoples of not having dignity maintained, for example, the impact on self-esteem and confidence. Understand the importance of family-centred care, recognising and respecting the needs of family and friends of. Demonstrate inclusiveness of family and friends within the care environment. Acknowledge and value the uniqueness and diversity of older people, families and friends, and how these impact on their preferences	Actively seek out older people's, families'/ friends' and colleagues' views of care and dignity, and respond to feedback. Role model and promote a culture of valuing the involvement of family and friends in the care environment. Plan with older people, families/ friends and colleagues improvements required regarding care and dignity. Recognise and manage situations when the care or dignity of older people may be compromised, and outcomes affected. Review and evaluate practice against equality and diversity legislation and policy. Influence and contribute to the development of a culture that promotes and supports equality and diversity.

	and choices. Practice in a non-judgemental manner that supports access to equal opportunities to care, and that adheres to legislation and policy concerning equality and diversity. Recognise, challenge, and report discriminatory behaviours.	Aware of competing values across different settings and works towards harmonising values.
	Appreciate and value cultural differences, and provide care that accounts for older people's, families' and friends' cultural beliefs, behaviours and needs.	Encourage and support staff to work in ways that demonstrate cultural competency.
	Is self-aware and self-reflective, recognising and reflecting upon own values, attitudes, behaviours and practice, and be aware how these might be perceived by others, and impact on care delivered. Respond appropriately to feedback i.e. respond to feedback in a professional manner, rather than taking remarks personally.	Is self-aware and self-reflective and encourage, support and enable others to reflect upon their own values, attitudes, behaviours and practice. Demonstrate the importance of positive role-modelling. Appropriately respond to, and offer, constructive feedback. Understand staff pressures and the importance of recognising and responding to staff stresses. Use coping and resilience strategies to support the self and colleagues. Recognise and respond when colleagues require emotional support, and support to cope.
	Recognise that caring can be emotionally and physically demanding. Aware of, and demonstrate, coping and resilience strategies. Seek timely support.	Develop, or contribute to the development of clinical supervision and support mechanisms that support workforce reflective practice and resilience, and that recognise and respond to staff pressures, stressors and stress.

	Work within professional standards frameworks or recognised codes of conduct.	Take action, and act as advocates for older people, families and friends when standards or codes are breached. Appreciative of, and uses, the evidence base for compassionate, relationship-centred care that values personhood. Aware of the values, resources and support required to deliver compassionate, relationship-centred care that values personhood.
Existing workforce competencies (WFCs) and resources	**WCFs** Skills for Health. *Core competencies for healthcare support workers and adult social care workers in England* 'Equality, diversity and inclusion' and 'Person-centred care and support' http://www.skillsforhealth.org.uk/images/standards/care-certificate/Core%20Competences%20-%20Healthcare%20Support%20.pdf NHS Employers. *Knowledge and skills framework* 'Equality and diversity' levels 1/2 http://www.nhsemployers.org/SimplifiedKSF Royal College of Nursing. *Integrated core career and competence framework for registered nurses* 'Core knowledge and skills framework dimensions' http://www.rcn.org.uk/professional-development/publications/pub-003053	**WCFs** NHS Employers. *Knowledge and skills framework* 'Equality and diversity' levels 2/3/4 http://www.nhsemployers.org/SimplifiedKSF NHS Leadership Academy. *Clinical leadership competency framework* 'Demonstrating personal qualities' http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf NHS Leadership Academy. *Healthcare leadership model* http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf Royal College of Nursing. *Integrated core career and competence framework for registered nurses* 'Core knowledge and skills framework dimensions' http://www.rcn.org.uk/professional-development/publications/pub-003053 Skills for Care. *Manager induction standards* 'Person-centred practice' and 'equality, diversity and inclusion' http://www.skillsforcare.org.uk/Documents/Standards-legislation/Manager-Induction-Standards/Manager-Induction-Standards.pdf NHS England. *Leading change, adding value* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf

	NHS England. *Leading change, adding value* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf **Resources** Skills for Care. *Code of conduct for healthcare support workers and adult social care workers in England* http://www.skillsforhealth.org.uk/images/services/code-of-conduct/Code%20of%20Conduct%20Healthcare%20Support.pdf Nursing and Midwifery Council. *Professional standards of practice and behaviour for nurses and midwives* https://www.nmc.org.uk/standards/code/ The Health Foundation. *Person-centred care resource centre* http://personcentredcare.health.org.uk Health Education England e-LfH. *Compassion in practice* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Cultural competence*	**Resources** Nursing and Midwifery Council. *Professional standards of practice and behaviour for nurses and midwives* https://www.nmc.org.uk/standards/code/ Health and Care Professions Council. *Standards of conduct, performance and ethics* http://www.hcpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/ General Medical Council. *Good medical practice* http://www.gmc-uk.org/Good medical practice English 1215.pdf 51527436. The Health Foundation. *Person-centred care resource centre* http://personcentredcare.health.org.uk Health Education England e-LfH. *Compassion in practice* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Equality and diversity* http://www.e-lfh.org.uk/home/

	http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Equality and diversity* http://www.e-lfh.org.uk/home/	

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

	appropriate staff from a range of agencies and organisations. Identify gaps, difficulties and challenges of accessing support from the wider team. Be proactive in obtaining required information. Listen actively, and respond confidently, respectfully and with clarity to requests for information and support from all colleagues involved in older people's care, working to ensure common understanding of information, and treatment and care decisions. Understand and apply principles of information governance and confidentiality. Effectively use communication, documentation and record-keeping tools and techniques, including information systems and digital technologies, to facilitate data sharing and information exchange to	Collaborate with a diversity of staff from a range of organisations to develop strategies to holistically meet older people's needs, and develop and improve care across and between services. Demonstrate persistence, resilience and tenacity when faced with barriers to accessing support from the wider team. Listen actively, and respond respectfully and appropriately to requests for support and specialist expertise from all colleagues involved in older people's care, to ensure safe, timely and effective care. Choose, use, facilitate, co-ordinate, and contribute to the development of effective communication, documentation and record-keeping tools and techniques, including information systems and digital technologies, to enhance data sharing and information exchange across professions, agencies and organisations. Ensure data sharing	region, and lead the translation of strategies into practice development to improve care quality. Encourage and empower others to communicate, and express their ideas, opinions and concerns, to ensure care decisions, care strategies, and developments in service provision are comprehensively informed, and to promote innovations in practice. Ensure that staff, systems and processes are compliant with information governance and staff are aware of, and uphold principles of confidentiality. Contribute to the development of local, regional or national innovations, guidelines and information governance policies to

	enhance team function, and transfer of care between services.	and information exchange accounts for confidentiality.	support effective communication, documentation, data sharing and information exchange across professions, agencies and organisations, and contribute to their implementation and evaluation. These should include innovations, guidelines and information governance policies that support widespread use of wifi and digital technologies.
	Recognise that older peoples, families and friends are part of the team. Build and maintain trusting, constructive relationships with team members, including older people, families and friends. Empathise with team members to gain insight into their perspectives.	Build and maintain trusting, constructive relationships with individual older people, families and friends, and older people/family/friends groups, and a range of staff, agencies and organisations.	Actively seek relevant contacts to develop a network across a range of professions, agencies and organisations.
	Perform effectively on teams and contribute to shared decision-making.	Engage and motivate others in order to develop teams from a range of professions, agencies and organisations appropriate to specific care situations. Co-ordinate and engage teams in shared decision-making and problem-solving, ensuring the inclusion of older people, families and friends.	Develop teams from a range of professions, agencies and organisations, including older people, families and friends. Motivate, co-ordinate and empower teams in shared decision-making and problem-solving that address service delivery challenges. Provide opportunities for colleagues to network and develop cross agency/organisational relationships.

	Understand the concepts of accountability and responsibility. Provide timely feedback to team colleagues about the effectiveness of teams.	Aware of formal shared governance arrangements with other professionals and other organisations. Share accountability with other professionals from a range of organisations for care outcomes. Provide and interpret feedback about the effectiveness of teams.	Demonstrate effective negotiation skills. Manage disagreements and conflict within teams about values, roles, goals and actions that arise among professions and organisations, in a constructive, positive, diplomatic manner. Apply leadership practices that support collaborative practices and team effectiveness, and reflect on individual and team performance for team performance improvement. Represent the inter-professional and inter-organisational team at local, regional, political, national, strategic and policy level. Use and engage with available evidence and research to inform effective teamwork.
Existing WCFs and resources	**WCFs** NHS Employers. *Knowledge and skills framework* 'Quality' levels 1/2 http://www.nhsemployers.org/SimplifiedKSF Health Education England. *Care navigation: A competency framework* 'Enabling access to services',	**WCFs** NHS Employers. *Knowledge and skills framework* 'Quality' levels 2/3 http://www.nhsemployers.org/SimplifiedKSF NHS Leadership Academy. *Clinical leadership competency framework* 'Working with others'	**WCFs** NHS Employers. *Knowledge and skills framework* 'Quality' levels 3/4 http://www.nhsemployers.org/SimplifiedKSF NHS Leadership Academy. *Clinical leadership competency framework* 'Working with others'

	‘coordination and integration’, ‘building and sustaining professional relationships’, ‘communication’ essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* ‘Communication’ practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf National Skills Academy. *The leadership qualities framework for adult social care* ‘Working with others’ Frontline worker http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx	http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf Health Education England. *Care navigation: A competency framework* ‘Enabling access to services’, ‘coordination and integration’, ‘building and sustaining professional relationships’, ‘communication’ enhanced https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* ‘Communication’ senior practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf National Skills Academy. *The leadership qualities framework for adult social care* ‘Working with others’ Frontline leader http://www.skillsforcare.org.uk/Leadership-management/Leadership-	http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf Department of Health. *Advanced level nursing* ‘Leadership and collaborative practice’ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215935/dh_121738.pdf Health Education England. *Care navigation: A competency framework* ‘Enabling access to services’, ‘coordination and integration’, ‘building and sustaining professional relationships’, ‘communication’ expert https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses*, ‘Communication’ advanced practitioner/consultant http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf

		Qualities-Framework/Leadership-Qualities-Framework.aspx Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'Rehabilitation and multi-disciplinary team working' https://www.rcgp.org.uk/.../Files/CIRC/GPwSI/RCGP GPwSI older people.ashx Skills for Care. *Manager induction standards* 'Communication' and 'partnership working and relationships' http://www.skillsforcare.org.uk/Documents/Standards-legislation/Manager-Induction-Standards/Manager-Induction-Standards.pdf NHS Leadership Academy. *Healthcare leadership model* http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf	National Skills Academy. *The leadership qualities framework for adult social care* 'Working with others' Operational/strategic leader http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'Rehabilitation and multi-disciplinary team working' https://www.rcgp.org.uk/.../Files/CIRC/GPwSI/RCGP GPwSI older people.ashx Royal College of General Practitioners. *Advanced nurse practitioner competencies* 'Leadership and collaborative practice' http://www.rcgp.org.uk/membership/practice-team-resources/~/media/16411E76AC5B4E818547E331F9D3CA97 NHS Leadership Academy. *Healthcare leadership model*

	Resources Health Education England e-LfH. *Leadership foundations* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *NHS SBAR communication in care homes* http://www.e-lfh.org.uk/home/	**Resources** Health Education England e-LfH. *Leadership Foundations* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Leadership for clinicians* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *SBAR communication in care homes* http://www.e-lfh.org.uk/home/ NHS England. *Information governance framework* http://www.england.nhs.uk/ourwork/tsd/ig/	http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf **Resources** Health Education England e-LfH. *Leadership for clinicians* http://www.e-lfh.org.uk/home/ NHS England. *Information governance framework* http://www.england.nhs.uk/ourwork/tsd/ig/
B2: Teaching, learning, and supporting competence development	Health and social care staff working with older people must acquire and maintain evidence-based knowledge and skills to ensure delivery of quality, seamless care that meets the increasingly complex needs of the older population. Accessing education and development opportunities can be challenging, which reinforces the need for staff to engage in, commit to, and support others, in the development of knowledge and skills on an ongoing basis in order to increase scope of practice and ensure a highly competent workforce.		
	Demonstrate willingness and commitment to continuous learning and personal development,	Demonstrate willingness and commitment to learning and teaching, and to the continuous development of own role and	Engage in continuous professional and inter-professional development to enhance own and team performance.

	understanding its significance to best evidence-based practice. Reflect on own personal development, seek feedback, and engage with appraisal processes and gain insight into own performance and development needs.	competency of colleagues across the workforce. Reflect on own personal development and performance as a specialist practitioner and teacher, using appraisal processes, supervision, feedback from students/learners and evaluations/audits of care delivery within own sphere of practice. Ensure own knowledge and skill bases are contemporaneous and evidence-based, to ensure teaching methods and materials align with contemporary research and evidence-based practice.	Identify training and education needs of the current and future workforce. Co-ordinate and conduct appraisals.
	Support and facilitate learning of students, new staff, and peers, and provide constructive feedback about their progress and performance.	Support and facilitate learning of students, new staff, and peers, and provide constructive feedback about their progress and performance. Engage in professional networks and share learning from these with colleagues. Contribute to the planning, development, facilitation and delivery of education, training, supervision and mentorship for a range of	Forge interdependent relationships with other professions, academic institutions, and organisations to advance learning. Empower and enable colleagues across organisations to access learning opportunities. Contribute to the planning, development, facilitation and delivery of education, training, coaching and supervision in a variety of settings including higher education settings.

		different learners in different settings and organisations.	Use and engage with available evidence and research to inform effective education and training strategies. Plan, commission, and quality assure training. Contribute to the development of education policy.
	View and utilise the work environment as a centre for learning, and view and utilise care practices and engagement with team members as opportunities for learning.	Act as a mentor and/or preceptor. Develop and creatively utilise the work environment as a centre for teaching and learning, and develop and utilise care practices and engagement with team members as opportunities for teaching and learning.	Engage with partners to develop cultures of learning in range of settings and methods. Develop and support strategies to implement learning in, and into, practice.
	Utilise online and distance learning packages where appropriate.	Utilise and promote access to online and distance learning for the self and others.	Develop creative, flexible teaching and learning strategies that are convenient to access, appropriate and relevant to the work setting, and cost-effective.
		Use a range of methods to constructively appraise and assess, or facilitate appraisal and assessment of, others' progress and competency, and identify and support others' development needs, both within and across organisations.	Evaluate, and provide constructive feedback about learning, teaching and assessment processes.

	Undertake delegated activities only if competent to perform these activities. Recognise and report pressures and challenges of learning, and accessing learning and development opportunities. Proactively engage in safety and service development by learning from incidents and incident evaluations.	Use competency assessments as a basis for delegation decisions to ensure safe practice. Understand own role and responsibility when delegating. Provide adequate support to delegatees to ensure their safe, competent practice. Acknowledge, interpret and report pressures and challenges of providing and accessing learning and development opportunities for the self and others, and contribute to developing flexible, innovative teaching strategies to address these challenges.	Build capacity and capability to support learning in practice settings and collaborate with education service providers and education commissioners to ensure workforce and student needs are met. Monitor staff engagement with education and training, and develop and implement strategies to improve engagement.
Existing WCFs and resources	**WCFs** Skills for Health. *Core competencies for healthcare support workers and adult social care workers in England* 'Personal development' http://www.skillsforhealth.org.uk/images/standards/care-certificate/Core%20Competences%20-%20Healthcare%20Support%20.pdf	**WCFs** NHS Employers. *Knowledge and skills framework* 'Personal and people development' levels 2/3 http://nhsemployers.org/SimplifiedKS Nursing and Midwifery Council. *Standards to support learning and*	**WCFs** NHS Employers. *Knowledge and skills framework* 'Personal and people development' levels 3/4 http://nhsemployers.org/SimplifiedKS Nursing and Midwifery Council. *Standards to support learning and*

	NHS Employers. *Knowledge and skills framework* 'Personal and people development' http://nhsemployers.org/SimplifiedKSF Skills for Care. *Ongoing learning and development in adult social care* http://www.skillsforcare.org.uk/Documents/Learning-and-development/Ongoing-learning-and-development-guide.pdf Health Education England. *Care navigation: A competency framework* 'Personal development and learning' essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS England. *Leading change, adding value* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf	*assessment in practice* https://www.nmc.org.uk/standards/additional-standards/standards-to-support-learning-and-assessment-in-practice/ General Medical Council. *Promoting excellence: Standards for medical education and training* http://www.gmc-uk.org/education/standards.asp Health Education England. *Care navigation: A competency framework* 'Personal development and learning' enhanced https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS England. *Leading change, adding value* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf	*assessment in practice* https://www.nmc.org.uk/standards/additional-standards/standards-to-support-learning-and-assessment-in-practice/ General Medical Council. *Promoting excellence: Standards for medical education and training* http://www.gmc-uk.org/education/standards.asp Department of Health. *Advanced level nursing* 'Developing self and others' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215935/dh_121738.pdf Royal College of General Practitioners. *Advanced nurse practitioner competencies* 'Developing self and others' http://www.rcgp.org.uk/membership/practice-team-resources/~/media/16411E76AC5B4E818547E331F9D3CA97 Health Education England. *Care navigation: A competency framework* 'Personal development and learning' expert https://www.hee.nhs.uk/sites/defaul

			t/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS England. *Leading change, adding value* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf

C: Leading, organising, managing and improving care			
C1: Leading, organising and managing care	All health and social care staff need to understand and use principles of leadership, organisation and management in order to facilitate provision of safe, effective and efficient practice that is relationship-centred and supports personhood. This involves understanding and engaging with care systems and clinical governance, and managing services and resources including staffing and skill mix. Staff also need to understand, negotiate and apply contractual and financial arrangements, and undertake business and budget management to maximise sustainability of services.		
	Essential practice	**Specialist practice**	**Advanced practice**
	Understand own role's contribution to the delivery of care. Understand own role and value within the integrated health and social care system.	Use comprehensive knowledge of long-term conditions and integrated care policy to inform the organisation and management of care.	Use comprehensive understanding of long-term conditions and integrated care requirements to lead on, and develop systems, and inform policy developments.
		Understand and use clinical governance to ensure safe, effective, relationship-centred care that supports personhood. Examples include: instigating and undertaking clinical audits and risk management strategies, actively seeking older people's and families' and friends' feedback as part of quality monitoring, and managing complaints in a timely, candid manner.	Lead and develop shared clinical governance practices and strategies to ensure safe, effective care across organisations and sectors. Use audit and inspection information and views of older people, families and friends to monitor standards and propose improvements. Evaluate data and validity of information derived from audits and inspections.
	Understand and follow health, safety and risk management legislation, regulations, inspections, policies and procedures, including Care Quality	Use systems and processes to ensure compliance with health, safety and risk management legislation, regulations, inspections, and organisational policies and	Develop, implement and monitor systems and processes to ensure compliance with current health, safety and risk legislation, regulations and organisational policies and

	Commission and local standards, to keep self and others safe. Assess, review and report about the effectiveness of services and resources to meet older people's needs. Prioritise workload using time and resources effectively.	procedures, including Care Quality Commission and local standards. Assess, acquire, develop, organise, manage and review services and resources to ensure these match older people's needs. Ensure staff levels and skill mix of staff is appropriate to meet service needs. Undertake staff skill mix reviews. Use workload tools to support rostering. Understand and ensure compliance with recruitment policies and procedures. Evidence, and negotiate with service providers, to address staff and skill mix needs, and to maximise continuity of care for older people. Lead and manage staff. Understand and undertake performance management of staff. Understand, negotiate and apply contractual and financial arrangements with local authorities, clinical commissioning groups and healthcare providers, to maximise sustainability of services and older	procedures, including Care Quality Commission and local standards. Assess, acquire, develop, organise, manage and review services and resources to ensure these reflect and address the needs of local, regional, or national population. Structure and re-structure staffing resources to meet older people's needs on establishment, organisational, service or sector basis. Analyse, investigate and respond to recruitment, absence and retention issues. Innovate and create new roles to meet older people's needs on establishment, organisational, service or sector basis. Has overall responsibility for leading and managing staff. Use comprehensive understanding of long-term conditions, integrated care requirements and NHS continuing healthcare policy, to lead and develop systems that influence and inform how care is commissioned and

		people's care outcomes, including those requiring NHS continuing healthcare assessments. Able to challenge funding outcome decisions and advocate for older people and families and friends when needed to ensure correct funding is in place.	financed to maximise sustainability of services and older people outcomes.
	Aware of market force and budget management aspects of service provision and their contribution to sustainability of services and quality improvement.	Understand and effectively undertake business and budget management. Contribute to service provision marketing strategies, ensuring marketing materials are fit for purpose and reflect available services. Advocate for older people by encouraging older people, families and friends to discuss/visit services, and use these interactions as a means to assess 'match' between older people's needs and preferences, and available services.	Efficient and effective business and resource manager. Fully conversant with market forces. Lead, develop, implement and review marketing policies and procedures. Ability to scope and identify opportunities for new business, and develop business plans. Demonstrate an entrepreneurial approach.
Existing WFCs and resources	**WCFs** NHS England. *Leading change, adding value* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf National Skills Academy. *The leadership qualities framework for adult social care* 'Managing services' and 'creating the vision' Frontline worker	**WCFs** NHS Leadership Academy. *Clinical leadership competency framework* http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf My Home Life. *My home life transformation package*	**WCFs** Department of Health. *Advanced level nursing* 'Leadership and collaborative practice' and 'improving quality and developing practice' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215935/dh_121738.pdf NHS Leadership Academy. *Clinical leadership competency framework* http://www.leadershipacademy.nhs.

	http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx	http://myhomelife.org.uk/wp-content/uploads/2015/07/My-Home-Life-Transformation-Package-brochure.pdf NHS England. *Leading change, adding value* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf National Skills Academy. *The leadership qualities framework for adult social care* 'Managing services' and 'creating the vision' Frontline leader http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx NHS Leadership Academy. *Healthcare leadership model* http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf	uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf Royal College of General Practitioners. *Advanced nurse practitioner competencies* 'Leadership and collaborative practice' http://www.rcgp.org.uk/membership/practice-team-resources/~/media/16411E76AC5B4E818547E331F9D3CA97 NHS England. *Leading change, adding value* https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf National Skills Academy. *The leadership qualities framework for adult social care* 'Managing services' and 'creating the vision' Operational/strategic leader http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx

	Resources Health Education England e-LfH. *Leadership foundations* http://www.e-lfh.org.uk/home/	**Resources** Health Education England e-LfH. *Leadership for clinicians* http://www.e-lfh.org.uk/home/	NHS Leadership Academy. *Healthcare leadership model* http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf **Resources** Health Education England e-LfH. *Leadership for clinicians* http://www.e-lfh.org.uk/home/
C2: Improving care	Health and social care staff need to ensure care delivered meets best practice standards. This means staff need to understand, and be committed to service improvement. Ongoing care improvement involves assessment, monitoring and evaluation of services and engagement with service improvement initiatives, evidence-based practice and research. It is essential that staff are open to early adaption and adoption of change.		
	Champion self and others in driving forward and improving care for older people. Contribute to achieving goals and visions of health and social care services and organisations. Understand the principles of audits and quality improvement and provide suggestions for improvements to policies, practice, and environments.	Role model and instil positivity in others regarding improving care for older people. Develop, and facilitate achievement of, goals and visions for health and social care services and organisations. Assess and monitor services and impact, to inform service improvement.	Visionary and inspirational about improving care for older peoples. Lead, develop, and facilitate achievement of goals for health and social care services and organisations. Evaluate quality, effectiveness and efficiency of services, and the link between interventions and outcomes, to inform service improvement on a local, organisational or national basis.

	Demonstrate comprehensive and accurate record keeping to ensure data required for audits and service evaluations is available. Integrate evidence-based practices to improve care. Open to change and improvement, and committed to early adaption and adoption of change.	Develop and participate in audits and quality improvement projects to inform and facilitate service improvement. Critically evaluate, and base practice on, best available evidence. Contribute to developing an environment of enquiry, change and improvement. Role model early adaption and adoption of change.	Lead, develop, implement and evaluate service improvement projects and audits. Lead, undertake, or facilitate the undertaking of, research projects to inform evidence-based practice and service improvement. Ensure completion to targets. Ensure staff compliance with best evidence-based practice. Influential in creating a culture of openness to change and improvement, and act as a change agent. Disseminate information about service improvement in a meaningful way, and lead change processes. Understand and apply change management theory to practice.
Existing WCFs and resources	**WCFs** NHS Employers. *Knowledge and skills framework* 'Service improvement' and 'quality' levels 1/2 http://www.nhsemployers.org/SimplifiedKSF NHS England. *Leading change, adding value*	**WCFs** NHS Employers. *Knowledge and skills framework* 'Service improvement' and 'quality' levels 2/3 http://www.nhsemployers.org/SimplifiedKSF NHS England. *Leading change, adding value*	**WCFs** NHS Employers. *Knowledge and skills framework* 'Service improvement' and 'quality' levels 3/4 http://www.nhsemployers.org/SimplifiedKSF NHS England. *Leading change, adding value*

	https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf National Skills Academy. *The leadership qualities framework for adult social care* 'Improving services', 'setting direction' and 'delivering the strategy' Frontline worker http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx	https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf National Skills Academy. *The leadership qualities framework for adult social care* 'Improving services', 'setting direction' and 'delivering the strategy' Frontline leader http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx **Resources** National Institute for Health Research. http://www.nihr.ac.uk/ Health Education England e-LfH. *Research, audit and quality improvement* http://www.e-lfh.org.uk/home/	https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf National Skills Academy. *The leadership qualities framework for adult social care* 'Improving services', 'setting direction' and 'delivering the strategy' Operational/strategic leader http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx **Resources** National Institute for Health Research. http://www.nihr.ac.uk/ Health Education England e-LfH. *Research, audit and quality improvement* http://www.e-lfh.org.uk/home/

D: Knowledge and skills for care delivery			
D1: Communication with older people, families and friends	Communication with older people, families and friends is integral to the development of trusting, therapeutic relationships and partnerships. Staff must use a range of communication methods to support safe, quality care decisions that account for older people's preferences and choices. Staff must recognise when older people, families and friends require support to communicate, and facilitate that support.		
	Essential practice	**Specialist practice**	**Advanced practice**
	Communicate clearly, sensitively and effectively with older people, families and friends, adapting communication styles and environments to account for individual's physical and illness conditions, sensory, functional and cognitive deficits, psychological and mental health needs, cultures and preferences.	Use, and support others to use, communication that is clear, sensitive and effective with older people, families and friends, adapting communication styles and environments to account for individual's physical and illness conditions, sensory, functional and cognitive deficits, psychological and mental health needs, cultures and preferences.	Provide expertise, or expert advice, where communication issues with individuals, families and friends are complex.
	Use communication and active listening skills to develop effective therapeutic relationships with older people, understand their preferences and choices, and support decision-making that accounts for their preferences and values.	Use, and support others to understand and use, communication and active listening skills to develop effective therapeutic relationships with older people, understand their preferences and choices, and support decision-making that accounts for their preferences and values. Where appropriate, apply communication techniques to resolve conflict.	Provide expertise, or expert advice, where the development of therapeutic relationships with individuals is complex.
	Use a range of non-verbal tools, formats and strategies, including information technology and	Use and support others to use a range of creative communication methods to overcome difficulties in	Contribute to the development of local, organisation or national

	technological communication aids, to enhance communication with older people. Listen to family members and friends, respect them as partners in the care of older people, and value their input in communication and care processes.	communication, including information technology and technological communication aids. Develop systems to support individual family members and friends, and family/friends groups. Communicate in a manner that supports older people, families and friends to actively participate in care decisions. Promote collaborative communication with older people, families and friends, and share information, decisions and discussions made by the care team with older people, families and friends.	guidelines regarding effective communication and communication technologies that support older people, families and friends. Facilitate older people and family groups to participate and collaborate in influencing local and national policies. Work and advocate on behalf of older people, families and friends ensuring their views are represented at local and national levels.
Existing WCFs and resources	**WCFs** Skills for Health. *Core competencies for healthcare support workers and adult social care workers in England* 'Effective communication' and 'handling information' http://www.skillsforhealth.org.uk/images/standards/care-certificate/Core%20Competences%20-%20Healthcare%20Support%20.pdf	**WCFs** NHS Employers. *Knowledge and skills framework* 'Communication' levels 2/3 http://www.nhsemployers.org/SimplifiedKSF Health Education England. *Care navigation: A competency framework* 'Communication' enhanced https://www.hee.nhs.uk/sites/defaul	**WCFs** NHS Employers. *Knowledge and skills framework* 'Communication' levels 3/4 http://www.nhsemployers.org/SimplifiedKSF HEE, *Care navigation: A competency framework* 'Communication' expert https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigatio

	NHS Employers. *Knowledge and skills framework* ‘Communication’ levels 1/2 http://www.nhsemployers.org/SimplifiedKSF Health Education England. *Care navigation: A competency framework* ‘Communication’ essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses*, ‘Communication’ and ‘relationships’ practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of Nursing. *Integrated core career and competence framework for registered nurses* ‘Core knowledge and skills framework dimensions’ http://www.rcn.org.uk/professional-development/publications/pub-003053	t/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses*, ‘Communication’ and ‘relationships’ senior practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of Nursing. *Integrated core career and competence framework for registered nurses* ‘Core knowledge and skills framework dimensions’ http://www.rcn.org.uk/professional-development/publications/pub-003053	n%20Competency%20Framework_Final.pdf NHS Scotland *Working with older people in Scotland: A framework for mental health nurses* ‘Communication’ and ‘relationships’ advanced practitioner/consultant http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf

	Resources Health Education England e-LfH. *Accessible information standard* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Communication with empathy* http://www.e-lfh.org.uk/home/	**Resources** Health Education England e-LfH. *Accessible information standard* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Shared decision-making* http://www.e-lfh.org.uk/home/	**Resources** Health Education England e-LfH. *Shared decision-making* http://www.e-lfh.org.uk/home/
D2: Care process	The process of caring for an older person is complex. It involves the ongoing comprehensive assessment of the individual's care needs, then the planning, implementation and evaluation of care that addresses the multiple and changing dimensions of the individual's life, health needs and contexts, and accounts for their preferences and expectations. Staff must have an in depth knowledge of common health problems within their own sphere of practice including co-morbidity. They must be able to demonstrate effective assessment skills, safely carry out a range of diagnostic and clinical interventions, and monitor the individual's progress against expected outcomes, amending care plans where necessary. The individual, families and friends should be fully involved in the care process. An important aspect of the care process is the management of medicines. Staff must have knowledge of pharmacology relating to older people, ensure medicines are managed safely and effectively, and involve the individual in decisions regarding the use of pharmacological interventions in their care.		
D2.1: Assessing, planning, implementing and evaluating care	Use day-to-day interactions with, and observations of the older person and their family and friends to generate knowledge that informs understanding of the older person's baseline and 'norms', and informs and contributes to comprehensive assessment of needs.	Participate in undertaking and recording a comprehensive geriatric assessment (CGA) of the older person, encompassing 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. Involve the older person and their family and friends as	Provide expertise, or expert clinical advice, in complex decisions relating to assessment of individuals. Use assessment skills and engage with research and evidence to assess the clinical needs of the older population on community, local or national bases.

		partners to identify preferences and expectations.	
	Utilise assessment and risk assessment tools that assess needs of individuals accurately and correctly to inform and contribute to comprehensive assessment of the older person's needs. Examples include assessment and risk assessment tools, including digital technology tools, for hydration, nutrition, sleep/rest, mobility, falls, personal care, continence, skin integrity/pressure damage.	Select, recommend and utilise valid and reliable screening, assessment and risk assessment tools, including digital technology tools, and use in conjunction with clinical judgement to assess the individual's needs.	Use advanced assessment, diagnostic reasoning skills and a range of other diagnostic support tools, including digital technology tools, to assess the individual's needs.
	Undertake a range of clinical assessment and diagnostic tests, including those utilising digital technology.	Identify the older people's needs, goals and problems by working in collaboration with the individual and family and friends, together with undertaking a range of clinical assessment and diagnostic tests, including those utilising digital technology, and critically interpreting assessment data **(some activities may require RHCP status).**	
	Use knowledge of the older person and their family and friends, to contribute to the formulation of plans of care, including plans regarding transfer of care between services.	Formulate with the older person and their family and friends plans of care based on the individual's identified needs and evidence-based practice, including plans regarding transfer of care between services.	Provide expertise, or expert clinical advice, in complex decisions relating to the planning of care for individuals.

			Establish a process for transfer planning to ensure smooth, effective, safe transfer of care services. Use expert clinical knowledge and engage with research and evidence to develop care plans that inform local or national care plan guidelines.
	Aware of the continuing healthcare process, including the requirement for completing continuing healthcare checklists. Provide evidence as part of NHS funded nursing and continuing healthcare assessments and reviews.	Recognise the requirement for, undertake, or facilitate, timely NHS continuing healthcare checklists, and co-ordinate assessments or refer potentially eligible older peoples for full assessment.	Co-ordinate, or contribute to NHS continuing healthcare assessment to inform Clinical Commissioning Group funding decisions.
	Demonstrate knowledge of anatomy and physiology, presentation of illness, and key interventions and conditions relevant to older people and the ageing process. Recognise factors that impact on health and offer health advice and support strategies for older people, families and friends. Utilise this knowledge to support older people to effectively address their fundamental care needs, accounting for their personal preferences. Examples include: supporting hydration, nutrition, personal appearance and hygiene, sleep/rest, mobility, continence, skin integrity.	Demonstrate knowledge of a broad range of conditions, care pathways, and evidence-based care management strategies relevant to older people. Examples include: diabetes, coronary heart disease, heart failure, hypertension, stroke, chronic obstructive pulmonary disease, arthritis, osteoporosis, Parkinson’s disease, cancer, frailty, dementia, common mental illnesses, and palliative and end of life care. Understand the presentations of multiple pathology, and age-related epidemiology of disease and presentation of illness. Utilise knowledge of common conditions,	Work clinically, and provide expert clinical advice in complex interventions. This may be in a broad range of interventions, or as an expert in a key area of care. Display originality of thought and utilise this in innovative development of models, approaches and interventions to ensure needs of older people are met.

		care pathways and evidence-based care management strategies to co-ordinate and manage care, including where the older people has complex care needs and multiple morbidities.	
	Provide a range of clinical care interventions to support the management of older people's health needs.	Provide a range of clinical care interventions to support the management of older people's health needs (**some activities may require RHCP status**).	Influence service providers/planners to ensure that the care environments, resources and ranges of clinical interventions available, meet the needs of individual older peoples, and older people populations.
		Embed anticipatory care into practice, and utilise ongoing development of care pathways which aim to reduce hospital admissions.	Proactively develop innovative and flexible clinical care management models for older people, and utilise to influence national and local practice guidelines.
	Recognise, respond and report changes and deterioration in physical, psychological, cognitive, and functional health, and behaviour. Examples include: symptoms of dementia, symptoms of delirium, exacerbations of diseases, falls, symptoms of fracture, symptoms of pain, weight loss, loss of appetite, reduced mobility, requirement for first aid, requirement for basic life support, reduced interaction, low mood, 'entry' into the dying stage.	Recognise, and respond in a timely manner to requests for support, to changes and deterioration in physical, psychological, cognitive, and functional health, pain, and behaviour. Where necessary, formulate a management plan based on the possibilities of differential diagnoses. Use a range of clinical care interventions and appropriate referrals, including appropriate hospital admission, to manage these changes/diagnoses.	

	Use, or facilitate access to, a range of clinical care interventions and appropriate referrals to manage these changes. Examples include: pharmacological interventions, first aid, life support, team expertise, appropriate referral to acute/specialist services. Follow the care plan. Monitor the individual in relation to expected care plan outcomes, continually evaluate the effectiveness of interventions and compare actual with anticipated outcomes, and report evaluation findings.	Monitor the individual in relation to expected care plan outcomes, continually evaluate the effectiveness of interventions and compare actual with anticipated outcomes, and provide evidence-based rationales to modify care plans according to evaluation findings.	Use expert clinical knowledge and engage with research and evidence to evaluate care models, approaches and interventions, and use these evaluations to inform local or national care guidelines. Demonstrate a critical understanding of systems of care, and respectfully challenge practice, systems and policies in an objective, constructive manner.
D2.2: Pharmacology and management of medicines	Adhere to systems and governance arrangements in the management and administration of medication, or in supporting older people to manage their medication, including non-prescription and over-the-counter medications. This includes: • support older people to self-administer medications	Provide advice, contribute to the development of, and adhere to systems and governance arrangements in the prescribing, and/or management and administration of medication, or in supporting older people to manage their medication, including non-prescription and over-the-counter medications **(prescribing medication**	Implement and review systems and governance arrangements to ensure safe, best practice in prescribing and medication management. This includes: • develop and establish policy across health and social care organisations to support older people to self-administer medication.

	unless a risk assessment has indicated otherwise. • work in accordance with the Mental Capacity Act to ensure older people have opportunities to be involved in decisions about the use of pharmacological interventions. • respond to, and report individual's reactions and responses to medication, contributing information that informs medication reviews. • correct ordering, checking and storing medications. • comprehensive and accurate record keeping.	**requires prescriber status)**. This includes: • undertake a risk assessment to determine the level of support an individual requires to self-administer medications. • work, and support others to work, in accordance with the Mental Capacity Act to ensure older people have opportunities to be involved in decisions about the use of pharmacological interventions. • undertake, or facilitate the undertaking of, regular medication reviews, using current evidence based practice, and in consultation with other staff, the older person, families and friends, to inform decisions. • oversee the correct ordering, checking, storing, dispensing and supplying of medications. • undertake and support others to undertake comprehensive and accurate recording of medicine management. • ensure covert administration only takes place in the	• Provide expert advice to inform complex mental capacity issues. • undertake, or provide expert advice about, regular medication reviews in consultation with older peoples, families and friends. • develop and establish policy on the covert administration of medicines across health and social care organisations. • develop and establish policy on non-prescription medicines or other over-the-counter-products across health and social care organisations. • develop and establish policy on the safe administration of medication via subcutaneous, intra muscular and intravenous routes, with the aim of providing continuity of care for older peoples and reducing hospital admissions.

		context of existing legal and good practice frameworks to protect older people, and staff involved in administering medicines. Understand specific pharmacological issues relating to older people, including polypharmacy, iatrogenic illnesses, contraindications, risks and benefits of anti-psychotics, anti-depressants, anxiolytics, anticonvulsants and cognitive enhancers. Ensure adverse reactions are reported.	Provide expert clinical advice on complex pharmacological issues for older people. Develop, appraise and use new and emerging research and knowledge of pharmacological interventions to enhance the health and wellbeing of older people.
Existing WCFs and resources	**WCFs** Health Education England. *District nursing and general practice nursing service education and career framework* https://www.hee.nhs.uk/sites/default/files/documents/Interactive%20version%20of%20the%20framework_1.pdf Health Education England. *Care navigation: A competency framework* 'Personalisation' and 'knowledge for	**WCFs** Health Education England. *District nursing and general practice nursing service education and career framework* https://www.hee.nhs.uk/sites/default/files/documents/Interactive%20version%20of%20the%20framework_1.pdf Health Education England. *Care navigation: A competency framework* 'Personalisation' and 'knowledge for	**WCFs** Department of Health. *Advanced level nursing* 'Clinical/direct care practice' and 'improving quality and practice development' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215935/dh_121738.pdf Health Education England. *District nursing and general practice nursing service education and career framework*

	practice' essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses*, 'Health and wellbeing' practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of Nursing. *Integrated core career and competence framework for registered nurses* 'Specific knowledge and skills framework dimensions' http://www.rcn.org.uk/professional-development/publications/pub-003053	practice' essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland *Working with older people in Scotland: A framework for mental health nurses*, 'Health and wellbeing' advanced practitioner/consultant http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of Nursing. *Integrated core career and competence framework for registered nurses* 'Specific knowledge and skills framework dimensions' http://www.rcn.org.uk/professional-development/publications/pub-003053 Joint Improvement Team Scotland. *Competency skills development for nurses and allied health professionals working in a hospital at home team* http://www.jitscotland.org.uk/wp-content/uploads/2014/08/Competency-Skills-for-Practitioners-for-Hospital-at-Home.pdf	https://www.hee.nhs.uk/sites/default/files/documents/Interactive%20version%20of%20the%20framework_1.pdf Health Education England. *Care navigation: A competency framework* 'Personalisation' and 'knowledge for practice' essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses*, 'Health and wellbeing' advanced practitioner/consultant http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'Comprehensive geriatric assessment', 'diagnosis and management of acute illness', 'transfer of care and discharge planning', 'intermediate care and

	Resources Health Education England e-LfH. *Communicating with empathy* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Essentials in care*	Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'Comprehensive geriatric assessment', diagnosis and management of acute illness', 'transfer of care and discharge planning', 'intermediate care and community geriatrics', 'long term care', 'falls', 'continence', 'stroke', 'orthogeriatrics', 'management of drug therapy' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP GPwSI older people.ashx Nursing and Midwifery Council. Standards of proficiency for nurse and midwife prescribers https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-proficiency-nurse-and-midwife-prescribers.pdf **Resources** National Institute for Health and Care Excellence. *Multimorbidity: Clinical assessment and management* https://www.nice.org.uk/guidance/ng56	community geriatrics', 'long term care', 'falls', 'continence', 'stroke', 'orthogeriatrics', 'management of drug therapy' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP GPwSI older people.ashx Royal College of General Practitioners. *Advanced nurse practitioner competencies* 'Direct clinical care', 'Long term conditions' and 'Acute presentation' http://www.rcgp.org.uk/membership/practice-team-resources/~/media/16411E76AC5B4E818547E331F9D3CA97 **Resources** National Institute for Health and Care Excellence. *Multimorbidity: Clinical assessment and management* https://www.nice.org.uk/guidance/ng56

	http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Pain* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Personalised care planning* http://www.e-lfh.org.uk/home/ NEWS. *National early warning score training package* https://tfinews.ocbmedia.com/ Social Care Institute for Excellence. *Dignity factors: Eating and nutritional care* http://www.scie.org.uk/publications/guides/guide15/factors/nutrition/ National Institute for Health and Care Excellence. *Managing medicines in care homes* https://www.nice.org.uk/guidance/sc1 Skills for Care. *Medication* http://www.skillsforcare.org.uk/Topics/Medication/Medication.aspx Royal Pharmaceutical Society. *The handling of medicines in social care* http://www.rpharms.com/support-	Health Education England e-LfH. *Continuing healthcare* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Pain* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Personalised care planning* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Sepsis in primary care* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Shared decision-making* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Safe prescribing* http://www.e-lfh.org.uk/home/ National Institute for Health and Care Excellence. *Managing medicines in care homes* https://www.nice.org.uk/guidance/sc1 Royal Pharmaceutical Society. *The handling of medicines in social care* http://www.rpharms.com/support-	Health Education England e-LfH. *Continuing healthcare* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Sepsis in primary care* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Shared decision-making* http://www.e-lfh.org.uk/home/ National Institute for Health and Care Excellence. *Managing medicines in care homes* https://www.nice.org.uk/guidance/sc1 Royal Pharmaceutical Society. *The handling of medicines in social care* http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf Cumbria Clinical Commissioning Group. *The STOPP START toolkit* https://www.networks.nhs.uk/nhs-networks/nhs-cumbria-ccg/medicines-management/guidelines-and-other-publications/Stop%20start%20pdf%20final%20Feb%202013%20version.pdf

	pdfs/handling-medicines-socialcare-guidance.pdf	pdfs/handling-medicines-socialcare-guidance.pdf Cumbria Clinical Commissioning Group. *The STOPP START toolkit* https://www.networks.nhs.uk/nhs-networks/nhs-cumbria-ccg/medicines-management/guidelines-and-other-publications/Stop%20start%20pdf%20final%20Feb%202013%20version.pdf	
D3: Promoting health, wellbeing and independence	Integral to relationship-centred care that supports personhood is the promotion of health, wellbeing and independence. To achieve this, staff must provide an enriched environment which accommodates older people's choices, rights, wishes, needs and aspirations about their life, health and activities, and their decisions about end-of-life. Staff must enable older people to enjoy equal access to health services; and promote and facilitate self-care, healthy lifestyle choices, and rehabilitation and reablement opportunities. Staff must also be able to work in partnership with older people, and their families and friends to manage risk and promote resilience. Central to the promotion of health, wellbeing and independence is staffs' thorough understanding and effective utilisation of the Mental Capacity Act, best interest decisions, and safeguarding.		
D3.1: Promoting and supporting independence and autonomy	Engage with older people to understand their preferences and aspirations, advocate and support them to exercise their rights and choices. Facilitate access to information in relation to rights and choices. Aware of how the Mental Capacity Act and the principles and process of Lasting Power of Attorney apply to	Act as a role model to support older people to exercise rights and choices. Provide, and advocate for, access to information in relation to rights and choices for older people, families and friends. Assess capacity where the individual has varying capacity. Assess capacity in relation to higher risk decisions,	Develop systems and practices that promote opportunities and advocacy for older people to exercise their rights and choices. Provide expert advice where informed consent is complex.

	older people. Understand the principles of capacity, and that the individual may have varying capacity. Assess capacity on an informal basis in relation to day to day decisions. Examples include: an individual agreeing to being supported with personal hygiene.	particularly where it is suspected that the individual wishes to make an unwise decision. Examples include: whether the individual can consent to having a dressing changed. Knowledge of the principles and process of Lasting Power of Attorney. Consider, and discuss Lasting Power of Attorney with older people, families/friends and colleagues as part of promoting and supporting autonomy.	Carry out formal assessment of capacity in relation to complex, or high risk decisions, and decisions that are likely to have a lasting impact. Examples include: situations where there may be legal consequences. Use relationship-centred best interest decisions where an individual lacks capacity to make complex and challenging decisions. Examples include: decisions about withholding or withdrawing life sustaining treatment.
	Understand and use relationship-centred best interest decisions, and adhere to deprivation of liberty safeguarding legislation and regulations where an individual lacks capacity to make day to day decisions. Example include: decisions about what clothes to wear.	Use relationship-centred best interest decisions, and adhere to deprivation of liberty safeguarding legislation and regulations where an individual lacks capacity to make more complex decisions. Examples include: decisions about changes in medication.	Provide expert advice where there are competing views about capacity/best interests, for example between family members; between families and staff.
	Understand the principles of ethics and ethical decision-making. Recognise ethical dilemma situations, and aware of how to access support in ethical dilemma situations. Examples include: differences of opinion between family members or between families and staff; end of life	Provide support for others when working with ethical dilemma situations. Ensure the views or older people, families and friends are taken into account, and facilitate access to independent advocates where appropriate.	Demonstrate thorough knowledge of ethics, moral reasoning and ethical decision-making. Provide expert advice about complex ethical considerations.

	decisions; issues regarding autonomy and risk.		
	Demonstrate awareness and understanding of advance care planning, and the times at which it would be appropriate.	Consider, and discuss advance care planning with older people, families/friends and colleagues as part of promoting and supporting autonomy.	Provide expert advice about complex advance care planning issues.
	Work in partnership with older people, families and friends to enable and empower self-care. Use basic teaching strategies with older people, families and friends to optimise self-care.	Promote, develop, and use models of self-care when working with older people, families and friends. Assess individuals' and families' and friends' learning needs and use teaching strategies to optimise self-care.	Develop systems and practices that emphasise and support older people, families and friends to use self-care strategies.
	Support older people's independence and senses of familiarity and security by facilitating individual routines and preferences. Examples include: familiar/preferred food, clothes, possessions, using clear signage, using adaptive equipment.	Promote older people's independence and senses of familiarity and security by adapting, and facilitating the adaption of, the environment. Examples include: acquiring and facilitating the acquisition of familiar/preferred food, clothes, possessions, clear signage, adaptive equipment.	Promote older people's independence by providing expert advice about the needs of the older population in order to inform designs, and policy about designs, of care environments and assistive technologies.
	Enable older people to utilise aids, equipment, technology, exercises, and rehabilitation regimes to support, maintain and improve their sensory, functional, cognitive and mobility abilities. Report progress to appropriate MDT professionals.	Assess the need for, develop, acquire, implement, and evaluate a range of tools, strategies and technologies to promote rehabilitation, re-ablement and independence for older people.	Influence service providers to develop flexible, innovative approaches to enable older people to access mainstream health and rehabilitation services.

	Demonstrate understanding of how care is funded, and signpost older peoples, families and friends to support for financial matters.	Assist, facilitate assistance for older people and families in financial matters relevant to personalised care funding support.	Contribute to the development of local, regional or national innovations, guidelines and information governance policies to support older people and families to understand and negotiate the financial implications of health and social care.
D3.2: Promoting and supporting holistic health and wellbeing	Recognise the contribution of biography and life story to providing quality holistic care that meets individual's health and wellbeing needs. Support older people, families and friends to access opportunities to socialise, engage in relationships, and engage in solo and group activities that are meaningful to them and reflect their individual needs and interests. Support older people to go out into the community, access community services and attend community events.	Use the older people's biography and life story to inform care decisions in order to meet health and wellbeing needs. Take a strengths-based approach to care. Provide support and advice to older people, families/friends and colleagues regarding the provision of a socially stimulating environment that reflects the individual's interests, and their changing needs as they progress through the life course. Engage with the local community to ensure strategies are in place to support older people to access and attend community services/events. Facilitate provision of transport and resources to enable older people to access community services/events.	Create a culture of enablement and empowerment where the focus of care is on knowing the individual's biography and life story. Influence service providers to develop flexible, innovative approaches to enable older people, families and friends to access mainstream and social activity services.

	Provide advice to promote healthy lifestyle behaviours and activities. Promote physical activity (including access to outside space) as a means of supporting and maintaining older people's health, abilities and independence. Provide and support access to preventative health strategies. Examples include: safe delivery of immunisation. Support access to health checks. Examples include: podiatry, dentistry, opticians, hearing tests. Adhere to safeguarding legislation and regulations. Prevent, identify and report abuse, and potential and actual safeguarding situations. Safeguard, ensuring confidentiality and privacy. Recognise factors associated with risk, and utilise appropriate assessment tools and strategies to identify and reduce risks. Examples	Develop resources for older people, families/friends and colleagues to support the improvement of health and wellbeing in the community, and provide information and advice on approaches to improve health and wellbeing. Organise and provide or facilitate provision, of a range of preventative health strategies and health checks. Examples include: safe delivery of immunisation, podiatry, dentistry, opticians, hearing tests. Apply and support others to adhere to safeguarding legislation and regulations. Practise, and support others to practice, in a way that enables the prevention, identification and reporting of abuse, and potential and actual safeguarding situations. Develop risk assessments and use in a person centred way to support older people safely.	Develop, implement, manage and review health improvement programmes, working across agencies, and organisations to maximise health improvement opportunities for older people. Apply, develop and monitor governance systems to prevent, identify and report abuse and potential and actual safeguarding situations. Develop, implement and manage support systems for staff, older people, and families and friends involved in safeguarding processes. Influential in developing and maintaining an open and transparent culture that supports whistleblowing. Develop and implement systems and processes to ensure compliance with risk assessment policies and procedures. Monitor, evaluate and improve risk management policies

	include: moving and handling, falls, infection control, VTE, pressure damage, food safety, management of hazards and hazardous substances.	Adopt a positive approach to risk-taking and work in partnership with older people, families/friends and colleagues to manage risk and promote resilience.	and practices. Influence policy and guidelines on organisational, local or national levels regarding risk and resilience, environmental and safety issues.
Existing WCFs and resources	**WCFs** Royal College of Nursing. *Integrated core career and competence framework for registered nurses* 'Specific knowledge and skills framework dimensions' http://www.rcn.org.uk/professional-development/publications/pub-003053 Skills for Care. *Common core principles to support self-care* http://www.skillsforcare.org.uk/Documents/Topics/Self-care/Common-core-principles-to-support-self-care.pdf Health Education England. *Care navigation: A competency framework* 'Personalisation' and 'knowledge for practice' essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf	**WCFs** Royal College of Nursing. *Integrated core career and competence framework for registered nurses* 'Specific knowledge and skills framework dimensions' http://www.rcn.org.uk/professional-development/publications/pub-003053 Skills for Care. *Common core principles to support self-care* http://www.skillsforcare.org.uk/Documents/Topics/Self-care/Common-core-principles-to-support-self-care.pdf Skills for Care. *Manager induction standards* 'Safeguarding and protection' http://www.skillsforcare.org.uk/Documents/Standards-legislation/Manager-Induction-Standards/Manager-Induction-Standards.pdf	**WCFs** Health Education England. *Care navigation: A competency framework* 'Personalisation' and knowledge for practice' expert https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses '*Respect, rights and choices' and 'health and wellbeing' advanced practitioner/consultant http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people*

	NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* 'Respect, rights and choices' and 'health and wellbeing' practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Skills for Health. *Core competencies for healthcare support workers and adult social care workers in England* 'Safeguarding', 'duty of care', 'infection prevention and control', 'health and safety', and 'moving and assisting' http://www.skillsforhealth.org.uk/images/standards/care-certificate/Core%20Competences%20-%20Healthcare%20Support%20.pdf Skills for Care. *Common core principles to support good mental health and wellbeing in adult social care* http://www.skillsforcare.org.uk/Documents/Topics/Mental-health/Common-core-principles-to-support-good-mental-health.pdf NHS Employers. *Knowledge and skills framework* 'Health, safety and security' levels 1/2	Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'Rehabilitation and multi-disciplinary team working' and 'long term conditions', 'mental health needs', medico-legal issues' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP Health Education England. *Care navigation: A competency framework* 'Personalisation' and 'knowledge for practice' enhanced https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* 'Respect, rights and choices' and 'health and wellbeing' senior practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Skills for Care. *Common core principles to support good mental*	'Rehabilitation and multi-disciplinary team working' and 'long term conditions', 'mental health needs', medico-legal issues' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP NHS Employers. *Knowledge and skills framework* 'Health, safety and security' levels 3/4 http://www.nhsemployers.org.SimplifiedKSF

	http://www.nhsemployers.org.SimplifiedKSF **Resources** Health Education England e-LfH. *Supporting self-care* http://www.e-lfh.org.uk/home/ Skills for Care. *Self care* http://www.skillsforcare.org.uk/Topics/Self-Care/Self-care.aspx Health Education England e-LfH. *Mental capacity and consent* http://www.e-lfh.org.uk/home/	*health and wellbeing in adult social care* http://www.skillsforcare.org.uk/Documents/Topics/Mental-health/Common-core-principles-to-support-good-mental-health.pdf Health Education England. *Care navigation: A competency framework* 'Knowledge for practice' enhanced https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Employers. *Knowledge and skills framework* 'Health, safety and security' levels 2/3 http://www.nhsemployers.org.SimplifiedKSF **Resources** Health Education England e-LfH. *Building community capacity* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Flu Immunisation* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Supporting self-care* http://www.e-lfh.org.uk/home/	**Resources** Social Care Institute for Excellence. *Safeguarding adults* http://www.scie.org.uk/adults/safeguarding/ Health Education England e-LfH. *Building community capacity* http://www.e-lfh.org.uk/home/ Care Quality Commission. *Mental Capacity Act: Guidance for providers*

	Skills for Care. *Mental Capacity Act* http://www.skillsforcare.org.uk/Standards-legislation/Mental-Capacity-Act/Mental-Capacity-Act.aspx Health Education England e-LfH. *Safeguarding adults* http://www.e-lfh.org.uk/home/ Skills for Care. *Safeguarding* http://www.skillsforcare.org.uk/Topics/Safeguarding/Safeguarding.aspx Social Care Institute for Excellence. *Safeguarding adults* http://www.scie.org.uk/adults/safeguarding/ Health Education England e-LfH. *Essentials in care* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Health and safety* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Manual handling* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Preventing pressure ulcers* http://www.e-lfh.org.uk/home/	Health Education England e-LfH. *Mental capacity and consent* http://www.e-lfh.org.uk/home/ Care Quality Commission. *Mental Capacity Act: Guidance for providers* http://www.cqc.org.uk/sites/default/files/documents/rp_poc1b2b_100563_20111223_v4_00_guidance_for_providers_mca_for_external_publication.pdf Social Care Institute for Excellence. *Safeguarding adults* http://www.scie.org.uk/adults/safeguarding/ Health Education England e-LfH. *Infection control* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Health and safety* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Preventing pressure ulcers* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Sepsis in primary care* http://www.e-lfh.org.uk/home/	http://www.cqc.org.uk/sites/default/files/documents/rp_poc1b2b_100563_20111223_v4_00_guidance_for_providers_mca_for_external_publication.pdf NHS England. *Mental Capacity Act 2005: A guide for clinical commissioning groups and other commissioners of healthcare services on commissioning for compliance* https://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf Health Education England e-LfH. *Health and safety* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Sepsis in primary care* http://www.e-lfh.org.uk/home/ National Institute for Health and Care Excellence. *Healthcare-associated infections: Prevention and control in primary and community care* https://www.nice.org.uk/guidance/cg139?unlid=103172669820161814315 3

	National Institute for Health and Care Excellence. *Healthcare-associated infections: Prevention and control in primary and community care* https://www.nice.org.uk/guidance/cg139?unlid=103172669820161814315 3 National Institute for Health and Care Excellence. *Infection prevention and control* https://www.nice.org.uk/guidance/qs61?unlid=66224664420151226546 25 Health and Safety Executive. *Moving and handling in health and social care* http://www.hse.gov.uk/healthservices/moving-handling.htm	National Institute for Health and Care Excellence. *Healthcare-associated infections: Prevention and control in primary and community care* https://www.nice.org.uk/guidance/cg139?unlid=103172669820161814315 3 National Institute for Health and Care Excellence. *Infection prevention and control* https://www.nice.org.uk/guidance/qs61?unlid=66224664420151226546 25 Health and Safety Executive. *Moving and handling in health and social care* http://www.hse.gov.uk/healthservices/moving-handling.htm	National Institute for Health and Care Excellence. *Infection prevention and control* https://www.nice.org.uk/guidance/qs61?unlid=66224664420151226546 25
D4: Management of dementia (these competencies are in addition to D1,2 and 3)	Domains D1, 2 and 3 apply equally to dementia care, but in addition, staff need to be competent in enabling and supporting older people with dementia to access dementia assessment, and appropriate interventions and therapies that assist them to live well. Staff must be competent in supporting older people with dementia to communicate and express their needs, choices and preferences.		
	Aware of, recognise, respond to, and report signs, including early signs, of a range of dementias and be aware that these signs may be associated with other conditions or circumstances. Aware of the process and criteria used to determine a diagnosis of dementia.	Demonstrate a broad knowledge of dementia, local care pathways and evidence-based management relevant to dementia care. Support equal access to dementia assessment and diagnosis for older.	Influence service providers/planners to ensure that older people have equal access to dementia assessment, diagnosis and therapies.

		Undertake a comprehensive assessment for dementia utilising appropriate investigations and tools. Explain the implications of diagnosis with sensitivity to the older people and family and friends.	Distinguish between dementia and other conditions with similar presentations, and provide or facilitate the provision of, a differential diagnosis of dementia.
	Recognise, respond to, and report symptoms of delirium in older people with dementia. Be aware of risk factors for delirium. Anticipate and prevent occurrences of delirium.	Recognise when dementia and delirium are compounded by each other.	Undertake, or provide expert advice about, dementia assessment and diagnosis.
	Provide support for families and friends, and signpost families and friends to relevant support services.	Assess the needs of families and friends, and provide, facilitate the provision of, family/friends interventions and relevant support services.	Provide expert advice regarding understanding complex family dynamics in caring for older people with dementia.
	Have, and promote, a positive attitude towards people with dementia. Recognise and interpret older people's behaviours and changes in behaviour as means of communicating unmet needs. Understand common causes of behaviour and proactively use a range of responses to address unmet needs.	Have, and promote, a positive attitude towards people with dementia, and anticipate and interpret the meaning of older people's behaviour changes. Support others to understand the communication implications of older people's behaviour.	Influential in creating a culture in which staff have, and promote, positive attitudes towards older people with dementia on an organisational, local or national basis. Influence the development of Dementia friendly environments. Provide expertise, or expert advice about behaviour.
	Demonstrate awareness of key interventions. Aware of actions and	Deliver or facilitate access to, a range of specialist pharmacological, non-	

	factors that support older people with dementia to live well. Utilise this knowledge to offer support strategies. Examples include: validation, reminiscence and life story work, sensory stimulation, understanding individuals' activity preferences.	pharmacological and physiopsychosocial and stimulation therapies, including complementary therapies, for older people.	Provide expert knowledge on how to enrich the lives of older people with dementia. Enable and empower staff, older people with dementia and families and friends to access interventions and therapies that enrich lives. Use expert knowledge of dementia and engage with research and evidence to develop, implement and evaluate care models, approaches and interventions, and use these evaluations to inform organisational, local or national care guidelines.
Existing WCFs and resources	**WCFs** Skills for Care. *Dementia core skills education and training framework*, Tiers 1,2 http://www.skillsforhealth.org.uk/images/projects/dementia/Dementia%20Core%20Skills%20Education%20and%20Training%20Framework.pdf?s=cw1 NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* 'Dementia' practitioner http://www.nes.scot.nhs.uk/media/3	**WCFs** Skills for Care. *Dementia core skills education and training framework*, Tiers 1,2,3 http://www.skillsforhealth.org.uk/images/projects/dementia/Dementia%20Core%20Skills%20Education%20and%20Training%20Framework.pdf?s=cw1 NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* 'Dementia' senior practitioner http://www.nes.scot.nhs.uk/media/3	**WCFs** NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* 'Dementia' advanced practitioner/consultant http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests*

	60583/older_people_framework_final__dec_08_.pdf **Resources** Health Education England e-LfH. *Dementia* http://www.e-lfh.org.uk/home/ Skills for Care. *Dementia* http://www.skillsforcare.org.uk/Topics/Dementia/Dementia.aspx	60583/older_people_framework_final__dec_08_.pdf Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'Mental health needs' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP	*(PwSIs): Older people* 'Mental health needs' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP
D5: Management of mental health (these competencies are in addition to D1,2 and 3)	Domains D1, 2 and 3 apply equally to mental health care, but in addition, staff need to be competent in enabling and supporting older people with mental health conditions to access appropriate assessment, and appropriate timely interventions and therapies that assist them to live well. Staff must be competent in supporting older people with mental health conditions to communicate and express their needs, preferences, feelings and fears.		
	Demonstrate awareness of the types, causes, symptoms, progression and recovery pathways of mental health conditions, and their impact on older people's health and wellbeing and their families' and friends' wellbeing.	Demonstrate a broad knowledge of mental health conditions, local care pathways and evidence-based management relevant to mental health care of older people. Support equal access to mental health	Influence service providers/planners to ensure that older people have equal access to mental health assessment, diagnosis and therapies.

	Be aware of how mental health conditions and crises impact on an individual's mood and behaviour. Recognise risk factors, symptoms and behaviour which may indicate a mental health condition or deterioration in mental health, and seek appropriate, timely support to aid recovery. Support older people to express their feelings, fears, grief and expectations regarding life transitions, and loss of significant others, roles, abilities. Aware of actions and factors that support older people with mental health conditions to recover, live well and access wellbeing in an individualised manner. Provide support for families and friends, and signpost families and friends to relevant support services.	assessment and diagnosis for older people. Undertake a comprehensive assessment for mental health utilising appropriate investigations and tools. Distinguish between mental health conditions and other conditions with similar presentations, and provide or facilitate the provision of, a differential diagnosis. Deliver or facilitate access to, a range of specialist psychological therapy interventions. Examples include: pharmacological interventions, MDT expertise, appropriate referral to acute/specialist services. Assess the needs of families and friends, and provide, facilitate the provision of, family/friends interventions and relevant support services.	Provide expertise, or expert advice in relation to older people with complex mental health conditions. Provide expert knowledge on how to enrich the lives of older people with mental health conditions. Enable and empower staff, older people and families and friends to access interventions and therapies that aid recovery. Use expert knowledge of mental health conditions and engage with research and evidence to develop, implement and evaluate care models, approaches and interventions, and use these evaluations to inform

			organisational, local or national care guidelines.
Existing WCFs and resources	**WCFs** Skills for Care. *Common core principles to support good mental health and wellbeing in adult social care* http://www.skillsforcare.org.uk/Documents/Topics/Mental-health/Common-core-principles-to-support-good-mental-health.pdf Health Education England. *Care navigation: A competency framework* 'Knowledge for practice' essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses*, practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf	**WCFs** Skills for Care. *Common core principles to support good mental health and wellbeing in adult social care* http://www.skillsforcare.org.uk/Documents/Topics/Mental-health/Common-core-principles-to-support-good-mental-health.pdf Health Education England. *Care navigation: A competency framework* 'Knowledge for practice' essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses*, senior practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using*	**WCFs** Health Education England. *Care navigation: A competency framework* 'Knowledge for practice' essential https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses*, advanced practitioner/consultant http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'Mental health needs' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP

		practitioners with special interests (PwSIs): Older people 'Mental health needs' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP	
	Resources Skills for Care. *Mental Health* http://www.skillsforcare.org.uk/Topics/Mental-Health/Mental-health.aspx	**Resources** Health Education England e-LfH. *Mental health awareness* http://www.e-lfh.org.uk/home/ Royal College of General Practitioners. *Improving access to psychological therapies* http://www.rcgp.org.uk/courses-and-events/online-learning/ole/improving-access-to-psychological-therapies.aspx Health Education England e-LfH. *Deprivation of liberty safeguards* http://www.e-lfh.org.uk/home/	**Resources** Royal College of General Practitioners. *Improving access to psychological therapies* http://www.rcgp.org.uk/courses-and-events/online-learning/ole/improving-access-to-psychological-therapies.aspx Health Education England e-LfH. *Deprivation of liberty safeguards* http://www.e-lfh.org.uk/home/
D6: Management of frailty (these competencies are in addition to D1,2 and 3)	Domains D1, 2 and 3 apply equally to caring for older people living with frailty, but in addition, staff need to be competent in recognising and responding to indicators of frailty, and use appropriate interventions and strategies to assist older people living with frailty to live well.		
	Aware of the causes, characteristics and progression of frailty, and their impact on older people's health and wellbeing.	Demonstrate a broad knowledge of frailty, frailty indicators and frailty progression, as well as local care pathways and evidence-based management relevant to frailty care.	Develop, implement and evaluate population-based approaches to identify frailty.

	Recognise, respond to, and report changes and deterioration that may indicate frailty in a timely manner. Use basic assessment tools to facilitate identification of frailty, for example Rockwood Frailty Index. Aware of the process and criteria used to determine a diagnosis of frailty.	Understand and recognise the association between characteristics of frailty syndrome and chronic conditions and co-morbidities. Distinguish between characteristics of frailty syndrome and conditions with similar presentations. Use appropriate tools, tests, questionnaires and indicators to provide, or facilitate provision of, a differential diagnosis of frailty. Examples include: gait speed, TUGT, Prisma 7, Clinical Frailty Scale, Rockwood Frailty Index.	
	Aware of actions, factors and interventions that support older peoples to live well with frailty.	Deliver or facilitate access to, CGA and a range of strategies and interventions that delay the progression of frailty or support the management of frailty. Examples include: addressing reversible medical conditions, medication reviews to account for the frail older person's susceptibility to medication side effects, accounting for frailty when applying disease based clinical guidelines, referral to geriatric medicine, anticipatory care planning (including escalation plans, emergency plans, advance care plans, end of life care plans).	Provide expertise, or expert advice where frailty is associated with complex co-morbidities, diagnostic uncertainty or problematic symptom control.

Existing WCFs and resources	Resources	Resources	Resources
	British Geriatric Society. *Fit for frailty* http://www.bgs.org.uk/campaigns/fff/fff_full.pdf	British Geriatric Society. *Fit for frailty* http://www.bgs.org.uk/campaigns/fff/fff_full.pdf NHS England. *Safe, compassionate care for frail older people using an integrated care pathway* https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf NHS England. *Toolkit for general practice in supporting older people with frailty* http://webarchive.nationalarchives.gov.uk/20160805124604/http://www.nhsiq.nhs.uk/media/2630779/toolkit_for_general_practice_in_supporting_older_people.pdf Royal College of Nursing. *Frailty in older people* https://www.rcn.org.uk/clinical-topics/older-people/frailty King's Fund. *Delivering integrated care for older people with frailty* https://www.kingsfund.org.uk/events/delivering-integrated-care-older-people-frailty	British Geriatric Society. *Fit for frailty* http://www.bgs.org.uk/campaigns/fff/fff_full.pdf NHS England. *Safe, compassionate care for frail older people using an integrated care pathway* https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf NHS England. *Toolkit for general practice in supporting older people with frailty* http://webarchive.nationalarchives.gov.uk/20160805124604/http://www.nhsiq.nhs.uk/media/2630779/toolkit_for_general_practice_in_supporting_older_people.pdf Royal College of Nursing. *Frailty in older people* https://www.rcn.org.uk/clinical-topics/older-people/frailty King's Fund. *Delivering integrated care for older people with frailty* https://www.kingsfund.org.uk/events/delivering-integrated-care-older-people-frailty

		National Institute for Health and Care Excellence. *Multimorbidity: Clinical assessment and management* https://www.nice.org.uk/guidance/ng56	National Institute for Health and Care Excellence. *Multimorbidity: Clinical assessment and management* https://www.nice.org.uk/guidance/ng56
D7: End of life care (these competencies are in addition to D1,2 and 3)	Domains D1, 2 and 3 apply equally to caring for older peoples with end of life care needs, but in addition, staff need to be competent in supporting individuals' and families' and friends' choices about end of life care, including advance care planning. Staff must be able to recognise and assess end of life and end of life symptoms, and support access to a range of palliative therapies and interventions to manage symptoms. Central to end of life care is the provision of support for families and friends during the dying stage and following the death of the older person.		
	Aware of the impact of death, dying and bereavement on older people, families and friends. Communicate sensitively with older people, families and friends regarding their wishes, preferences and concerns about end of life, and provide information and support. Recognise individuals' and families' and friends' spiritual needs and refer to specialists or ministers for spiritual, religious or pastoral care if needed. Aware of the principles of advance care planning and documentation, and the legal and ethical status and implications of the advance care planning process with regard to end of life care. Examples include: Mental Capacity Act, advance care plans (ACP), emergency health care plans	Engage with, and support others to engage sensitively with older people, families and friends about their wishes, preferences and concerns about end of life, and provide information and support. Assess and respond to the spiritual needs of older people, families and friends and refer to specialists or ministers for spiritual, religious or pastoral care if needed. Comprehensive understanding of the principles of advance care planning and documentation, and the legal and ethical status and implications of the advance care planning process with regard to end of life care. Examples include: Mental Capacity Act, advance care plans (ACP),	Develop practices that enable older people, families and friends to make choices about end of life care. Work across professions and organisations to agree referral protocols and packages of care. Provide expert advice about complex end of life care issues, including complex ethical considerations and advance care planning issues.

	(EHCP), do not attempt cardiopulmonary resuscitation (DNACPR), advance decision to refuse treatment (ADRT).	emergency health care plans (EHCP), do not attempt cardiopulmonary resuscitation (DNACPR), advance decision to refuse treatment (ADRT). Comprehensive understanding of the protocols, guidance and principles of advance care planning and end of life care. Examples include: Deciding right, 6 steps end of life register, NHS end of life care strategy.	
	Contribute to the implementation of personalised advance care plans and end of life care plans to ensure that end of life care is delivered effectively.	Consider, discuss and document personalised advance care planning with older people, families/friends and colleagues as part of ongoing assessment and intervention with regard to end of life care. Regularly review these to take account of changing needs, priorities and wishes. In partnership with the older person, family, and team colleagues, develop an end of life care plan which balances disease-specific treatment with care and support that meets the needs and wishes of the older person.	
	Recognise, respond to, and report an individual's 'entry' into the dying stage, and associated pain and other symptoms. Recognise and refer when an individual requires specialist support.	Use prognostic indicators to recognise end of life and to assist when making decisions around treatment. Assess pain and other symptoms using appropriate	Use expert knowledge of end of life care and engage with research and evidence to develop and evaluate end of life care models for older people, and use these evaluations to

		assessment tools, and specialist clinical skills.	inform organisational, local or national care guidelines.
	Maintain dignity, comfort and privacy for the individual throughout the end of life process. Aware of, and support access to, a range of palliative therapies and interventions. Examples include: pharmacological interventions, physical therapies, counselling, complementary therapies**.**	Deliver, or support access to, a range of palliative therapies and interventions to manage symptoms. Examples include: administration of medication via infusion and injection devices in the home setting, physical therapies, counselling, complementary therapies.	Provide expertise and expert advice about symptom management.
		Understand the process and documentation required to verify expected death according to local protocols. Understand indications for informing the coroner of an expected death. Undertake verification of expected death according to local protocols**.**	Develop, implement and monitor governance systems to facilitate the timely verification of death.
	Following the death of the individual, provide support for the family and friends, and facilitate transition into bereavement support services where appropriate.	Following the death of the individual, provide, or facilitate the provision of, bereavement support for the family and friends where appropriate.	Lead the development, implementation and evaluation of bereavement support services and policies. Ensure older people, families, friends and staff are involved in these processes.
Existing WCFs and resources	**WCFs** Skills for Care. *Common core principles and competences for social*	**WCFs** Skills for Care. *Common core principles and competences for social*	**WCFs** NHS Scotland. *Working with older people in Scotland: A framework for*

	care and health workers working with adults at the end of life http://www.skillsforcare.org.uk/Documents/Topics/End-of-life-care/Common-core-principles-and-competences-for-social-care-and-health-workers-working-with-adults-at-the-end-of-life.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* 'End of life care' practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf **Resources** Health Education England e-LfH. *End of life care* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Pain* http://www.e-lfh.org.uk/home/	*care and health workers working with adults at the end of life* http://www.skillsforcare.org.uk/Documents/Topics/End-of-life-care/Common-core-principles-and-competences-for-social-care-and-health-workers-working-with-adults-at-the-end-of-life.pdf NHS Scotland. *Working with older people in Scotland: A framework for mental health nurses* 'End of life care' senior practitioner http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'End of life care' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP **Resources** Department of Health. *End of life care strategy* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf	*mental health nurses* 'End of life care' advanced practitioner/consultant http://www.nes.scot.nhs.uk/media/360583/older_people_framework_final__dec_08_.pdf Royal College of General Practitioners and Royal Pharmaceutical Society. *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): Older people* 'End of life care' https://www.rcgp.org.uk/.../Files/CIRC?GPwSI/RCGP Royal College of General Practitioners. *Advanced nurse practitioner competencies* 'End of life care' http://www.rcgp.org.uk/membership/practice-team-resources/~/media/16411E76AC5B4E818547E331F9D3CA97 **Resources** Department of Health *End of life care strategy* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf

	Skills for Care. *End of life care* http://www.skillsforcare.org.uk/Topics/End-of-Life-Care/End-of-life-care.aspx Skills for Care. *Real stories, real insight* http://www.skillsforcare.org.uk/Documents/Topics/End-of-life-care/Real-stories-Real-insight-Competences.pdf	NHS Northern England Strategic Clinical Networks. *Deciding right* http://www.nescn.nhs.uk/common-themes/deciding-right/ My Home Life. *Step by step guide: The route to success in end of life care* http://myhomelife.org.uk/wp-content/uploads/2014/11/mhl_stepbystep_endoflife.pdf Health Education England e-LfH. *End of Life Care* http://www.e-lfh.org.uk/home/ Health Education England e-LfH. *Pain* http://www.e-lfh.org.uk/home/ The Gold Standards Framework. *End of life care* http://www.goldstandardsframework.org.uk/home Skills for Care. *Real stories, real insight* http://www.skillsforcare.org.uk/Documents/Topics/End-of-life-care/Real-stories-Real-insight-Competences.pdf	The Gold Standards Framework. *End of life care* http://www.goldstandardsframework.org.uk/home

Appendix 1: Review of existing workforce competency literature

Part of the study commissioned by Newcastle Gateshead Clinical Commissioning Group in April 2016 (Cook et al. 2016) involved capturing and sharing existing knowledge and literature relating to the care of older people. Literature searches were carried out, and an electronic reference library was shared with the Gateshead Care Home team. The current study used this library as a resource for a literature search regarding the topic of workforce development for the care of older people. In addition, in order to capture literature published since the development of the library, searches on electronic databases dated from January 2016 to November 2016 were undertaken. This literature (referenced below) has informed the development of the EnCOP workforce competency framework.

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Appendix 2: Existing workforce competency frameworks and resources

Development of the EnCOP workforce competency framework included reviewing existing frameworks and resources that are applicable to the care of older people with complex needs. These documents are referenced below. Existing frameworks and resources that have been aligned with or incorporated into the EnCOP framework are indicated by an asterisk.

Workforce competency frameworks

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