NMC consultation: Joint response from representatives of the adult social care sector in England (August 2021)

Introduction

We are delighted to be able to respond jointly to the NMC consultation on post registration standards; we see this a once in 20-year opportunity to address this long-standing issue.

We are also very grateful for the presentations from and opportunities for dialogue with the NMC Team during the consultation period to help us consider the consultation in more depth and for the extensive input from our National Care Forum membership and our partners.

We feel our response does not fit easily into the online questionnaire so we are responding separately.

We would also recommend that you read our co-authored article on this consultation published on 16 July 2021 in the Nursing Times: https://www.nursingtimes.net/opinion/advocating-for-a-specialist-practitioner-qualification-in-adult-social-care-16-07-2021/.

The **National Care Forum** has joined forces with **Care England, Registered Nursing Home Association, National Care Association, My Home Life, Eden Alternative UK, NICHE-Leeds and Providers and Academics Transforming Care Homes together (PATCH)** to amplify our collective voice and our aligned views on this consultation. For more details of these organisations, please see Appendix 1. **Together, we represent a significant number of providers working in adult social care.**

Key messages:

- ✓ Our members and partners have been very clear that they believe that the **NMC should create an SPQ annotation that recognises the nursing skills and specialism required to work in adult social care.**
- ✓ It is **imperative that the NMC develops an SPQ in Community Nursing (Adult Social Care) or an SPQ (Adult Social Care Nursing)** to ensure that adult social care nursing is recognised as a field, in its own right; and treated with dignity and respect on a par with other community nurses (e.g., district nurses). **Hereafter, referred to as SPQ for ASC.**
- ✓ This consultation offers a unique opportunity to build a future in which **nurses working in adult social care are regulated, supported and influenced through the development of an SPQ for ASC**
- ✓ It is **vital that this SPQ for ASC does not lead to the over medicalisation of older people in care homes,** with the risks of compromising holistic care and reducing the value base of the primacy of home within a care home workforce.
- ✓ The **language of the platforms needs attention** as it is currently too medically focussed and needs to be better aligned with the approach, thinking and practice of adult social care nursing, and correspondingly, the wording of the standards underpinning the platforms needs to be aligned to this approach as well.

Context

The NMC recently revised its 5-year strategy (2020 – 2025) to support the delivery of excellent nursing and midwifery, **by focusing on helping those on the NMC register to deliver safe and effective care in response to the coronavirus pandemic**. A number of other programmes of work are to be revisited later in the year, but the three underpinning pillars – **regulate**, **support** and **influence** remain the same.

Covid19 has highlighted the lack of support, investment and training for nurses working in Adult Social Care (ASC). However, there is now a unique opportunity **to build a future in which nurses working in adult social care are regulated, supported, and influenced through the development of an SPQ for ASC ensuring safe and effective care for some of the sickest and most vulnerable citizens in our society.**

The government has made a pledge to deliver 50,000 more nurses by 2025. Like others[1], we are very concerned that the nursing needs of the **adult social care sector remain an unaddressed afterthought** for the Department of Health & Social Care and, as such, the sector's nursing workforce is not adequately supported.

Understanding Adult Social Care Nursing – setting the scene

An estimated 18,500 separate organisations - employing a total of 1.49 million people – are involved in providing or organising adult social care across England[2]. These organisations include private, voluntary, not-for-profit and independent providers of different sizes and they incorporate all types of service provision - day, domiciliary, respite, out-reach, long and short-term care. They encompass different service user groups such as people with learning disabilities, those living with enduring physical or mental health needs, and conditions associated with old age, plus individuals who experience social exclusion through such things as addiction, or homelessness.

The adult social care sector workforce includes employment of 41,000 Nursing and Midwifery Council (NMC) registered nurses bound by the Code of Professional Standards of Practice. They work in a range of environments and with people of all ages and all form of diagnosis; however, most nurses in social care support people over the age of 65 years in care homes.

Social care nurses have a distinct role, a relationship-based approach to support wellbeing, provide person-centred nursing practice, lead and enable others, operate within a complex regulatory and organisational landscape, and work at the frontline of health and social care boundaries. Registered

[1] House of Commons Public Accounts Committee (2020) *NHS nursing workforce,* Eighteenth Report of Session 2019–21 Report, together with formal minutes relating to the report Ordered by the House of Commons to be printed 14 September 2020 (https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/408/408.pdf)

[2] Skills for Care (2019) *Registered Nurses. Recognising the responsibilities and contribution of Registered Nurses within social care.* London: Skills for Care (https://www.skillsforcare.org.uk/Documents/Learning-and-development/Regulated-professionals/Registered-nurses-recognising-the-responsibilities-and-contribution-of-registered-nurses-within-social-care.pdf).

nurses in adult social care enjoy high levels of professional autonomy and responsibility. This supports confident and innovative practice together with strong clinical decision-making. The multi-faceted nature of their role means they also develop a wide range of transferable expertise with the need to be flexible, resourceful and creative in finding solutions to short, medium and longer-term care and business needs.

There are many misconceptions around what it is to be a nurse in Adult Social Care. These are highlighted in the Skills for Care "Ten Myths about being a Registered Nurse on Adult Social Care"[3]. With the regulation, influence, and support of the NMC, this can now be corrected.

In the aftermath of the first wave of Covid19 a new post was created – Chief Nurse in Adult Social Care – to recognise the need to support nurses in this sector. Our concern is that the support for Adult Social Care nurses will be reactionary and temporary. An SPQ for ASC will help to consolidate the importance and value of adult social care nursing.

However, it should be noted that both the NHS and social care employers recruit from the same pool of employees across all roles, including nursing. The NHS is able to typically provide better pay, terms and conditions, and career progression; for example, there is a 7% gap between the pay rates for adult social care nurses, and the rates available for nurses in the NHS. To put adult social care nursing on a sustainable footing, the sector as a whole must be secured financially. An SPQ for ASC will only go part way to solving the problems in recruitment and retention of nurses working in adult social care.

Rationale for our response

Recognition for adult social care nursing: Adult social care nursing is highly skilled, hugely autonomous, with high levels of responsibility and accountability in a complex, rapidly evolving environment. This must be recognised within the SPQ framework, in the same way as other nurses working in the community.

The NMC **must develop an SPQ for ASC nursing to ensure that adult social care nursing is recognised as a field, in its own right**; and treated with dignity and respect on a par with other community nurses (e.g., district nurses). For too long, the system has focused on the NHS and it is now time to recognise the important role that adult social care plays and help strengthen its public image and professional identity.

Busting the myths: currently not all nurses are regarded as equal. Adult social care nursing is perceived as less skilled, less rewarding, less ambitious, and less valued than other nursing roles. This must change. A dedicated SPQ will start to shift those perceptions.

Sustaining the nursing workforce in adult social care: In July 2021, Registered Nurses were one of the only jobs in adult social care to see a significant decrease over the period (down 17,000 or 33%) since 2012/13[4]. The decline in nurses is significant as the social care workforce will need increase by

[3] https://vimeo.com/335849465

[4] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-size-and-structure-of-the-adult-social-care-sector-and-workforce-in-England.aspx

36% to approximately 2.2 million jobs by 2035 if the demand for the social care workforce grows proportionally to the projected number of people aged 65 and over. If the direction of travel is to move more complex care from hospital to home, then making social care community nursing more attractive is critical.

Lack of awareness about the nature of adult social care: At present, the levels of awareness around what the role entails, and the benefits of adult social care nursing have not been fully elucidated. Many who fulfil the role, in fact, prefer it to working in the NHS. One often cited reason includes the fact that adult social care nursing environments are often less hierarchical in nature when juxtaposed with hospitalised settings.

Our view is that **an SPQ for ASC is key to attracting future adult social care nurses to support the evolving model of care out of acute settings and into the community.** An SPQ for ASC will be an invaluable route for existing nurses to develop the skills and competencies to be the senior social care nurses of the future in leading and shaping social care practice and in supporting nurses in adult social care both now and the future, as well as shaping the adult social care nursing leaders of the future. An SPQ for ASC will open doors and provide so many opportunities for the sector.

Supporting an integrated approach to health & care workforce planning: boosting the nursing workforce for social care with an SPQ for ASC will benefit both those who use and those who run adult social care services because it offers the opportunity to support registered nurses to become recognised specialists in adult social care nursing. An SPQ for ASC will ensure that nurses at this level of leadership are developed and supported through a programme of learning opportunities to meet the increasingly complex needs of people living in care homes. This will help to alleviate pressure upon the NHS. We also hope it will address the flow of nurses from social care into the NHS and attract newly qualified nurses into adult social care nursing by providing similar status for adult social care nursing, supporting a more integrated approach to future workforce planning.

Explaining the need for a Specialist Practice Qualification for social care nursing: The NMC recognises that nurses in the community have historically been considered a high-risk group of registrants as they usually undertake sole practice and often provide care and support for vulnerable patients and families in their own homes. They also work not just with individuals but with populations to improve their holistic health. However, we believe that there are some shared skills (as with nurses across all sectors) each area has its own specialism. The expertise and skills required to nurse in social care are distinct because:

- Social care nurses (especially the majority working in care homes) **exercise high levels of autonomy and accountability,** working alone without immediate support from other health professionals.
- They **work collaboratively across the complex public and private system of health and social care to coordinate care and services** to meet the specific needs of individuals and improve systems and services.
- They provide a **24-hour/day, 7-days/week, 52 weeks/year nurse-led service with full responsibility** for the immediate health and wellbeing of all residents in the home.

- They **negotiate partnership working with people** living in care homes, their family and friends, and other health and social care colleagues to assess, plan and evaluate for individual preferences and abilities to meet both physical and mental health needs.
- They **promote best evidence-informed care and reflective practice**, sharing learning about individuals, who often lack mental incapacity (practical knowledge) and contributing to research (scientific knowledge).
- They **balance safety with positive risk taking** to ensure quality of life and quality of care.
- They **create a sense of security, belonging, continuity, purpose, achievement and significance** in residents, relatives, and staff to ensure a thriving community for all.
- They **help maintain people's identity** within a complex system of communal living and competing interests.
- They **enable choice and control** in their care planning and how the care home is run.
- They **foster a sense of community** between residents, relatives and staff and connection with their local community through individually meaningful activities, relationship centred care, and active citizenship.
- They **help people to live well and adapt** to their changing circumstances, as they grow older, frail and become less independent.
- They **promote wellbeing**, prevent ill-health where possible, and access to health care services where needed, to ensure quality of life and avoidance of hospital admission, where appropriate.
- They support people **to live a life worth living** and **experience a good death.**
- They **develop team leadership, support, and education of others in person-centred, relational, and appreciative practice**.
- They **lead improvements for quality of life** as well as quality of care, using appreciative methods.

The consequences of NOT having an SPQ for ASC: without an SPQ for ASC, the sector will continue to be side-lined and under-valued by other health and social care professionals **putting at risk safe and effective care for over 400,000 older people** in receipt of adult social care.

Having an SPQ for ASC: could bring new thinking and could bring a number of the proposed standards and relational based values and approaches into services commissioned and delivered by the NHS in all settings (e.g., services for people with mental health needs, learning disability, long-term health conditions, and community frailty services). This sharing of knowledge and expertise would support a **genuinely integrated approach and allow for better transportability of the qualification**.

The importance of specific standards for adult social care nursing: We, like others[5] are concerned that core standards of proficiency, without specific standards for the annotated qualifications, risk leading to considerable unwarranted variation in community post-registration qualifications, resulting in confusion and inconsistency for students, educators, and employers. Without field-specific

[5] https://www.qni.org.uk/explore-qni/policy-campaigns/nmc-review-of-post-registration-standards/

standards set by the NMC or any other expert professional organisation, ultimately there is **a risk that the public will not be adequately protected.**

Recognising the importance of an SPQ for social care nursing across the devolved nations: there is a very strong voice across England that nurses need an SPQ in Community Nursing (Adult Social Care or Social Care) or an SPQ (Social Care Nursing). We recognise the challenge that this may present in some of the devolved countries in terms of terminology. **The NMC needs to further consult devolved countries on how to resolve this, whilst recognising the strength of feeling on this in England.**

Our response to the draft standards of proficiency for an SPQ for ASC

The NMC propose the standards cluster around seven platforms:

1. Being an accountable and autonomous professional
2. Promoting health and preventing ill health
3. Assessing people's abilities and needs, and planning care
4. Providing and evaluating evidence based care
5. Leading and managing teams
6. Leading improvements in safety and quality of care
7. Care co-ordination and system leadership

Within the SPQ for ASC, we see a key role in educating and supporting others, helping the rest of the social care workforce to skill up, to educate and support health colleagues in the personalisation agenda, working with the public and older people and their families to take a role in their own care, and working collaboratively across complex systems.

With this in mind, we would prefer the sense and wording to describe the platforms to be changed to:

1. Being an accountable and autonomous professional and partner in care (amended)
2. Enabling choice, promoting wellbeing, preventing ill health, and supporting a good end of life (amended)
3. Assessing and planning for people's abilities and needs, in partnership with them and their carers (amended)
4. Negotiating and evaluating evidence-informed care, both individually and collectively (amended)
5. Leading, supporting, and educating others in person-centred, relational, and appreciative practice (amended)
6. Balancing risk and leading improvements in quality of life and quality of care, through the development of communities (amended)
7. Care co-ordination, collaborative working, and wrapping services around the individual across complex systems (amended)

We are suggesting that there are two platforms that are missing:

8. Understanding frailty and taking an asset-based approach to its management (new)
9. Engaging technology to enhance practice (new)

We have reviewed the seven platforms to support the above observations and has given detailed consideration to the details underpinning those platforms – our extensive comments can be found in Appendix 2.

Other important observations relating to the consultation

Implications for Education – implementation considerations

Funding: funding for this specialist qualification needs to come from central sources, in the same way as it does for the NHS. Individual nurses on relatively lower incomes and employers, who are not funded a fair rate for care, are unlikely to be in a position to pay themselves.

Suitable, accessible courses: Employers are unlikely to be able to release staff for prolonged periods of time, so academic institutions need to develop part-time courses, with blended learning methods that can be built up incrementally in stages over time.

Staged qualifications: Students should be able to exit the SPQ pathway, at various stages and still obtain a post-graduate qualification (certificate, diploma or masters). They should also be able to re-enter at any stage to continue to master's level.

For example, if they are successful at stage 1 and choose to exit then, they should get a certificate and be allowed back onto the programme later at stage 2 to convert their certificate into a diploma and again at stage 3 to convert to a masters.

Suggested stages in the qualifications: Stage 1 (certificate) should involve competencies that enable nurses to work effectively as individuals in care homes. Stage 2 (diploma) should involve competencies that enable them to work effectively as team leaders in care homes (educating and supporting residents, relatives and staff). Stage 3 (masters) should involve competencies that enable them to work effectively as advanced practitioners in care homes (prescribing, collaborating, and working across whole systems). This would mean that only those who complete stage 3 get the SPQ for ASC.

Alternatively, a system could be considered where everyone does the same course together but submits assignments at their preferred academic levels (certificate, diploma or masters) and is awarded for the level they achieve. This would mean that those who complete stage 3 get an SPQ for ASC but at a variety of different academic levels certificate/diploma/master's level. This will allow for those nurses who are keen to learn and professionally develop, but struggle with academic work.

Importance of a clear career pathway in social care nursing: nurses need to see a career pathway, which is recognised by an NMC post registration qualification and which encourages them to come into or remain in social care. If opportunities are available and recognised in other areas and not social

care, then there is the risk that they will be tempted by pathways which they perceive have more credibility.

Employer Engagement – implementation considerations

Importance of supporting social care nurse development: nurses who choose to study for a post graduate qualification such as the SPQ require the backing of their employer. Employers in Adult Social Care are more likely to support a qualification that is role specific, effective and makes a difference in practice. An SPQ for ASC would provide this incentive. Employers are likely to be more invested in the NMC-approved qualifications due to their UK-wide recognition and monitoring of quality.

Design of the courses: employers would need to be involved in the design of courses, so that they are fit for purpose. Schools of Nursing have not traditionally provided education for people in social care and may need support and guidance. Funding for a pilot study for an academic institution to work with employers to develop a curriculum that is fit for purpose is essential. Sharing of this curriculum would enable other institutions to offer similar courses more easily and ensure quality of programmes.

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Appendix 1 - Who are we?

Providers and Academics Transforming Care Homes together (PATCH): is a group of social care providers and academics (Anita Astle MBE, Wren Hall Nursing Home, Nottingham; Ros Heath, Landermeads Nursing Home, Nottingham; Peter Hodkinson, Westward Care, Leeds; Professor Julienne Meyer CBE, My Home Life, London; Professor Karen Spilsbury, NICHE-Leeds; Margot Whittaker, Southern Healthcare, Dawlish; Geoffrey Cox, Eden Alternative UK, Dawlish) who are committed to improving the quality of life, choice and identity of people living in care homes. Ours is a lived experience and we bring a tangible understanding of the reality of working in the sector. Our focus is nurse and manager led. We know that real change comes from knowing the people we support, understanding what works in practice and building effective career progression in direct collaboration with higher education.

NCF THE NATIONAL CARE FORUM

The National Care Forum is the membership organisation for not-for-profit organisations in the care and support sector. NCF supports its members to improve social care provision and enhance the quality of life, choice, control and wellbeing of people who use care services. We are the voice of the not-for-profit care and support sector. Our members:

- ✓ Provide care and support to around 194,000 people
- ✓ Operate over 7,300 services
- ✓ Provide more than 47,700 care home places
- ✓ Employ over 102,700 staff & 13,000 volunteers

CARE ENGLAND Representing independent care providers

Care England is a registered charity and the leading representative body for independent care services in England.

We speak with a unified voice for our members and the care sector. We are committed to supporting a united, quality-conscious, independent sector that offers real choice and value for money.

Our aim is to create an environment in which care providers can continue to deliver and develop the high-quality care that communities require and deserve.

The Care England membership extends across single care homes, small local groups, national provider and not-for-profit voluntary organisations and associations, as well as private providers.

Members provide approximately 114,000 care home places across England and a variety of services for older people and those with long-term conditions, learning disabilities and mental health problems.

National Care Association remains the most respected and established of the trade bodies due to our strong ethos of putting members at the heart of all that we do. Our reasons for engagement at any level with national associations including CQC is to ensure that our member's views are heard. The voluntary Board who govern the Association are primarily care providers and specialists in their fields, giving up their time to ensure that the challenges providers face individually are supported by our team in Head Office. One of our greatest strengths is the ability to respond to members queries within 24 hours with an on-call contact which goes directly though to our Executive Chairman. Our primary aim is to be the support our members need when they need it! Amongst the many services provided by the Association are preferential rates for services and products through our partners, as well as support with toolkits and specialist advice. Members tell us that savings through our partners cover the costs of their individual membership many times over.

National Care Association is a hub for care providers to access all services which will enable you to recruit safely through our DBS service, access support and advice when needed, personalised toolkits to support your service, keep up to date on developments nationally and locally, attend our national and local conferences and seminars, receive discounts on products and services and much, much more… Being part of an Association like ours only matters when it matters, and when it matters our members know that we will stand with them with help, advice and support.

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The Registered Nursing Home Association is the only national association exclusively representing the interests of owners of SME care homes with nursing.

RNHA has 600 members and provides a supporting organisation for nursing home owners to help in ensuring that they provide quality nursing care. RNHA impacts approximately 20,000 older people living in nursing homes, who employ roughly 30,000 staff.

Formed in 1968 to provide a supporting organisation for nursing home owners to help in ensuring that they provided quality nursing care, it is the oldest of the care sector representative bodies.

My home life Charity

My Home life (www.myhomelife.org.uk) promotes quality of life and delivers positive change in care homes for older people. Our vision is a world where all care homes for older people are great places to live, die, visit, and work. Creating a sense of community is at the heart of My Home Life (MHL). Not only between residents, relatives, and staff, but also, between care homes and their local communities, including the wider health and social care system. Our guiding principles are:

- ✓ Developing best practice together
- ✓ Focusing on relationships
- ✓ Being appreciative
- ✓ Having caring conversations

Since its inception in 2006, it has grown into a social movement for practice development in care homes with initiatives in England, Northern Ireland, Scotland, Wales, Australia, and Germany. MHL Charity exists to support the work of MHL Partners. MHL Charity is governed by a Board of Trustees who all have many years of experience working in the social care sector.

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The Eden Alternative was founded in 1991 in the USA by Dr Bill Thomas and Jude Meyer-Thomas. It is based on the core belief that ageing should be a continued stage of development and growth, rather than a period of decline. The philosophy was originally applied to nursing homes but has since been adopted with little modification by all forms of residential care, community care and other long term care environments.

The Eden Alternative is about improving the historic culture of care. Studies show that implementation of this philosophy is a powerful tool for improving quality of life and quality of care for those living in long term care. Most importantly the people in residence, supported by care givers, can once again direct their own daily lives.

The beauty of the Eden Alternative philosophy is its flexibility and adaptability. As it is a philosophy, and not a project, it has been implemented successfully in a wide range of cultural environments across the world. This philosophy of care is strikingly simple. Regional Coordinators, Mentors and Eden Associates teach that people should live in positive environments, not sterile medical institutions. The philosophy is based on ten principles and seven domains that have been developed to support the elimination of the challenges that make life intolerable in so many of today's nursing and residential homes.

NICHE-Leeds (https://niche.leeds.ac.uk/) is an innovative partnership between Leeds Care Association and the University of Leeds, with care providers (Westward Care and Springfield Healthcare) and Leeds City Council which aims to enhance the quality of care and life of older people living in care homes. We have two organising principles:

1. *our **resident-centred focus*** ensures research and development concentrates on issues that actually matter to people living in care homes or impact on quality of work for staff – work which directly influences residents' care; and
2. quality needs genuine ***interdisciplinary collaboration*** between care, policy, education, and research.

Our partnership provides the leadership, expertise and catalysing collaboration for quality and effective innovation in care homes.

Appendix 2 Detailed comments on the details underpinning the proposed platforms for an SPQ for ASC

Platform 1: Being an accountable and autonomous professional and partner in care (amended from original NMC wording: Being an accountable and autonomous professional)

All registered nurses act in the best interests of people, putting their needs first and providing nursing care and social support that is person-centred, safe, and compassionate. They act professionally at all times and use their knowledge and experience to make person-centred, evidence-informed decisions about care and support. They communicate effectively, are role models for others, and are accountable for their actions.

Registered nurses with an adult social care practice qualification are required to work autonomously in people's homes, close to home or in the community, with people of all ages, in particular frail older people with complex co-morbidities (including dementia). They work in interdisciplinary and interagency environments, and work in partnership with, and negotiate delegation of work to, diverse teams involved in providing care, including registered professionals, paid unregulated carers, family members and significant others, and volunteers and others working in third sector organisations.

They work in environments that can be highly complex (interface of public and private sectors), unconventional (interface of housing, health and social care), dynamic (often working with people who lack mental capacity) and unpredictable (often working with people near the end of life), and consequently high risk (need to balance positive risk taking with safety to ensure quality of life). The specialist nurse (adult social care) is a clinical expert who can work independently, using higher levels of knowledge and skill, expert decision making and professional judgement in order to function effectively in this type of environment as an autonomous, accountable professional.

Registered nurses with this qualification will be able to:

1.1 understand and act in accordance with the NMC Code of Professional standards of practice and behaviour for nurses, midwives and nursing associates, and fulfil all registration and post registration requirements

1.2 practise with autonomy and accountability, proactivity and innovation, and be self-aware, emotionally intelligent and open to change

1.3 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgments and decisions in routine, complex and challenging situations

1.4 lead and manage a 24/7 nurse-led service in a home-like environment, with the ability to effectively admit, provide appropriate support and care, promote quality of life and quality of

care, ensure peaceful end of life, discharge and refer

1.5 note when individuals' care needs change in order to access relevant funding e.g., Continuing Healthcare

1.6 manage deterioration and support individuals and those significant to them to confidently chose, when the time is right for them, a natural death and avoid hospitalisation.

1.7 be a role model able to provide expert person-centred, relational and appreciative care in complex, challenging and unpredictable circumstances with ingenuity, flexibility and professionalism

1.8 be accountable for their decisions, actions and omissions, recognising their own personal competence when working with complexity, risk, unpredictability and incomplete information

1.9 understand and apply relevant legal, regulatory and governance requirements, policies, and professional and ethical frameworks, including any mandatory reporting duties, to all areas of practice, differentiating where appropriate between the devolved legislatures of the United Kingdom, with particular reference to those who lack mental capacity

1.10 lead and promote care provision that is person-centred, anti-discriminatory, culturally competent and inclusive

1.11 identify the need for and lead on action to provide reasonable adjustments for people, groups and communities, by adapting their practice, promoting best practice in others and influencing policy

1.12 create and maximise opportunities for people to remain independent where possible and foster interdependency, where not

1.13 communicate effectively in a person-centred way using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, social, physical, cognitive and behavioural health challenges

1.14 demonstrate the skills and abilities required to support people at all stages of life in any health and care setting who are emotionally or physically vulnerable

1.15 enable choice, promote wellbeing and prevent ill-health where possible, including avoidance of hospital admission where appropriate

1.16 maintain people's identity in an environment of collective living, where there may be competing interests

1.17 involve people and those significant to them in decisions about services provided, and nature of the home environment

1.18 understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes

1.19 critically reflect and recognise when their personal values and beliefs might impact on their behaviour and practice

1.20 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to mental, social and physical health and wellbeing

1.21 apply the advanced numeracy, literacy, digital and technological skills required to meet the needs of people, and those significant to them, to ensure safe and effective nursing practice and the promotion of wellbeing

1.22 lead, promote and influence the nursing profession in wider housing, health and social care contexts to effect measurable change which improves the care of communities through partnership working

1.23 provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, capacity, needs and preferences, taking account of any need for adjustments

1.24 influence the development and implementation of housing, health and social care strategies and policies at a local, regional and national level.

1.25 demonstrate an understanding of research methods, ethics and governance in order to critically analyse, safely use, share and apply research findings to promote and inform best nursing practice to include the wellbeing of those they care for

1.26 demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence informed decisions in all situations

1.27 demonstrate the skills and abilities required to develop, manage in partnership and maintain appropriate relationships with people, those significant to them, and working colleagues

1.28 demonstrate the ability to keep complete, clear, accurate and timely records

1.29 take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop their professional knowledge and skills

1.30 demonstrate the knowledge and confidence to contribute effectively and proactively in an interdisciplinary team

1.31 as an ambassador, upholding the reputation of their profession and promoting public confidence in nursing, health and care services, and

1.32 demonstrate evidence-informed practice in all skills and procedures

Platform 2: Enabling choice, promoting wellbeing, preventing ill health, and supporting a good end of life (amended from original NMC wording: Promoting health and preventing ill health)

Registered nurses play a key role in planning, improving and maintaining the mental, social, physical, cognitive and behavioural health and wellbeing of people, families, communities and populations through partnership working. They support and enable people at all stages of life and in all care settings to make informed choices about how to manage health challenges in order to live life to the full by maximising their quality of life and improving health outcomes and wellbeing. They are actively involved in the prevention of and protection against disease and ill health and engage in public health, promotion of wellbeing, community development and global health agendas, and in the reduction of health inequalities.

Registered nurses with this qualification will be able to:

2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health and promotion of wellbeing and quality of life when engaging with people and those significant to them

2.2 help people understand their rights and express their views by being their advocate or ensuring access to more appropriate advocacy services

2.3 demonstrate knowledge of epidemiology, demography, genomics and the wider determinants of health, illness and wellbeing and apply this to an understanding of global patterns of health and wellbeing outcomes

2.4 understand the factors that may lead to inequalities in housing, health and social care outcomes

2.5 identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, social, physical, cognitive, and behavioural health and wellbeing, in the context of people's individual circumstances and understanding of what matters to them in the context of their own home

2.6 critically assess health needs in partnership with people, families, communities and populations, supporting them to own their actions and the behaviours necessary for behavioural change

2.7 promote, maintain and improve mental, social, physical, cognitive, behavioural and other health related outcomes by understanding and explaining the principles, practice and evidence-base for health screening programmes

2.8 understand the importance of early years and childhood experiences and the possible impact

on life choices, mental, social, physical and behavioural health and wellbeing

2.9 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, social, physical, cognitive, and behavioural health outcomes

2.10 explain and demonstrate the use of up-to-date approaches to behaviour change to enable people to use their strengths and expertise and make informed choices when managing their own health and wellbeing and making lifestyle adjustments

2.11 using a person-centred approach, appropriate communication skills and strengths-based approaches in partnership with people to make informed choices about their care and support to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, capacity, ill health and disability across all care settings

2.12 provide information in accessible ways to help people understand and make decisions about their journey through health and wellbeing life choices, illness and care including end of life care

2.13 promote health and wellbeing and prevent ill health by understanding and explaining to people, in the context of their own home, the principles of pathogenesis, immunology and the evidence-base for immunisation, vaccination and herd immunity, and protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance

2.14 critically analyse and assess the characteristics of communities, their assets and any gaps in order to build networks and alliances that can enhance health outcomes for people and families

2.15 promote and support people, communities and populations to connect effectively with local initiatives, support networks, programmes and third sector organisations that support their health and wellbeing

2.16 evaluate the impact of networks to enhance and support the mental, social, physical, cognitive, and behavioural needs of people, families and communities, and address any gaps that emerge

2.17 understand the application of genomics and epigenetics in sufficient detail to inform and advise people, families and communities on the potential benefits in relation to their personalised health care

2.18 maximise opportunities for people, families, communities and populations to use their own strengths and assets to make informed choices about their own health and wellbeing, in the

context of their own home

2.19 apply a range of advanced communication skills to develop and make accessible public health information that enables people to make their own informed decisions about their health, wellbeing and life choices

2.20 plan for and protect the health of people, families and communities through an evidence-informed approach to infection prevention and control, including community led communicable disease surveillance and antimicrobial stewardship.

Platform 3: Assessing and planning for people's abilities and needs, in partnership with them and their carers (amended from original NMC wording: Assessing people's abilities and needs, and planning care)

Many people who receive care and support from specialist nurses (adult social care) are living with complex long term conditions and multiple co-morbidities that affect their mental, social, physical, cognitive, and behavioural health and wellbeing.

Registered nurses with a specialist adult social care qualification have the knowledge, skills and attributes to be the lead professional in caring for the people they serve. They are highly skilled in using an evidence-informed approach when undertaking holistic assessments of each person's mental, physical, cognitive, behavioural, social and spiritual abilities and needs, always taking the wider social and environmental context into account.

They work appreciatively to develop therapeutic relationships with people and those significant to them to facilitate shared decision making and to co-produce personalised plans of care. They take into account the diverse experiences, abilities, needs, preferences and challenges people are living with in order to make sure that plans are achievable and capable of providing meaningful outcomes for the person.

They use their professional judgement to agree and prioritise a person's capabilities and needs when applying a person-centred approach to assessing and planning care. This includes empowering, promoting and supporting self-care where possible, and encouraging a sense of mutual interdependence, where not.

They are able to plan for the provision of appropriate evidence-informed care and for making or receiving referrals to and from other health, social care and third sector agencies in partnership with the person receiving care and those significant to them.

Registered nurses with this qualification will be able to:

2.21 carry out a comprehensive assessment to meet an individual's acute and long-term care needs, improve their quality of life and sense of wellbeing, and maintain their independence as long as possible.

2.22 combine a working knowledge of biopsychosocial sciences, human development, family dynamics, public and private resources as well as funding sources, to ensure care and wellbeing needs are met and services wrap around individuals

2.23 take an strengths-based and salutogenic approach to identifying needs, preferences, capabilities, and assets, in preference to using a deficit and dependency model

3.1 advocate for clients and those significant to them, including those with cognitive impairment, throughout the continuum of care

3.2 create and apply a person-centred, relational and appreciative approach to care, facilitating a partnership approach to assessment, shared decision making and care planning when working with people, their families, communities and populations

3.3 recognise and assess the impact of, and the interplay between, people's preferences, their close relationships and support systems, their home environment, and the influence of social, economic, environmental, and spiritual factors when assessing abilities, understanding needs and planning care and treatment interventions

3.4 recognise and apply the principle of the presumption of capacity and the requirement toseek informed consent as an ongoing process

3.5 make reasonable adjustments to maximise opportunities for people to be involved inmaking decisions about their assessment, treatment and evaluation of care

3.6 make best interests decisions within the required legislative framework if, after seeking informed consent and making reasonable adjustments, your professional judgement is that a person lacks capacity to make an informed decision at that time

3.7 assess and plan the care of people when they are vulnerable, agreeing whether there is a need for support and advocacy and if so at what level, to ensure maximum levels of independence and interdependence through the continuum of care and in the context of their own home

3.8 ensure that reporting, planning and coordination of care is prioritised and evaluated for people in need of safeguarding

3.9 select and use appropriate communication strategies and relationship management skills when interacting with people, including those significant to them, who have a range of mental, physical, cognitive, behavioural and social health challenges, and those at or near the end of life

3.10 undertake a person-centred and informed assessment by proactively obtaining and critically evaluating a range of sources of information, seeking additional advice or guidance when indicated

3.11 critically analyse complex assessment data, and distinguish between normal and abnormal findings, recognising when prompt action is required, including requesting additional investigations and, when appropriate, escalating to or involving others

3.12 critically apply diagnostic reasoning to clinical decision making, taking into account differential diagnosis and the potential for diagnostic overshadowing

3.13 capitalise on the use of technology and informatics to undertake assessment and diagnosis, and to co-produce care plans

3.14 understand and use new and emerging advances in science and technology, including genomics, to underpin and inform decisions made during assessment and in shaping personalised care and treatment options

3.15 maximise opportunities for shared decision making when developing care plans and planning future anticipatory care planning through the use of a range of problem solving, influencing and negotiation skills

3.16 effectively communicate the potential for different options for care and uncertainty to the person and those significant to them and how they will be supported in a mutually agreed plan of care

3.17 pro-actively seek to mitigate risks in relation to a person's changing mental and physical health circumstances, their living environment, social arrangements, or relevant conditions

3.18 encourage positive risk taking, in a safe manner to deliver what the person wants

3.19 make autonomous decisions in challenging and unpredictable situations, and be able to take appropriate action to assess and manage risk.

Platform 4: Negotiating and evaluating evidence-informed care, both individually and collectively (amended from original NMC wording: Providing and evaluating evidence based care)

Registered nurses with a specialist adult social care qualification take the lead in negotiating, providing and evaluating evidence-informed, person-centred, compassionate, effective and safe interventions in relation to support and care.

They are able to initiate a range of housing, health and social care interventions, including social and independent prescribing, that can be preventative, supportive, curative, symptom relieving or palliative.

They are independently able to undertake a range of interventions to address the impact of mental, physical, cognitive, psychological, and social factors and to manage complete episodes of health and social care and ensure appropriate housing.

They can communicate complex information in a simple way that supports, advocates for, and enables people, and those significant to them where appropriate, to have voice, choice and control about their treatment, care and support taking into account the most likely benefits and risks.

They work in partnership with people and those significant to them, peers and interdisciplinary and interagency colleagues to assess the impact of care on an ongoing basis. This includes evaluating the health and social care outcomes and whether the housing and intervention being provided is safe and remains effective and continues to be in line with the wishes, preferences and desired outcomes of the person receiving care, which in turn may change over the course of time.

They ensure that the care they provide or delegate is person-centred flexible, dynamic and is of a consistently high standard.

Registered nurses with this qualification will be able to:

4.1 assess the continuing nursing needs of people and ensure appropriate service provision, in the context of their own home

4.2 advise on housing, health and social care provision and welfare benefits, signposting people to appropriate resources to best meet their needs

4.3 remain up to date with the evidence for best practice and share this knowledge with others, to inform care planning and practice development

4.4 observe, notice and record what works for individuals, in particular for those with mental incapacity and communication difficulties to inform personalised care planning

4.5 critically reflect on and evaluate everyday practice, at the individual and collective level, in

order to advise and lead on quality improvement and practice development

4.6 autonomously co-ordinate and manage complex episodes of care during their acute and chronic phases, making timely referral to other appropriate services or agencies

4.7 agree with the person and those that are significant to them when a person's ongoing assessment, care planning and treatment can be safely delegated to an alternative person

4.8 recognise changes in motivation or dissatisfaction with the careand treatment plan, and work in concordance with people to influence and negotiate any revisions to the plan and care

4.9 proactively engage with and respectfully advocate for, people usingservices provided by other professionals or agencies to identify and address any concerns that they might have

4.10 initiate a range of evidence-informed health and social care and treatment interventions, including social and independent prescribing, that can be preventative, supportive, curative, symptom relieving or palliative

4.11 use safe and effective independent and supplementary prescribing (V300) andmedicines administration, optimisation and medicines reconciliation

4.12 evaluate and adjust plans to ensure support that safeguards people when theyare vulnerable and enables them to enjoy a quality of life

4.13 work with people and where appropriate those significant to them to agree and provide evidence-informed, person-centred nursing and relationalcare for those who are dying or near to the end of life

4.14 sensitively accommodate the preferences, beliefs, cultural requirements and wishes ofthe deceased and people who are bereaved

4.15 maintain therapeutic professional relationships with people and those significant to them throughout the episode of health and social care and treatment, working appreciatively to agree a way forward

4.16 work in partnership with people and those significant to them and other members of the team tocontinuously monitor and evaluate the outcome of the care plan and agree any changes

4.17 include people and those significant to them in making decisions about their care or circumstances to safely manage new, existing or escalating risks, whilst ensuring quality of life

4.18 accurately record and clearly explain the rationale for decisions, actions taken and the resulting outcomes in writing, or using digital technology which can be shared with the person and those significant to them, and other professionals.

Platform 5: Leading, supporting, and educating others in person-centred, relational, and appreciative practice (amended from original NMC wording: Leading and managing teams)

Registered nurses with a specialist adult social care qualification provide and lead services in a variety of community settings, but mainly care homes registered for nursing. They act as role models for best practice in the provision of clinical treatment, nursing, and social care to support quality of life. They are responsible for leading services and managing care for individuals and groups of people. They put the best interests, needs, preferences and aspirations of people first when taking action to balance positive risk with safety.

They are accountable for the delegation of activities to team members, including delegation to other housing, health and social care professionals and those colleagues who are not on a professional register, and provide advice and guidance to family and other significant carers.

In leading and managing an interdisciplinary team, they are able to work appreciatively, collaborate and communicate effectively and relationally with colleagues. They are able to influence and build professional working relationships with other disciplines and those working in other agencies to achieve seamless, effective and safe provision of services for people.

They are able to work appreciatively to minimise and resolve any disagreement or conflict between those providing care, using the skills of negotiation and advocacy to arrive at mutually acceptable solutions.

Registered nurses with this qualification will be able to:

5.1 understand the need to base all decisions regarding care, support and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions

5.2 create wellbeing in the community through relationship-centred care, a sense of vibrancy and individually meaningful activities in a home-like environment

5.3 help fulfil a sense of security, belonging, continuity, purpose, achievement, and significance in individuals

5.4 help people to live a life worth living and adapt to their changing circumstances

5.5 enable choice, promote wellbeing and prevent ill-health where possible, including avoidance of hospital admission where appropriate and access to healthcare services

5.6 negotiate advanced care plans with people and those significant to them to ensure provision of a good death

5.7 educate and support others to provide evidence-informed and reflective practice

5.8 help create a positive culture in which people can thrive and flourish

5.9 evaluate a range of indicators for quality of life and quality of care to determine the skill mix and workforce required to meet the health and wellbeing needs of those living in the care home.

5.10 nurture and support the development of the workforce through coaching, mentoring and teaching to enhance knowledge, skills and confidence

5.11 review and confidently manage the people, financial and other resources required to effectively and safely meet the health and wellbeing needs of those living in the care home.

5.12 take an asset-based approach to make best use of people's capabilities to enhance their quality of life

5.13 promote the importance of meaningful activities to promote wellbeing and prevent ill health

5.14 identify, collaborate with and facilitate access to a range of community resources, including third sector and faith-based support resources

5.15 foster intergenerational engagement to tackle ageism, enhance quality of life and enable active citizenship

5.16 critically analyse the collective needs of those living in the care home and the associated care requirements and those of the wider team to effectively and appropriately prioritise activities in order to manage demand and capacity

5.17 safely and effectively delegate responsibilities to team members based on an assessment of their level of knowledge, attitude, skill, experience and confidence

5.18 clinically supervise the work of others and educate and support them to develop health-related and nursing skills

5.19 use digital technology to maximise effective interagency and interdisciplinary team working

5.20 in collaboration with individuals and those significant to them construct cogent arguments and effectively communicate complex information to justify difficult decisions about resource allocation

5.21 work with commissioners (including self-funders) to influence service provision to meet the changing needs of people

5.22 welcome feedback from others (including inspectors) to learn how best to improve and enhance

service provision

5.23 balance the care and support needs of the individual with the collective needs of others together with the business needs of the organisation, reporting when the needs of individuals are not being safely and effectively met

5.24 know how to effectively delegate responsibility for the management of budget, people and other resources to team members, while retaining accountability

5.25 procure equipment and disposable items in line with relevant procurement policies, value for money considerations and health and safety requirements

5.26 articulate and document a clear and evidence-informed rationale for complex decision making and judgement when leading teams in challenging situations

5.27 continually reflect on their own transformational leadership approach and take action to adapt their leadership style to different situations, for example, when working with diverse teams who may be geographically dispersed

5.28 effectively and sensitively use systems to measure the impact, quality, productivity and cost efficacy of interdisciplinary and interagency teams to allow effective performance management of teams, recognising where there are gaps or where improvements in information are required and to act upon this

5.29 conduct professional conversations with individuals and those significant to them about their experience and feed back to team members, providing opportunities for positive reinforcement and challenge, through clinical supervision, and agreeing any development plans or remedial actions in line with appraisal processes

5.30 use a range of approaches and resources available to educate, support and stimulate people, manage talent and succession plan, either through mentorship or leadership

5.31 recognise and act upon individual abilities and learning needs when applying the standards of education and training for pre- and post-registration nursing, midwifery and nursing associate students, in order to educate, supervise and assess effectively

5.32 apply a range of strategies that are safe and effective in supporting positive team development and cohesion across disciplines and agencies, and to understand the importance of rota management and skills mix.

5.33 select and implement strategies which are appropriate to the composition of the team, to enable supervision, reflection and peer review, and evaluate their suitability, impact and resilience.

Platform 6: Balancing risk and leading improvements in quality of life and quality of care, through the development of communities (amended from original NMC wording: Leading improvements in safety and quality of care)

Registered nurses with a specialist adult social care qualification develop and lead the implementation of strategies to improve care, treatment and services and to enhance health outcomes and peoples' experience of housing and health and social care services. They are proficient in quality improvement and research methodologies.

They are able to capitalise on their specialist knowledge, skills and experience, and to safely manage the range of risks, complaints and concerns associated with providing care in diverse community settings, whilst ensuring an environment of wellbeing and quality of life for residents, relatives and staff. They are able to translate the outcomes of risk management activities into lessons learned and improved operational practices.

They are able to advocate for and lead evidence-informed quality improvement initiatives and influence decision making across the interdisciplinary team and in interagency settings.

Registered nurses with this qualification will be able to:

6.1 demonstrate awareness that human rights are the basic rights and freedoms that belong to every person in the world, from birth until death. Apply this in practice regardless of where people are from, what they believe or how they choose to live their life.

6.2 demonstrate an understanding of the Mental Capacity Act (MCA) designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment and an ability to apply this in practice

6.3 understand what safeguarding is and why it's important and take actions to protect vulnerable groups from harm, in the context of their own home.

6.4 interpret and act upon housing, health and safety legislation and regulations in order to develop local policy and guidance to support staff working across the range of home and community environments

6.5 evaluate the outputs and recommendations of internal and external risk reporting to enable prioritisation, decision making and the development of action plans to mitigate risk

6.6 demonstrate a commitment to and understanding of positive risk assessments balancing quality of life and quality of care with integral involvement of the person and/or their advocate in a home-like environment.

6.7 exercise the professional judgement, knowledge and skills required to balance competing risks and priorities, ensuring that actions to reduce safety risks remain person-centred and least restrictive

6.8 co-produce strategies and plans for the development of communities recognising the importance of integration to improve quality of life outcomes

6.9 take an asset-based approach to enable people living with frailty to support them to remain active citizens, connected with their local communities

6.10 encourage intergenerational linking to challenge ageism and enhance leadership and citizenship skills across the age spectrum for mutual benefit

6.11 demonstrate an evidence-informed involvement of service users in leading improvements in quality of life and quality of care and identify how this involvement can shape future plans for quality of life and quality of care

6.12 co-produce strategies and plans for service design with people, families and communities to improve care outcomes

6.13 effectively use innovative and emerging technology to ensure optimum collection, storage, analysis and forecasting of data and intelligence that will support the development of plans to improve safety and quality outcomes

6.14 evaluate people's experiences of continuity of care to improve the quality of life and wellbeing in service delivery, and to promote and lead a caring, kind and compassionate team, leading by example

6.15 evaluate different research designs and methodologies and their application to address research questions and generate evidence for service improvement

6.16 lead a continuous quality improvement programme from end to end, selecting appreciative methods, collating and presenting results, and planning any improvement actions

6.17 critically appraise published results of service evaluation, research and audit, and distil relevant learning that can be applied in practice to bring about service improvement

6.18 present relevant research findings and associated proposals for care improvement to a range of audiences.

Platform 7: Care co-ordination, collaborative working, and wrapping services around the individual across complex systems (amended from original NMC wording: Care co-ordination and system leadership)

Registered nurses with a specialist adult social care qualification have a critical understanding of relevant social, political and economic policies and the way they impact on the broader community, and of the wider determinants of health and health inequalities.

They have a detailed understanding of the functions of the wide range of different agencies within the community that have a direct or indirect impact on health, wellbeing and quality of life. They have an in-depth knowledge and understanding of their political and economic drivers, constraints and risks, which enables them to successfully build productive working relationships for the benefit of people and communities.

They are able to design and provide a safe and effective model of person-centred, relational and appreciative practice that are integrated within, and maximise the contribution of, other agencies and services, for not only those they care for, but also the wider care team. They have the knowledge, skills and attributes to influence and work collaboratively with their team and other agencies to provide co-ordinated, sustained and productive change within this context.

They are able to use their knowledge, skills and experience to influence and bring about evidence-informed change at a local, regional and national level for the benefit of people and communities.

Registered nurses with this qualification will be able to:

6.19 critically analyse the political, social and economic policies and drivers that may have an impact on the health, care and wellbeing of local communities, as well as emotional and psychological effects that may be impacting on this or causing individual distress

6.20 apply the principles of housing, health and social care economics and their relevance to resource allocation in integrated primary and community care services

6.21 synthesise epidemiological, demographic, social, political and economic trends to forecast their impact and influence on current and prospective adult social care services

6.22 help co-ordinate services to wrap around individuals to meet their person-centred needs and preferences, in a home-like environment

6.23 maximise effective collaboration and co-design between interdisciplinary and interagency teams, through evaluation of the roles and responsibilities of other agencies that provide integrated housing, health and social care

6.24 apply appreciative methodologies to drive continuous service improvement within the services

provided by a variety of different organisations and agencies

6.25 proactively lead on or take a part in the creation and development of effective networks that enhance communication and decision making across organisations and agencies

6.26 to understand and effectively apply the difference between the management role and the leadership role.

We are suggesting that there are two platforms that are missing:

Platform 8: Understanding frailty and taking an asset-based approach to its management (new)

Demonstrate an understanding of frailty (physical and mental) in later life and the ability to build systems in which people who are living with frailty are identified. Develop asset-based assessment approaches to its management in which a person's mental and physical resilience are prioritised recognising a person's ability to reverse frailty.

Build collaborative systems which use a recognised language of frailty to offer consistency of care and support in transitions.

Registered nurses with this qualification will be able to:

8.1 demonstrate an in-depth understanding ('phenotype' and 'cumulative deficit' models) of what is meant by the concept of frailty (physical and mental) as a long-term condition of reduced resilience and increased vulnerability to deterioration as a result of relatively minor stress factors

8.2 Have an understanding of frailty as a complex and multi-dimensional state linked to other concepts including multi- morbidity, disability, dependency and personal resilience, which can fluctuate over time

8.3 Explain how living with frailty (including dementia) from first presentation to end of life affects and is affected by many different aspects of a person's life (including the person's physical health, immobility, mental health, loneliness, cognitive function and their social and home environment) and how best to manage this in the context of their own home

8.4 demonstrate an appreciation that people living with frailty are more at risk of confusion, falls, incontinence, problems with mobility and side effects of medication demonstrate an understanding that in frailty it is usually the number of things that have 'gone wrong' and the inability to do everyday tasks that is more important than the exact nature of the individual problems (examples of 'problems' may include poor vision, hearing or mobility, loneliness, history of falls and memory loss, as well as diagnosed long term physical and mental health conditions) valuate the underlying causes of frailty and advise on the five conditions often associated with frailty (delirium, recurrent falls, sudden deterioration in mobility, new or worsening incontinence, medication side-effects)

8.5 educate others (residents, relatives and staff) to safely and effectively manage common conditions associated with ageing (e.g., hearing loss, cataracts and refractive errors, back and neck pain and osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression, and dementia).

8.5 support and signpost with sensitivity and in ways that are acceptable to the person and appropriate to their communication needs where further information can be obtained for people with frailty and those significant to them

8.6 show an awareness of the importance of early recognition and timely management of frailty syndromes, e.g. that there are interventions to improve independence and quality of life for people living with frailty

8.7 be able to carry out a comprehensive and holistic assessment of frailty (e.g. CGA) in partnership with people living with frailty and as part of a multi-professional team6

8.8 interpret the physical characteristics of frailty, e.g. weight loss, poor nutrition and hydration, fatigue, weakness, reduced physical activity and general 'slowing down'

8.9 display an understanding of the importance of equal access to frailty assessment, e.g. for people from diverse communities or with specific needs (such as sensory or cognitive impairment

8.10 Instruct reasons for caution about assessing frailty in a person who is acutely unwell

8.11 demonstrate an understanding of the concept of a 'frailty index' as a means of measuring frailty7

8.12 be able to use relevant frailty screening and assessment tools in accordance with local policy such as Gait (Walking) Speed Test; Time Up and Go (TUG) Test; PRISMA-7 Questionnaire; Edmonton Frail Scale; Clinical Frailty Scale also known as the Rockwood Score.

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6 Comprehensive Geriatric Assessment (CGA) is a process of care comprising a number of steps. Initially, a multidimensional holistic assessment of an older person considers health and wellbeing and leads to the formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). Interventions are then arranged in support of the plan. Progress is reviewed and the original plan reassessed at appropriate intervals with the interventions reconsidered accordingly. Some bodies prefer to call it a comprehensive older age assessment (COAA). It is also referred to as geriatric evaluation management and treatment (GEMT). Ref: http://www.bgs.org.uk/cga-toolkit/cga-toolkit-category/what-is-cga/cga-what)

7 A frailty index is a measure of the health status of individuals - as a proxy measure of aging and vulnerability to poor outcomes. This is distinct from the electronic frailty index (eFI) which is a specific tool which uses data that is routinely available in the GP electronic health record to identify and severity grade frailty.

Platform 9: Engaging technology to enhance practice (new)

Registered nurses with a social care specialist practice qualification support: digitally enabled health and social care that creates better outcomes for patients, enables better experiences for staff, and offers opportunities to make working practices more efficient. They are proficient in the use of technology used in the provision of nursing & social care.

Registered nurses with this qualification will be able to:

9.1 demonstrate an awareness of the full range of technology as it applies to housing, health and social care, including, including artificial intelligence, telehealth and telecare, assistive technology, medical technology, social robotics, digitalised care planning systems etc.

9.2 autonomously and confidently use technology in the provision of nursing and social care, and be self-aware and open to change around the adoption of new technologies

9.3 use available technology to communicate with other health and social care professionals as part of a multidisciplinary approach to providing nursing care

9.4 be a role model in the use of technology and the benefits of technology to provide expert person-centred care in the context of their own home

9.5 be accountable for their decisions around technology, this should include an understanding of the risks of cyber security and digital clinical safety

9.6 critically understand and apply relevant legal, regulatory and governance requirements to the use of technology

9.7 understand the barriers to adoption of technology for the people they support, apply a knowledge of accessibility adaptions to common technologies to prevent inequalities.

9.8 promote the use of available technology to encourage people to make informed decisions about their health, wellbeing and life choices.

9.9 confidently use available digital tools and technologies to support the planning and provision of care to individuals

9.10 use available technology to strengthen evidence-informed and person-centred best practice

9.11 use available technology to communicate with individuals and their families and carers where appropriate.

9.12 keep accurate and contemporaneous documentation and digital records in line with data protection