**EAST & NORTH AND WEST HERTFORDSHIRE**
**PRIMARY CARE TRUSTS**

**PBC DRAFT**

# SERVICE SPECIFICATION FOR THE PROVISION OF

# COMMUNITY MATRONS

# TO

# HERTFORDSHIRE PCT COMMISSIONERS

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## 1. Introduction

The purpose of this document is to provide the Commissioners in Hertfordshire Primary Care Trusts with a specification for a Hertswide Community Matron Service. The current service provision comprises several distinct services with slightly different structures and processes.

The Community Matron service has been developed over a period of years and has been provided in response to the national agenda of delivering care closer to home. Each Community Matron Service has developed differently depending on the financial resources allocated and the historic provision available prior to the changing national agenda. This has resulted in different models of delivery but principally the direction of travel is similar.

There is considerable debate about appropriate and effective caseload size for community matrons. The size of a caseload at any given time will reflect the dependency of the patients and the intensity of management they require. Locally it is also influenced to some degree by the effectiveness of other Health and Social Care services. To optimise the effectiveness of case management and have a cost efficient service, a key factor affecting caseload size is the percentage of the Community Matron's time that is spent providing direct hands on care that could and should be delegated to other staff. By discharging patients into supported self care, the Community Matrons create capacity and optimise effectiveness, otherwise there is a risk that caseloads can become clogged.

According to an analysis of the Very High Intensity Users per Practice Based Locality, (as shown in Appendix A), this has identified the current need for 22 Community Matrons, with each having a caseload of 65 in accordance with the EoE SHA guidelines. According to the LDP, the Herts PCTs only require 22 Community Matrons by March 2008, although they are expected to have between 80 and 100 VHIU's each. However, what is meant by VHIU will vary from one area to another and could include both 'active' and 'inactive' cases.

## 2. Recommendation

At present, the Community Matron establishment across Hertfordshire is 24 (Source: LDPR Q1 data). In order to provide an equitable service, then each locality should have a number of Community Matrons that roughly matches their population size. **The "Proposed Establishment" outlined in Appendix A does this and shows the need for 25 Community Matrons across Herts.** Half posts have been included, so that the rates are roughly equal across all localities, which may mean a shared-post across 2 localities or part time workers. It would thus seem reasonable to use this plan now and as the status quo thereafter, as in theory it should generate a similar workload per Community Matron.

## 3. Purpose of the Service

The purpose of the Community Matron Service is to improve the health and quality of life for people with complex Long Term Conditions using the case management approach, avoiding the need for crisis intervention, optimising the care and treatment offered and reducing inappropriate Accident & Emergency attendance, hospital admissions and premature death.

The Community Matron is responsible for the pro-active management of a caseload of identified very high intensity users with complex needs, working autonomously within a clinical governance framework and as part of a team. The service will provide a comprehensive, advanced assessment and care package, utilising support services and liaising with other agencies to ensure the complex needs of this client group are met.

## 4. Objective of the Service

The objective of the Community Matron Service is to ensure people with Long Term Conditions become more independent and in control of their lives, through timely intervention and referral across Primary, Secondary and Social Care. The aim of the service is to provide support to the very high intensity users with Long Term Conditions, using a proactive systematic case management approach, in order to reduce reliance on secondary care services to ensure the delivery of effective community services to the patient .

The specific objectives of the service are to:-

- Prevent avoidable admission to acute units
- Reduce A & E / UCC attendances
- Reduce G.P visits / attendances
- Reduce occupied bed days
- Reduce outpatient appointments
- Reduce medication costs
- Co-ordinate care across services
- Maximise therapy/treatment
- Promote self care/self management
- Proactively support those with Long Term Conditions and their carers
- Improve quality of life of patients and carers
- Improve patient experience
- Offer care 'in the right place, by the right person at the right time' (Our Heath, our Care, Our Say – DoH 2006)
- Deliver care closer to home

Natnal Guidance

Little local flexibility

Rnider arm brought in UHE looking @ CM model

What roles should like told to by SHA finished work on Friday (not may be intenitive later report final)

## 5. Background

The introduction of Community Matrons is a national initiative by the DOH and follows successful pilots across the UK. Nationally there are 17.5 million people who report living with a Long Term Condition. This figure will double by 2030 for those over 65. 5% of the population, many with conditions such as Asthma, Diabetes or Arthritis, account for 42% of all acute bed days (DOH 2005). Long Term Conditions management is highlighted in the NHS Improvement Plan and is a key element in the National Service Frameworks (NSFs). The NHS Improvement Plan (DOH 2004) states that by 2008 there will be 3000 Community Matrons using case management techniques to care for around 250,000 patients with complex needs.

Long Term Conditions are defined as incurable and often progressive states of ill health that can affect any aspect of a person's life. Symptoms may come and go. Although most conditions have no cure, there are often things that can be done to maintain and improve the quality of people's lives (Healthcare Commission 2006).

## 6. Eligibility to the Community Matron Service

The Community Matron Service will be offered to Patients At Risk of Re-Hospitalisation (PARR) using PARR data as the prime source in pro-actively selecting patients. In addition, Consultants, G.Ps and Specialist Nurses may make direct application to this service. Please refer to 6(a) Referral Criteria.

## 7. Care Pathway

The commissioners and the providers are working together to agree a care pathway for the delivery of Community Matron Services.

## 8 (a) Referral Criteria

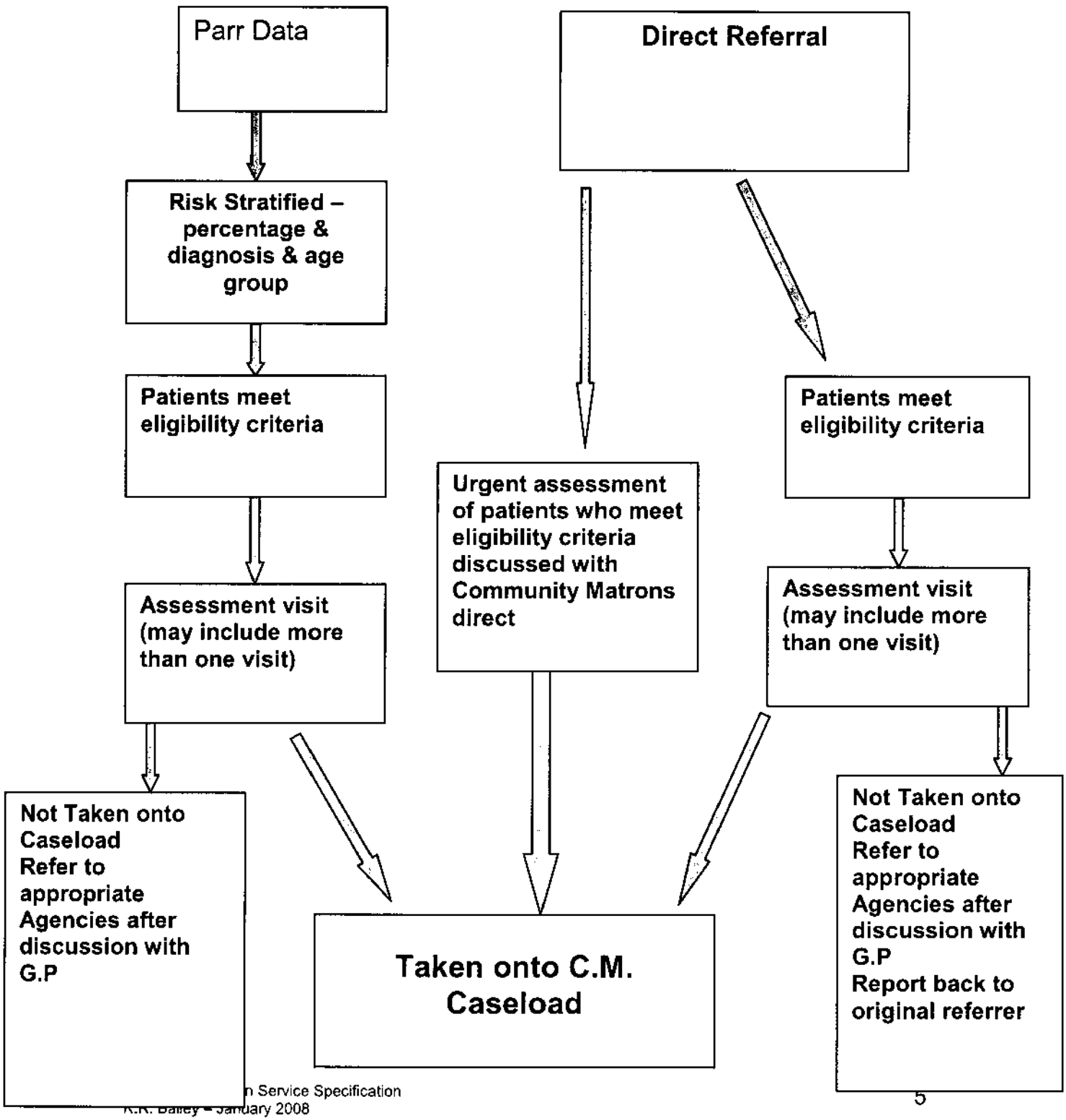
Adults with three or more active Long Term Conditions who also meet three of the following criteria:-

- In the top three per cent of G.P. users
- Recently bereaved and at risk of medical decline
- Two or more falls in the last two months
- Two or more A & E attendances or unplanned hospital admissions in the last twelve months
- Significantly impaired in an instrumental activity of living, particularly where no support systems are in place
- Evidence of non-compliance with medication
- Exacerbation of a Long Term Condition in the last two months
- Two or more encounters in the last twelve months with other prevention of admission services, such as Intermediate Care Team; Step-Up Services, Community Hospital or Emergency Care Practitioners

## 8(b) Inappropriate Referrals

All patients will be reviewed by the Community Matron. Following discussion with the patient's G.P., and the original referrer, the Community Matron will advise whether or not the patient is suitable to be case managed or will be referred to the appropriate agency.

## 8(c) Assessment by the Community Matron Service



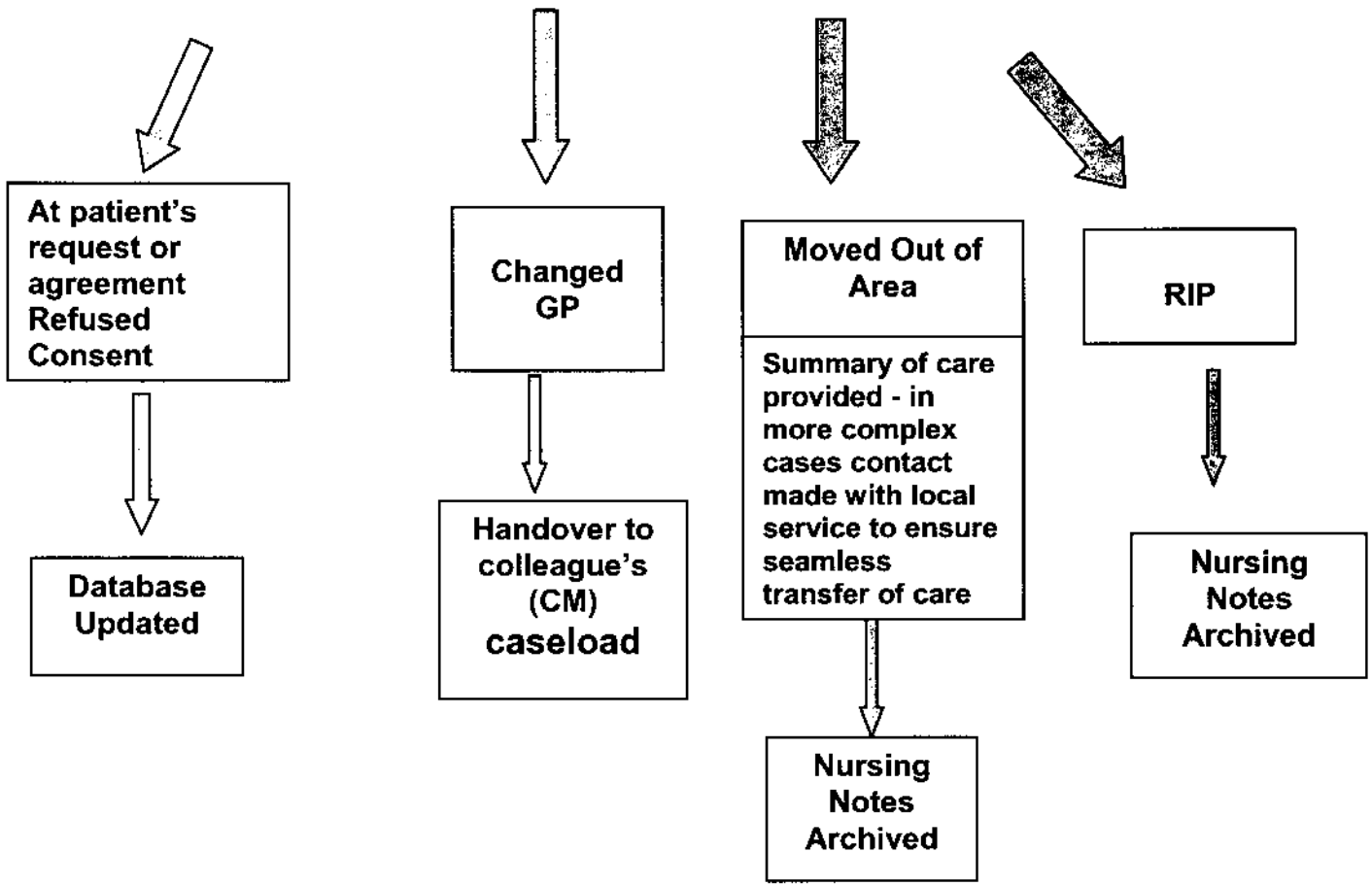
## 9. Exit from the Service – Discharge Criteria

Patients will be discharged when:

- Patients are able to manage a Long Term Condition safely
- Patient is referred to another service for further management of their condition, or has been admitted to a long-term inpatient facility
- Options for care delivery will be reviewed and Community Matron input may be discontinued in cases where patient/carer is non-compliant and/or their behaviour is inappropriate (e.g. threatening, abusive etc)

Exit from the Community Matron Service is shown on the following Flow Chart(A) :-

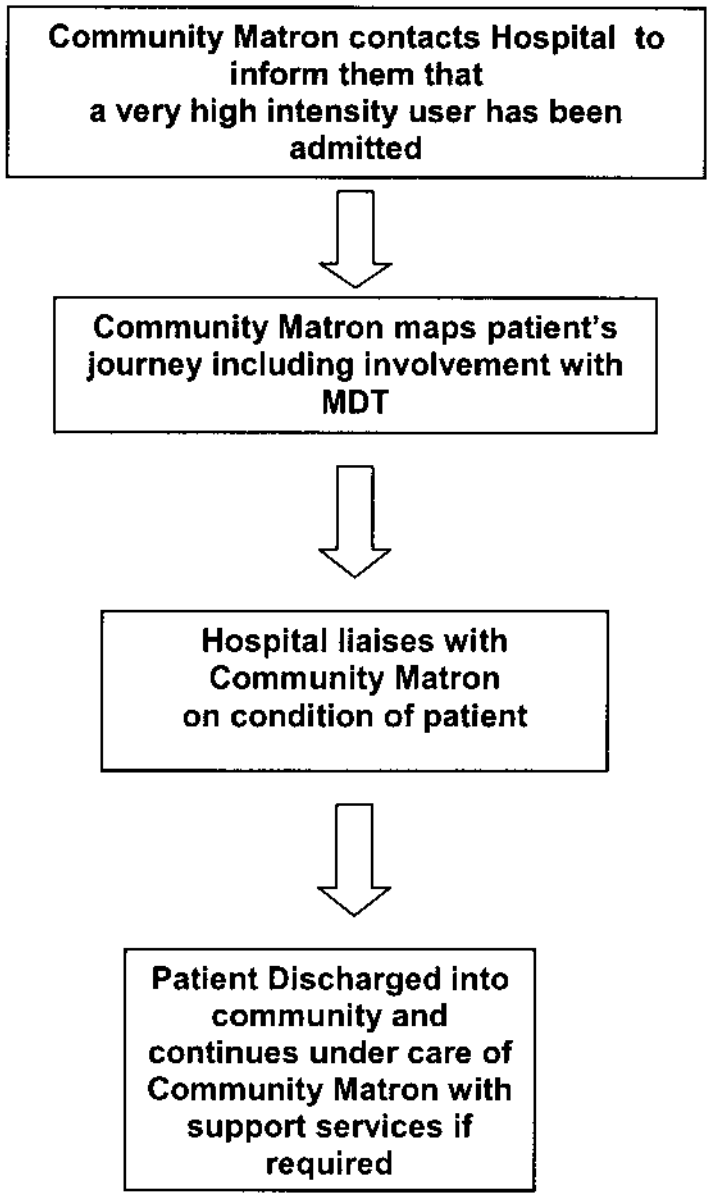
# FLOW CHART (A)
# PATIENT DISCHARGED FROM
# THE COMMUNITY MATRON SERVICE



## 10. Re-entry into the Community Matron Service

Patients admitted for a short episode of treatment into an inpatient facility will be regularly reviewed by the Community Matron, in order that they may be discharged home as soon as clinically possible. Re-entry into the Community Matron Service is shown on the following Flow Chart(B):-

## FLOW CHART (B)
## RE-ENTRY INTO THE COMMUNITY MATRONS SERVICE



## 11. The Community Matron Service

### 11(a) Case Finding

- Use of predictive model e.g. PARR[1] and risk stratification tools to identify appropriate patients at risk of repeated hospitalisation and high consumption related healthcare resources.

- Referrals will also be accepted directly from primary and secondary care.

### 11(b) Assessment

- Comprehensive assessment of medical and psychosocial condition using advanced clinical skills and assessment tools, e.g.Mini Mental State Exam (MMSE) to develop a plan of proactive care.

### 11(c) Care Co-Ordination

- Co-ordination of complex individual care plans by collaborating with health, social and voluntary care providers preventing fragmented care and optimising effective use of resources across organisational boundaries.

- Promotion of self-care by teaching patients and carers about the early signs of deterioration, progression of disease, initiation and choice of treatment.

### 11d) Intervention

- Diagnose and intervene early in cases of exacerbation of symptoms and other minor illnesses, prescribing independently and optimising current drug regimes, carrying out proactive medication reviews

- Initiate and interpret diagnostic tests.

- Navigate cases through health services and facilitate early discharge.

- Reduce unnecessary hospital attendances including follow up consultant appointments.

- Reduce GP attendances and home visits

- Advanced care planning for end of life

1. PARR case finding algorithm which incorporates a broad range of variables relating to the patient, community and hospital to help predict risk of readmission.

## 11e) Continual review

- Regular multidisciplinary team meetings & GP/Consultant reviews.
- Use of the traffic light system to monitor the level of risk and decide degree of intervention and frequency of visits – as outlined in following Clinical Risk Stratification Tool:-

| Risk Category | Criteria | Clinical Strategies |
|---|---|---|
| | • New admission to caseload until initial assessment has taken place.<br>• Acute change in condition from baseline status<br>• Change in functional status/decline in condition since last visit<br>• Post discharge from hospital.<br>• History of acute infection in past 30 days.<br>• Hospitalisation, A&E/MAU/CDU/CAUMU transfer, Rapid Response Input/POA.<br>• Carer not coping with care package.<br>• Evidence of rapid deterioration in cognitive status.<br>• Dying at home with minimal support from other services. | • Daily telephone contact with patient and/or face to face visit.<br>• Instigate social network support i.e. referral to appropriate services.<br>• Review any changes in plan of care with GP, other stakeholders.<br>• Increased GP collaboration – telephone and/or joint visits.<br>• Hospital readmissions – Liaison with Discharge planning for early discharge.<br>• Document scheduled diagnostic tests and plans for follow up.<br>• Document changes in patient choices and discuss with appropriate parties. Incorporate current status, prognosis and risk/benefits of treatment options.<br>• Review with GP/Multidisciplinary team.<br>• Move to AMBER when condition has remained stable, but medically changeable.<br>• Complete advanced directive/DNR.<br>• Document any changes to medications as per clinical management plan. |
| **Yellow Medically Changeable** | • Unexplained falls.<br>• Recurrent infections.<br>• Weight loss/unexplained and/or continued.<br>• Evidence of change of condition from baseline.<br>• Unexplained decline in cognitive status.<br>• Skin integrity compromised. | • Weekly face to face visits, plus 2-3 phone contacts per week.<br>• Document changes in patient choices and discuss with appropriate parties. Incorporate current status, prognosis and risk/benefits of treatment options.<br>• GP collaboration as needed.<br>• Document any changes to medications as per clinical management plan.<br>• If change in plan of care appropriate update stakeholders.<br>• Review with MDT as needed.<br>• Move to GREEN when condition medically stable. |
| | • Stable chronic conditions.<br>• Medical and social support of patient and carer. | • Routine monitoring and reassessment every 4-6 weeks.<br>• Clear documentation of support and care given.<br>• Review with MDT as needed. |

### 11f) Service Development

- Leading on change and innovation to develop the service for people with complex Long Term Conditions in primary care. Eg. virtual ward rounds, elderly care clinics and following patients into accident and emergency and medical assessment units to prevent an admission.

- Commitment to develop a service locally in partnership with all stakeholders and in response to local needs and service provision.

## 12. Clinical Governance

The Clinical Governance Framework will ensure that systems are in place across the organisation for maintaining and continuously improving the quality of care, creating an environment in which excellence can be developed and encouraged.

The Community Matron Service will work to the principles of the PCT Clinical Governance Framework identifying key attributes:-

- Recognisable and measurable high standards of care
- Transparent responsibility and accountability of the standards through audit and outcome measures.
- Constant dynamic improvement developing a highly skilled workforce
- Patient participation and involvement to inform care delivery centred around the patient experience.
- Individuals responsible for the quality of their own clinical practice, ensuring that Community Matrons are appropriately qualified and training is provided in line with their individual development plans.
- Improving care using quality improvement methods (Clinical Audit), identifying aspects of care that need improvement and monitoring outcomes.
- Promoting a culture of learning – having systems in place to deal with and learn from incidents and complaints, identifying and managing risk

## 13. Key Performance Indicators

The Community Matron Service will require continual performance monitoring and evaluation in order to meet the needs of the population service.

The Key Performance Indicators are outlined on the following Table:-

**Community Matron Service – Key Performance Indicators**

| | |
|---|---|
| ***Acute Prevention of Admission*** | When a single visit, activity of liaison prevents a patient's admission to hospital.<br>***Examples may include:-***<br>• Liaison with GP to titrate diuretics for someone in acute phase of heart failure<br>• Commencing therapy for an acute exacerbation of COPD or instigating ICT involvement. |
| **Long Term Prevention of Admission** | When a number of activities over a longer space of time has prevented the admission of a patient.<br>***Examples may include:-***<br>• Daily visits to monitor effect of drug therapy and liaison with medical staff to titrate / alter drug therapy.<br>• Organisation of respite to prevent the home situation breaking down. |
| **Averted GP Visit** | A visit or liaison, which prevents the need for a GP appointment or home visit, or an Outpatient appointment<br>***Examples may include:-***<br>• Diagnostic physical examination of the patient.<br>• Nurse prescribing of antibiotics or other drug therapy. |
| **Averted Health Professional Visit** | A visit or appointment becomes unnecessary due to Case Manager involvement.<br>***Examples may include:-***<br>• Cancellation of consultant outpatient appointments with patient agreement due to extra support now being given.<br>• Community nursing visit not required as specific intervention carried out by CM. |
| **Improved Outcome** | An improved health or social outcome as a result of Case Manager intervention.<br>***Examples may include:-***<br>• Improvements in blood chemistry such as HbA1c.<br>• Reduction in exacerbations due to medicine management or teaching active cycle of breathing in COPD patients.<br>• Referral for housing modifications such as stair lifts to aid independence. |
| **Medicine Management** | Review or monitoring of medications, which leads to increased compliance, prevention of drug stock piling or removal of items from repeat list. |
| **Key Patient / Carer Support** | An intervention, which has led to an improvement in the physical, social or emotional situation of the patient or carer.<br>***Examples might include:-***<br>• Referral for pulmonary rehab.<br>• Bereavement counselling.<br>• Smoking cessation classes.<br>• Benefits or money advice.<br>• Counselling. |

| | |
|---|---|
| | • Support groups.<br>• Carer assessments. |

## 14. Availability

The Community Matron Service will be available Mondays to Fridays 9 a.m. until 5 p.m.

## 15. Accommodation

Care will be provided by the Community Matron in the patient's home environment. Patients can also be seen in hospital, at the G.P Surgery, Day Hospice, Day Hospital, Day Centre or Nursing/Residential Homes.

Community Matrons will be based in a variety of locations, including Health Centres, G.P. Surgeries and Community Hospitals.

## 16. Equipment and Resources

### 16(a) Equipment

The Community Matron service will access those support services that are provided by the PCT to assist in the effective running of the service (e.g. finance, H.R., education etc)

Nursing equipment used in day-to-day routine interventions and care, general stationery and travel expenses will be included in the current non-pay budget.

Equipment required for use by patients in their home will be provided, upon application, by the Hertfordshire Equipment Service, funded through a pooled PCTs and Adult Care Services budget.

### 16(b) Resources

- Mandatory training
- Specific training including:
    1. Top-to-toe
    2. Disease specific study days
    3. National Conference for Long-term Conditions
    4. Mentoring/continuing professional development/clinical supervision with Elderly Care Consultants / Specialist Consultants
    5. Non-medical prescribing

## 17. Communication and Support

Each Community Matron will have the support of a G.P., generally attached to no more than two Practices, dependent upon the population size (total population not to exceed 30,000). An identified G.P mentor from each practice will be allocated to a Community Matron, in order to provide support, guidance and advice.

The Community Matron should be able to use the G.P's I.T. systems for diagnostics, non-prescribing and documenting visit outcomes.

The Community Matron will be required to present data at Practice Based Commissioning Groups and Practice Meetings, as appropriate.

## 18. Record Keeping

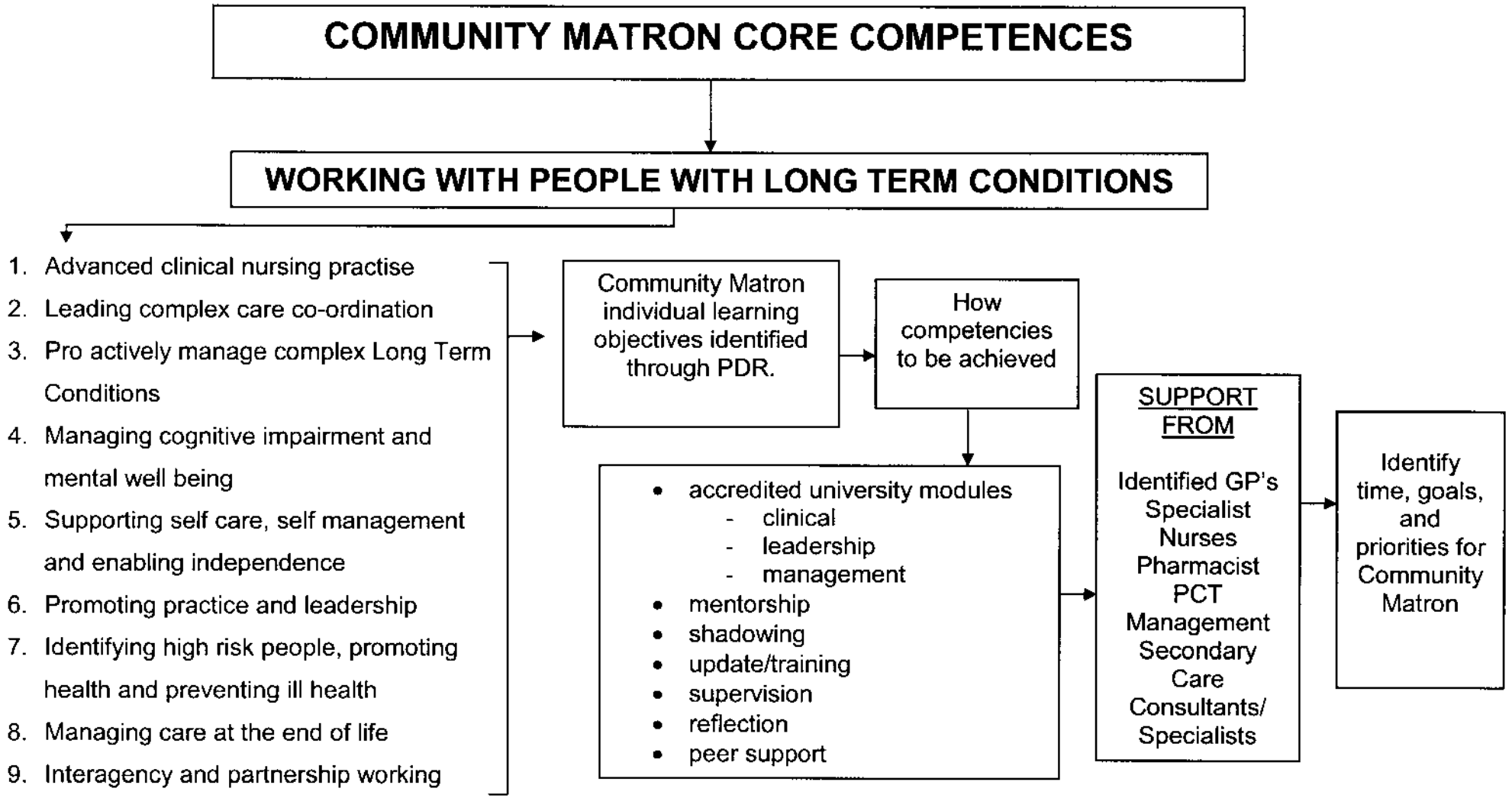
Hand held notes in patients' homes.

G.P systems – audit trail :– The Community Matron will have access to this system, as well as the opportunity to input information onto this system.

## 19. Workforce

Community Matrons need to have advanced clinical assessment and diagnostics skills and practice at an advanced level. This includes self-directed learning, managing risk, authority to act on behalf of patient, higher level communications and negotiation skills.

The core principle of the Community Matron competences are outlined in the attached Appendices B-J and have been identified as:


COMMUNITY MATRON CORE COMPETENCES
WORKING WITH PEOPLE WITH LONG TERM CONDITIONS
1. Advanced clinical nursing practise
2. Leading complex care co-ordination
3. Pro actively manage complex Long Term Conditions
4. Managing cognitive impairment and mental well being
5. Supporting self care, self management and enabling independence
6. Promoting practice and leadership
7. Identifying high risk people, promoting health and preventing ill health
8. Managing care at the end of life
9. Interagency and partnership working
Community Matron individual learning objectives identified through PDR.
How competencies to be achieved
accredited university modules
- clinical
- leadership
- management
mentorship
shadowing
update/training
supervision
reflection
peer support
SUPPORT FROM
Identified GP's
Specialist Nurses
Pharmacist
PCT Management
Secondary Care Consultants/ Specialists
Identify time, goals, and priorities for Community Matron

## 20. Equal Opportunities

The Community Matron Service will be mindful of the particular needs of patients from hard to reach groups (e.g. families from low socioeconomic backgrounds or families for whom English is not their preferred language) and will make every effort that their needs are identified and responded to, in accordance with the Trust's existing policies and procedures

**December 2007**

References:


Department of Health (2005) *Supporting People with Long-Term Conditions Liberating the Talents of Nurses Who Care For People With Long-Term Conditions.* London, HMSO

Department of Health (2005) *Supporting People with Long Term Conditions. Supporting Experienced Hospital Nurses Move into the Community Matrons Roles.* London: HMSO

Department of Health (2006) *Case Management in Coventry An evaluation of the first year of case management by Community Matrons : Annual Report: 2005-2006,* Coventry tPCT

Department of Health (2006) *Our Health, Our Care, Our Say*, London HMSO

Department of Health (2006) *Healthcare Commission on State of Health Care*, London, HMSO

Recommend ← UHE & Evercare Optim (1) DH Optim (2)

## APPENDIX A

### Community Matron Establishment per Practice Based Locality

Optim 3 Optim (4)

Active patients

| Locality | VHUI's 40-100% re-admission probability | C.M Caseload (50) | C.M Caseload (65) | Current Establishment | Population (a) | Proposed Population per matron (b) | Proposed Establishment (a) ÷ (b) | New Posts/ changes | Population per Matron c30,000* Proposed Establishment | New Posts / changes |
|---|---|---|---|---|---|---|---|---|---|---|
| Watcom PBC Ltd | 197 | 3.94 | 3.03 | 2 (1 Vac.) | 187,454 | 46,864 | 4 | 2 | 6 | 4 |
| DacCom PBC Ltd | 189 | 3.78 | 2.91 | 2 | 153,776 | 51,259 | 3 | 1 | 5 | 3 |
| St Albans Harpenden | 157 | 3.14 | 2.42 | 3 | 129,691 | 43,230 | 3 | | 4 | 1 |
| Hertsmere LMG | 170 | 3.4 | 2.61 | 3 (1 Vac.) | 96,421 | 48,211 | 2 | -1 | 3 | |
| North Herts | 89 | 1.78 | 1.37 | 3 | 114,085 | 45,634 | 2.5 | -0.5 | 4 | 1 |
| Welwyn/ Hatfield | 102 | 2.04 | 1.57 | 2 | 111,790 | 44,716 | 2.5 | 0.5 | 4 | 2 |
| Stevenage | 85 | 1.7 | 1.3 | 3 | 93,455 | 46,728 | 2 | -1 | 3 | |
| South Locality | 126 | 2.52 | 1.94 | 3 | 72,924 | 40,513 | 1.8 | | 4 | 1 |
| East Locality | 125 | 2.5 | 1.92 | | 49,447 | 41,206 | 1.2 | | | |
| North Locality | 87 | 1.74 | 1.34 | 3 | 35,337 | 44,171 | 0.8 | | 4 | 1 |
| West&Central Locality | 98 | 1.96 | 1.51 | | 93,133 | 42,333 | 2.2 | | | |
| Total | 1425 | 28.5 | 21.92 | 24 (2Vacs) | 1,137,513 | 45,501 | 25 | 1 | 37 | 13 |

*Population Circa 30,000 Intermediate Care Commissioning Framework (Page 17)

Working [redacted] with v high intensity users



Wants PBC to agree what we could use – want consistency across Wards

**APPENDIX B**
**1. Advanced Clinical Nursing Practice**

| Element of Competence | Performance Criteria |
|---|---|
| • Advanced clinical assessment skills.<br>• Advanced risk assessment and appropriate management of risk<br>• Advanced ability to use information in undertaking assessments, clinical decision making and diagnosis<br>• In-depth knowledge and understanding of the presentation, progression, pathophysiology and prognosis of common Long Term Conditions<br>• Advanced communication and interpersonal skills<br>• In-depth knowledge of and ability to apply relevant legislation, and full understanding of the ethical issues involved in caring for people with Long Term Conditions<br>• Sophisticated application of holistic person centred approaches to care.<br>• In-depth knowledge and understanding of therapeutic interventions, including relevant pharmacology and medicine management | a) The type of care in the home involving assessing and managing risk associated with working in isolation<br>b) That the nurse is working autonomously in a manner that enables assessment diagnoses and prescribing<br>c) Competent in medical history taking and advance clinical nursing practice<br>d) Taking responsibility of initiating and interpreting diagnostic tests: critical thinking: diagnosis: decision-making<br>e) Competent in independent prescribing to manage acute exacerbation of multiple LTC<br>f) Management of cognitive impairment and well being within the clinical care they provide<br>g) Evaluating and re-evaluating care packages<br>h) Empowering the individual to self-manage |

## APPENDIX C
## 2. Leading Complex Care Coordinator

| Element of Competence | Performance Criteria |
|---|---|
| • Advanced skills in use and management knowledge.<br><br>• In-depth knowledge and understanding of health and wellbeing issues for people with Long Term Conditions<br><br>• Sophisticated application of holistic person-centred approaches to care<br><br>• In-depth knowledge of and ability to apply relevant legislation, and full understanding of the ethical issues involved in caring for people with long tern conditions<br><br>• In-depth knowledge and understanding of and ability to mange interdisciplinary and team based approaches to care<br><br>• Knowledge and understanding of service resource and procurement and management<br><br>• Knowledge and understanding of government policy and guidance on Long Term Conditions<br><br>• Skills in identifying and protecting those at risk (particularly in relation to adult abuse), and caring for and supporting those individuals who have suffered abuse. | a) Being competent in proactively coordinating and organising complex care packages – supporting personalised care plans<br><br>b) Risks management plans that support independence and daily living for individuals to be care for at home/or their preferred care setting<br><br>c) Communication skills that will effectively deliver the desired outcome for the individual in their care<br><br>d) Monitoring the care provided for patients with LTC, which may result in hospital admission and readmission<br><br>e) Record keeping and report writing identifying methods and systems to promote effective communication and engagement<br><br>f) Knowledge and interpretation of consent and confidentiality |

## APPENDIX D
## 3.Proactively Manage Complex Long Term Conditions

| Element of Competence | Performance Criteria |
|---|---|
| • Knowledge and understanding of the impact of socio-economic and personal circumstances on people with Long Term Conditions<br>• In- depth knowledge and understanding of the impact of lifestyle choices on LTC | a) care planning that supports the individual to live at home:<br>- identifying safety and security in the working environment<br>- allowing the individual to make choices<br>- agreement of care planning for individual |
| • Skills in managing clinical events, including risk assessment and appropriate management of risk | b) promotion of individual with LTC of choice and well-being ensuring that:<br>- individual rights are met that include difference and preferences<br>- respect of their diversity is address |
| • Advanced knowledge in managing and facilitating patient and carer education | c) negotiates with the carer on the roles and responsibilities required to<br>undertake the agreed plan of care |
| • In-depth knowledge and understanding of and ability to manage inter-professional and interagency working<br>• In-depth knowledge and understanding of and ability to support the care of individuals in the home environment | d) working knowledge of evidence based practice and its role in improving services |

## APPENDIX E
## 4. Managing Cognitive Impairment and Mental Well Being

| Element of Competence | Performance Criteria |
|---|---|
| • Knowledge and understanding of sources of information on mental health and related services<br>• Skills in the assessment of mental health needs, including risk assessment<br>• Knowledge and understanding of physical, behavioural, emotional and psychological indications of mental health needs<br>• Knowledge and understanding of counselling and psychological support methods | a) Knowledge of basic assessment for mental health needs that leads to:<br>- individual care planning<br>- signposting to relevant services<br>- empowering carers: and others to support individual with LTC |
| • Skills in interpreting responses to LTC, including recognizing signs of depression<br>• In-depth knowledge and understanding of diversity, discrimination and stigmatization | b) Promote the individual in self management of their disease |
| • Knowledge and understanding of therapeutic interventions<br>• Advanced communication and interpersonal skills | c) Working in the inter-disciplinary team environment towards achieving agreed objective with service uses |

## APPENDIX F
## 5. Supporting Self Care, Self Management and Enabling Independence

| Element of Competence | Performance Criteria |
|---|---|
| • Knowledge Skills in partnership working with patients and carers<br>• Knowledge and understanding and application of cognitive behavioural therapy techniques<br>• Advanced conflict and dispute management skills<br>• In-depth knowledge and understanding of community resources and support networks<br>• Advanced skills in empowering patients and enabling self care<br>• In-depth knowledge and understanding of self advocacy<br>• In-depth knowledge and understanding of the impact of LTC on everyday living<br>• Knowledge and understanding of individual rights<br>• Advanced skills in facilitating participation and independence<br>• Advanced change management skills<br>• Advanced teaching, learning and coaching skills<br>• In-depth knowledge and understanding of the impact of lifestyle choices on LTC | a) Through care planning:<br>- promote the expert patient programme<br>- education provided to the individual<br>- enable the individual with LTC to cope with changes to health and wellbeing<br>- enable individuals learning through self-management<br>- realistic goals to be achieved |
| | b) Promotion of individual with LTC of choice and well-being ensuring that:<br>- individual rights are met that include difference and preferences<br>- respect of their diversity is address |
| | c) Negotiates with the carer on the roles and responsibilities required to undertake the agreed plan of care |
| | d) Working knowledge of evidence based practice and its role in improving services |

## APPENDIX G

## 6. Professional Practice and Leadership

| Element of Competence | Performance Criteria |
|---|---|
| • In-depth knowledge and understanding of professional accountability<br><br>• In-depth knowledge and understanding of workforce development, professional development, supervision and appraisal<br><br>• Highly developed reflective practice skills<br><br>• In-depth knowledge and understanding of relevant clinical governance issues<br><br>• Advanced leadership skills<br><br>• In-depth knowledge and understanding of organisational development and change management<br><br>• In-depth knowledge and understanding of the issues relating to personal and professional competence | a) Clinical leadership and take responsibility for the continuing professional of self and others by:<br>- personal development<br>- supervision and support<br>- team working and development<br>- educational programmes, coaching<br>- communication skills within the team and other services/agencies |
| | b) Development of organisation policy and practice |
| | c) Working knowledge of primary care and identifying learning needs to others, enabling development of knowledge and practice for the role |
| | d) Acts within the limits of your competency and authority |
| | e) Develop sustain and evaluate collaborative work with others |

## APPENDIX H
## 7. Identifying High Risk People, Promoting Health and Preventing Ill Health

| Element of Competence | Performance Criteria |
|---|---|
| • Skills in analysing, interpreting and presenting public data<br><br>• Knowledge and understanding of evaluation methodologies and associated ethics<br><br>• in-depth knowledge and understanding of social constructions of health and illness | a) Collaborative working with:<br>- Public health practitioners to analyse and interpret data and information about health and wellbeing and/or stressors to health and wellbeing in a define caseload<br>- Communicate information in a define caseload to individuals, groups and communities |
| | b) report writing in the context of defendable documentation |
| | c) knowledge of data storage and retrieval systems |
| | d) development of Telecare in the management of LTC |
| | e) research and evidence base practice applied to LTC |
| | f) working knowledge how to analyse quantitative and qualitative data validly and reliably |

## APPENDIX I

### 8. Managing Care at the End Of Life

| Element of Competence | Performance Criteria |
|---|---|
| • Knowledge and understanding of life stages and change and losses associated with LTC | a) Development of services for individuals families and groups when experiencing end of life issues |
| | b) Maintaining the individuals independence and physical ability and acts as advocates and interpreter to express their views |
| • Knowledge and understanding of how individuals respond to distress | c) Implementing 'End of life/Liverpool/Palliative care pathway' as choice for the individual and utilising the multidisciplinary approach |
| • Skills in the care of dying and bereavement | d) Training in:<br>- verification of death<br>- counselling especially in bereavement<br>- working knowledge of allowances, funds etc<br>- clinical practice i.e. syringe drivers: management of prescribed drugs |
| | e) working knowledge of key people and others for the needs of the individual |

## APPENDIX J

### 9. Interagency and Partnership Working

| Element of Competence | Performance Criteria |
|---|---|
| • In-depth knowledge and understanding of collaborative and interagency working | a) Working across organisation and professional boundaries to enable personalised care to be delivered |
| | b) provision of leadership in joint working agreements and practices and reviews effectiveness |
| | c) be able to identify organisational factors, tensions and constraints which impact on service delivery to promote the best outcome for the individual |
| • In-depth knowledge and understanding of performance review | d) effective communication skills that ensure that the outcome of the individual is achieved |
| | e) plan and implementation transfer of care and discharge of an individual who have a LTC and their carers along with deadlines and responsibilities |
| • Advanced conflict and dispute management skills | f) when high risk is identified to an individual that the implementation of action, monitoring, review |
| | g) working knowledge of national service standards and organisational policies |
| • Advanced communication and interpersonal skills | h) being an agent of change for the improvement of service delivery for individual having a working knowledge, boundaries and roles of<br>- contractual arrangement relating to services offered by the organisation: social care: across other agencies |