Nursing & Midwifery Council

# Standards of proficiency for community nursing specialist practice qualifications

## Contents

Originally published:
**7 July 2022**



These standards were approved by Council at their meeting on 26 May 2022. They were redesigned in March 2024.

# Introduction

## What we do

The Nursing and Midwifery Council are required to set standards of proficiency, education and training for nursing and midwifery professionals seeking to join our registers for the first time. As part of this we review our standards regularly to ensure they continue to protect the public, are fit for purpose, and are necessary for safe, effective and kind care. When we review any of our standards, including standards that lead to annotation, we take into account new evidence, the changes taking place in society and changes in health and care.

## Education and training beyond initial registration

We recognise that in today's health and care services, the roles of nurses, midwives and nursing associates (in England) are changing and expanding, requiring higher levels of clinical autonomy, knowledge and skill in order to achieve their full potential and to contribute to the delivery of services for the benefit of the **people** they serve. Everyone on our register undertakes additional education and training after their initial professional registration to develop further knowledge and skills, but not all of this ongoing education is, or needs to be, regulated.

We take a proportionate approach to the regulation of post-registration qualifications. We reserve regulation for those areas where ensuring consistency of standards of proficiency, and standards for education and training, is needed to achieve a higher level of quality and safety in order to mitigate risk and to reassure the public. One of the means that we have of recognising post-registration qualifications is through setting standards for **specialist practice** qualifications (SPQs).

Specialist practice qualifications are annotations to our register. They indicate that a registered nurse has successfully undertaken an NMC approved SPQ programme that meets our standards in a particular area of practice. To undertake a specialist practice qualification, you must be a first level registered nurse.

## Community nursing in the 21st century

In the 21st century, support and care of people of all ages is increasingly being delivered in the community, in people's homes and in settings close to their homes. These settings include care homes, hospices, general practice, residential and educational settings, and prisons and offender health settings. As a result, new models of community care are emerging, new nursing roles have been developed and there are likely to be more in the future. The limited number of **community nursing** SPQs that we currently have – community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing and general practice nursing – no longer represent the totality of specialist nursing practice in the community.

Holding a community nursing specialist practice qualification is not a requirement to work in the community or to care for any individual client group. For the majority of nursing roles, a combination of the standards of professional behaviour and conduct enshrined in **the Code**, and the requirement to meet the knowledge and skills specified in the pre-registration nursing standards of proficiency, along with subsequent and ongoing revalidation, is sufficient for effective regulation. In order to take a proportionate approach, we need to consider which roles and activities justify regulation at a post-registration level.

## About these standards

This document contains our new outcome-focused specialist community nursing standards of proficiency for registered nurses. These proficiencies reflect the specialist knowledge, skills and attributes required by nurses working in the community in any roles which involve more autonomous decision-making, in situations that require registered nurses to manage greater clinical complexity and risk, both in terms of the people they care for, the **caseloads** they manage and the services they work within, which in turn may be integrated with other agencies, professionals and disciplines.

In our **2020-2025 strategy** we have made a commitment to explore whether the regulation of advanced practice is needed. These new specialist community nursing qualifications incorporate standards of proficiency that will support registered nurses working in the community to advance their clinical, managerial, research and educative practice. This will enable greater clinical autonomy, independent decision-making and leadership in complex and high-risk situations for the benefit of people and services.

It is likely that more community nursing roles will be developed in the future that also demand higher levels of clinical autonomy. These standards therefore serve to build on current good practice and intend to promote learning and create ambition and opportunity for other registered nurses who work in the community. This is why we have introduced a new SPQ for other fields of community nursing practice.

## The nature of regulatory standards

Regulatory standards are intended to be high level and outcome-focused. They are translated by education institutions and their practice placement partners into more detailed curricula and programme learning outcomes. These standards apply to all fields of community nursing practice, however the evidence base and their application in different fields of community nursing will differ. These standards should therefore be read alongside the standards for education and training, which sets out our expectations regarding provision of all pre-registration and post-registration NMC approved nursing and midwifery education programmes.

These standards apply to all approved education providers and are set out in three parts:

- Part one: Standards framework for nursing and midwifery education
- Part two: Standards for student supervision and assessment
- Part three: programme standards, which are the standards specific for each pre-registration or post-registration programme.

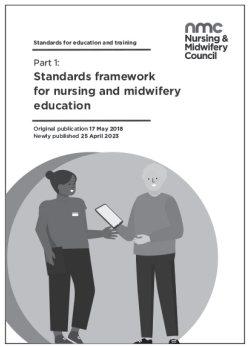
Educational institutions must meet our programme standards in order to be approved to deliver a programme which leads to one of the following SPQs: community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing or specialist community nursing.

The rationale for the new community nursing SPQ annotation which does not specify a particular field of community nursing role is that it can be applied to registered nurses who work in different community roles, including potential new roles that are emerging in the community, which require professionals to have the knowledge and skills that are specified in these standards in order to practise with higher levels of clinical autonomy and provide a better service for the people in their care.

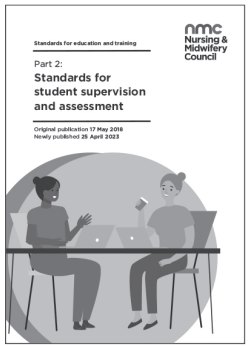
Together these standards aim to provide Approved Education Institutions

# Standards for education and training

## Part 1

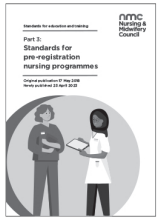


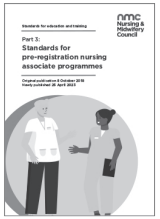

## Part 2



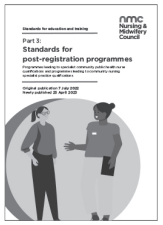

## Part 3 - Programme standards

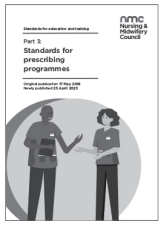
### Pre-registration

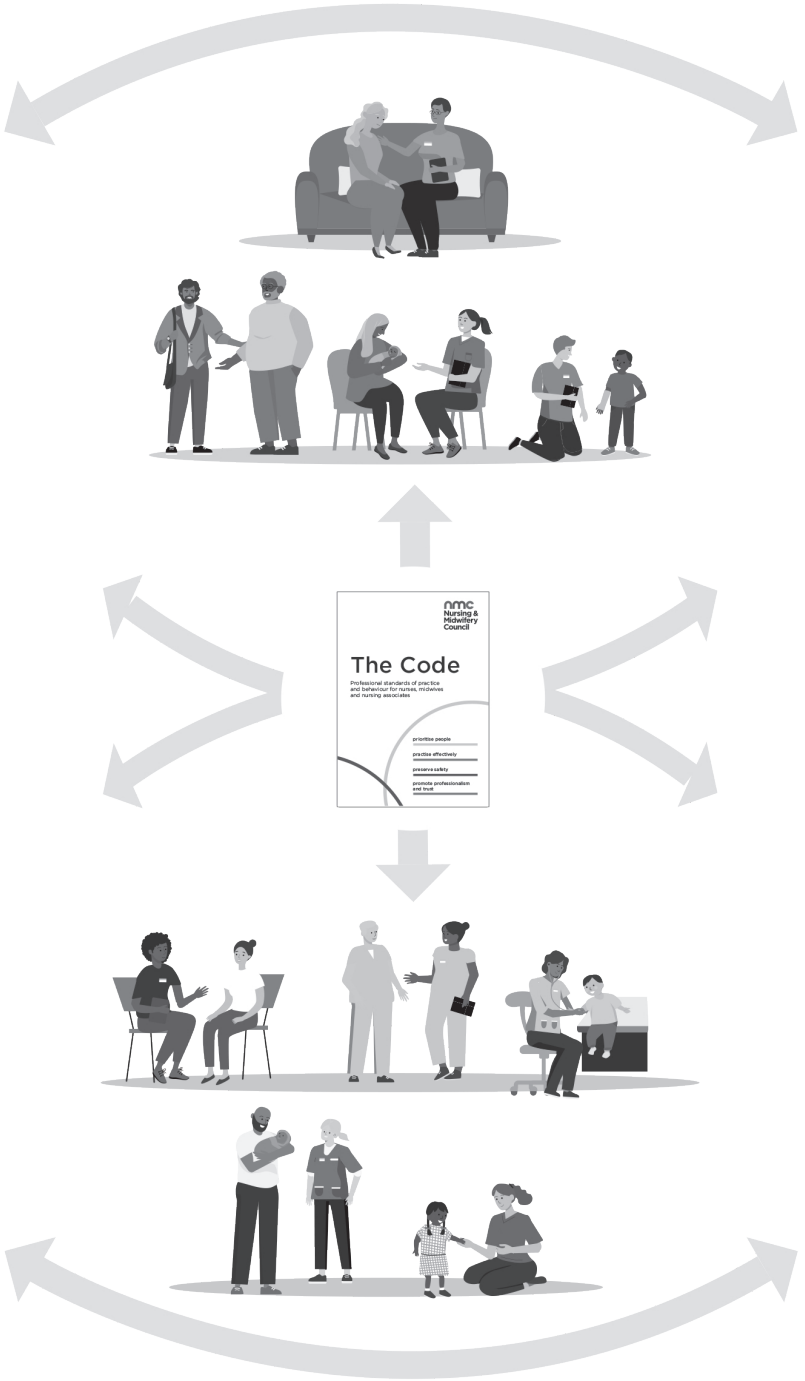




### Post-registration

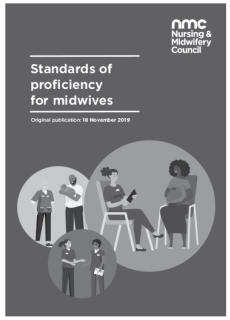


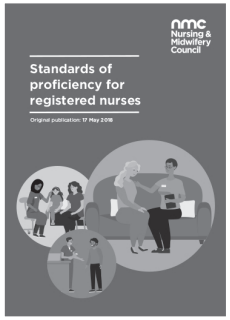





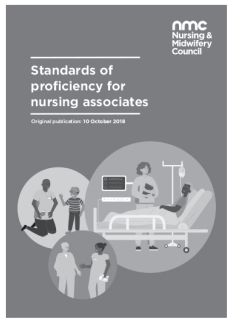


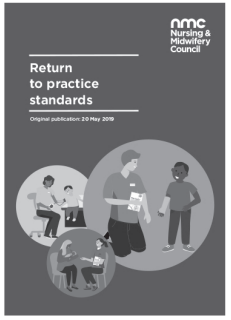

# Standards of proficiency





## Structure of these standards

The approach to the standards of proficiency for community nursing specialist practice qualifications aligns with that of our **Standards of proficiency for registered nurses**.

The standards are organised under seven headings, and were designed to ensure that across all fields of nursing practice, registered nurses are able to meet the **person-centred**, holistic care needs of the people they encounter in their practice who may have a range of mental, physical, cognitive, behavioural, social or spiritual needs. This ambition also applies to specialist community nursing to meet the diverse needs of people of all ages, in their home, in settings close to home and in the community.

Professionals on our register already possess the knowledge and skills required to be registered as a nurse. These specialist community nursing standards of proficiency state the additional knowledge and skills required for community nursing SPQs.

These proficiencies will provide new post-graduate community nurses with SPQs entering the profession with the knowledge, skills and behaviours they need when they record their qualification on the register. Community nurses with a SPQ will build on these proficiencies as they gain experience and fulfil their professional responsibility. They will demonstrate their commitment to develop as a specialist community practitioner and to build a career pathway, engaging in ongoing education and professional development opportunities necessary for revalidation.

## The seven platforms

**Platform 1:** Being an accountable, autonomous professional and partner in care

**Platform 2:** Promoting health and wellbeing and preventing ill health

**Platform 3:** Assessing people's abilities and needs, and planning care

**Platform 4:** Providing and evaluating **evidence-based care**

**Platform 5:** Leading, supporting and managing teams

**Platform 6:** Leading improvements in safety and quality of care

**Platform 7:** Care coordination and system leadership

Taken together these proficiencies, developed in an appropriately structured educational programme, will provide nurses undertaking community nursing SPQs with the knowledge, skills and behaviours they need to work within their intended field of community nursing practice.

## Legislative framework

Article 19(6) of the **Nursing and Midwifery Order 2001** ('**the Order**') allows the NMC to establish standards of education and training for any additional qualifications that may be recorded on the register.

Articles 15(3) to (9) and articles 16 to 18 of the Order will apply in respect of those standards as if they were standards established under article 15(1)(a). This means the NMC may establish standards of education and training and may approve a course of education or qualification in relation to SPQs.

# Platform 1
## Being an accountable, autonomous professional and partner in care

All registered nurses with a community nursing specialist practice qualification are required to work autonomously in people's homes, close to home or in the community, with people of all ages. They work in interdisciplinary and interagency environments, and they work with, and delegate to, diverse interdisciplinary and interagency teams involved in providing care. These teams include registered professionals, other colleagues who are not on a professional register, carers, family members, volunteers and others working in third sector organisations.

They often work in unpredictable, unconventional and complex settings, with consequently higher risks. They work independently, and require specialist knowledge and skill, in order to work effectively as an autonomous, accountable professional.

Many community nurses specialise in caring for a particular client group or are specialists in a particular field of practice. They apply their specialist community knowledge and skill in the context of their intended field of practice and the setting they practise in. As registered nurses, they abide by **the Code**, and meet all of the Standards of proficiency for registered nurses relevant to their field of specialist community nursing practice.

### Outcomes

**Registered nurses with this qualification in their intended field of practice, will be able to:**

**1.1** practise autonomously, proactively and innovatively, demonstrating self-awareness, emotional intelligence and openness

**1.2** lead and manage a service, with the ability to effectively admit, discharge and refer people to other professionals, services and agencies as appropriate

**1.3** deliver specialist person-centred care in complex, challenging and unpredictable circumstances

**1.4** account for their decisions, actions and omissions when working with complexity, risk, unpredictability and when all of the information required might not be available

**1.5** critically understand and apply relevant legal, regulatory and governance requirements, policies, and professional and ethical frameworks, differentiating where appropriate between the devolved legislatures of the United Kingdom

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

**1.7** demonstrate critical awareness of stigma and the potential for bias, taking action to resolve any inequity arising from either, and educate others where necessary

**1.8** recognise the need for, and lead on action to provide, reasonable adjustments for people, groups and communities, influencing health policy and promoting best practice

**1.9** demonstrate the principles of courage, transparency and the professional duty of candour, taking responsibility to address poor practice wherever it is encountered

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

**1.11** assess the opportunities, risks and demands of specialist community nursing practice, and take action to maintain their own mental and physical health and wellbeing

**1.12** apply the numeracy, literacy, digital and technological skills required to deliver safe and effective specialist practice that meets the needs of people, their families and carers

**1.13** be an effective ambassador and role model, and a positive influence on the profession.

# Platform 2
## Promoting health and wellbeing and preventing ill health

Registered nurses with a community nursing specialist practice qualification are pivotal to health protection and the promotion of health and wellbeing. They play a central role in co-designing the provision of care that supports and improves mental, physical and behavioural health and wellbeing with the people, families, communities and populations that they serve.

They engage effectively, working with people of all ages at home, close to home or in the community, and support them to make their own choices and decisions that can improve their health and care. They promote health and reduce health inequalities, actively promoting participation in local and national public health programmes and interventions. Using their knowledge of **community assets**, community nurses with a specialist qualification build on their day-to-day interactions to support people to make positive changes to their mental and physical health and wellbeing.

### Outcomes

**Registered nurses with this qualification in their intended field of practice, will be able to:**

**2.1** apply specialist knowledge of epidemiology, demography and the social **determinants of health** and illness, taking action to influence policy, service design and delivery

**2.2** critically analyse the factors that may lead to inequalities in health outcomes, and their associated ethical dilemmas, to plan care in partnership with people, families and communities to improve them

**2.3** recognise health as a fundamental human right and evaluate the effects of social influences, **health literacy**, individual circumstances, behaviours and choices on people's current and future mental and physical health

**2.4** critically assess health needs in partnership with people, families, communities and populations, to support them to take decisions and actions that improve their own mental, physical, and behavioural health and wellbeing

**2.5** maximise opportunities for people, families, communities and populations to use their personal strengths and assets to make informed choices about their own health and wellbeing

**2.6** conduct, interpret and evaluate health and social care assessments, screening and profiling activity for people and communities, to take appropriate action to improve health outcomes

**2.7** apply specialist knowledge of social prescribing to support individual and community health outcomes

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

**2.9** 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

**2.10** utilise and evaluate the impact of networks to enhance and support the mental and physical needs of people, families and communities, and identify and address any deficiencies in support

**2.11** understand the role and application of genomics and epigenetics in sufficient detail to inform and advise people about the implications for personalised health care

**2.12** apply a range of advanced communication skills to develop public health information that is accessible and enables people to make informed decisions about their health and wellbeing

**2.13** share information regarding communicable diseases and approaches necessary for communicable disease surveillance, infection prevention and control, including immunisation and vaccination programmes

**2.14** mitigate risks of environmental factors and other pollutants that have the potential to affect the health and wellbeing of people now and in the future.

## Platform 3

# Assessing people's abilities and needs, and planning care

People of all ages receive care and support at home and in the community. They may have complex acute care needs, or are living with life limiting or long term conditions, or have multiple co-morbidities that affect their mental and physical health.

All registered nurses with a community nursing specialist practice qualification have the knowledge, skills and attributes to be the lead professional in caring for people within their intended field of community nursing practice. Their specialist knowledge and skills gives them the ability to exercise a high level of professional judgement and be capable of complex decision-making. They are highly skilled in using an evidence-based approach, and see the person before the condition, in order to undertake an individualised **holistic assessment**. They **co-produce** evidence-based care plans with people, taking the wider social and environmental context into account, along with each person's mental, physical, cognitive, behavioural, social and spiritual abilities and needs.

They develop therapeutic relationships with people, their families, carers or **nominated person** to facilitate shared decision-making. 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 delivering positive outcomes.

They provide information and support people, and their families, carers or nominated persons where needed, to make decisions about how their care is delivered and agree opportunities for supported self-care. They identify and provide the appropriate level of support, education and knowledge for others such as parents, family, formal and informal carers, or a nominated person. They assess and manage risks when making referrals to or receiving referrals from other interagency teams.

## Outcomes

**Registered nurses with this qualification in their intended field of practice, will be able to:**

**3.1** create and apply a person-centred approach to care, working in partnership to support shared decision-making within the assessment and care planning process when working with people, their families or carers, and communities

**3.2** use advanced communication strategies and relationship management skills when interacting with people, including families and carers, who may have a range of mental, physical, cognitive, behavioural and social health challenges

**3.3** recognise and apply the **principle of the presumption of capacity**, and the requirement to seek informed consent throughout the assessment and planning process

**3.4** make reasonable adjustments to maximise opportunities for people to understand the outcome of their abilities and needs assessment, and the implications for their treatment and care

**3.5** make **best interest decisions** within the required legislative framework if, after seeking informed consent and making reasonable adjustments, their professional judgement is that a person lacks capacity to make a decision or give consent at that time

**3.6** assess and plan the care of **people when they are vulnerable**, agreeing on the required level of support needed to ensure maximum levels of independence throughout the continuum of care

**3.7** escalate, report, plan and coordinate immediate and continuing care for people in need of safeguarding

**3.8** proactively obtain and distil information from formal and informal sources to inform individual assessments, involving others as required

**3.9** critically analyse complex assessment information and data, distinguishing between normal and abnormal findings, recognising when prompt action is required, including requesting additional investigations, and involving others when appropriate

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

**3.11** maximise the potential use of technology and informatics to assist with assessment and diagnosis

**3.12** apply knowledge and understanding of new and emerging science and technology, including genomics, to inform assessment and treatment options, when agreeing personalised care plans with people and their families, carers or nominated persons

**3.13** apply a range of problem solving, influencing and negotiation skills to maximise opportunities for shared decision-making when co-producing care plans

**3.14** assess individual abilities and needs when co-producing plans of care, agreeing opportunities for supported self-care and treatment interventions

**3.15** take into account the impact of people's preferences, their close relationships and support systems, their home environment, and the influence of social, environmental and spiritual factors when agreeing the plan of care

**3.16** create and maximise opportunities for people, and where needed their families, carers or **nominated person**, to remain independent and to facilitate self-care

**3.17** effectively communicate the benefits and risks of different care and treatment options, explaining how the person and their family or carers will be supported in the choices they make

**3.18** anticipate and explain the impact that unexpected events and changes may have on the plan of care.

## Platform 4
# Providing and evaluating evidence-based care

### All registered nurses with a community nursing specialist practice qualification take the lead in providing evidence-based, person-centred and safe interventions, in the context of the specific client groups and settings within their intended field of SPQ practice.

They are able to initiate and deliver a range of care and treatment that can be supportive, curative, symptom relieving or palliative. They ensure that the care they provide or delegate is flexible, dynamic and is of a consistently high standard.

They are independently able to undertake a range of interventions to positively impact a person's health and wellbeing, and to manage complete episodes of care in relation to their intended field of SPQ practice.

They can communicate complex information in a way that supports, advocates for, enables and seeks to maximise the involvement of people, their families, carers or nominated person. They support people to make decisions and choices about their care and treatment, taking into account the benefits and opportunities for supported self-management, and any risks.

They work in partnership with people, peers and interdisciplinary and interagency colleagues to assess the impact of care on an ongoing basis, including supporting and managing **transition between services**. They evaluate the care outcomes and whether planned interventions continue to be effective and in line with the wishes, preferences and desired outcomes of the person receiving care, which may change over time.

## Outcomes

**Registered nurses with this qualification in their intended field of practice, will be able to:**

**4.1** autonomously manage and evaluate complex episodes of care from referral to service and admission, to discharge from caseload, or referral to other appropriate services or agencies

**4.2** assess and manage transition of people to other services or agencies, proactively collaborating with colleagues of other disciplines and agencies to find solutions to mitigate any risks

**4.3** agree and negotiate with the person and where necessary their family, carer or nominated person, the implications of delegation of any aspect of their care to an alternative person

**4.4** recognise reduced **concordance**, changes in motivation or dissatisfaction with the care and treatment plan, and work in partnership with people to influence and negotiate any revisions to the plan

**4.5** proactively engage with, and effectively advocate for, people using services provided by other professionals or agencies to identify and find solutions where there is inconsistency, disagreement or conflict

**4.6** initiate a range of evidence-based care and treatment, including care, therapeutic interventions and social prescribing, that may be supportive, curative, symptom relieving or palliative

**4.7** safely and effectively manage complex medicines administration, optimisation and medicines reconciliation, and continually evaluate to ensure optimum effectiveness

**4.8** evaluate and adjust plans to ensure adequate safeguards for people when they are vulnerable

**4.9** maintain therapeutic relationships with people, their families and/or carers throughout the episode of care and treatment, and actively address any differing views

**4.10** understand and apply a range of techniques to educate people, their families, carers or nominated persons about their condition, treatment and care, to promote independence and confidence in supported self-care and self-management

**4.11** work in partnership with people, their families, carers and other members of the team to continuously monitor and evaluate the care and treatment provided

**4.12** include people and their families or carers in making decisions about their care and mitigate any risks as a result of changes in a person's mental and physical health, their living environment, or social arrangements

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

**4.14** work with people and where appropriate their families, carers or nominated person to agree and provide evidence-based person-centred nursing care for those who are dying or near to the end of life

**4.15** sensitively accommodate the preferences, beliefs, cultural requirements and wishes of the deceased and people who are bereaved

**4.16** clearly explain and accurately record the rationale for decisions, actions taken and resulting outcomes either in writing, or using digital technology, which can be shared with the person, their family, carers, nominated person and interdisciplinary and interagency teams.

## Platform 5
Leading, supporting and managing teams

All registered nurses with a community nursing specialist practice qualification provide, manage and lead services related to their intended field across a variety of settings. They act as role models for good practice in the delivery of evidence-based treatment, nursing, interdisciplinary and interagency care. They are responsible for leading services, effectively managing the coordination of care of individuals, groups of people or defined caseloads. They put the abilities, needs, preferences and best interests of people first when taking action to manage the specific risks associated with their intended field of community nursing practice and the setting in which care takes place.

They are accountable for the delegation of activities to team members, including delegation to other interdisciplinary and interagency professionals and those colleagues who are not on a professional register, and to carers. They are able to teach and support the professional development of colleagues and students.

In leading and managing an interdisciplinary team, they are able to collaborate and communicate effectively. They are able to recognise and address any disagreement or conflict between those planning and delivering care, using the skills of negotiation and advocacy to arrive at mutually acceptable solutions that recognise the abilities, needs, preferences and best interests of people receiving care. Using their influencing and negotiation skills, they build professional working relationships within and between agencies to achieve seamless effective delivery of person-centred services.

## Outcomes

**Registered nurses with this qualification in their intended field of practice, will be able to:**

**5.1** demonstrate leadership in applying human rights, equality, diversity and inclusion, to improve the health and wellbeing of people, families and communities

**5.2** demonstrate compassionate leadership when managing community nursing, interdisciplinary and interagency teams, to promote equality, diversity and inclusion, support individual professionals' wellbeing, motivate, and encourage team cohesion and productivity

**5.3** lead, promote and influence the nursing profession in wider health and social care contexts and know how to influence and improve the care of communities through partnership working

**5.4** identify available local community assets and engage with a range of providers, including third sector and faith-based support organisations and networks, to enhance the support and care of people

**5.5** evaluate a range of indicators to determine the skill mix and appropriate characteristics of the workforce required to meet the needs of specific caseloads

**5.6** review, lead and manage the people, financial and other resources required to safely meet caseload requirements, making professional risk based decisions when necessary to resolve resource issues

**5.7** construct cogent arguments and effectively communicate complex information to justify decisions about resource allocation

**5.8** delegate responsibility for the management of budget, people and other resources to team members, while retaining overall accountability

**5.9** critically analyse their personal workload requirements and that of the wider team to lead and prioritise activities in order to manage demand and capacity

**5.10** safely and effectively delegate responsibilities to team members based on an assessment of their level of knowledge, skill and confidence

**5.11** use digital technology to maximise the use of resources across interdisciplinary and interagency teams

**5.12** procure equipment and other items in line with relevant procurement policies, value for money considerations and health and safety requirements

**5.13** articulate a clear and evidence-based rationale for complex decision-making and professional judgement when leading teams in challenging situations

**5.14** continually reflect on their own leadership approach and take action to adapt their leadership style to different situations, including but not limited to when working with diverse teams who may be geographically dispersed

**5.15** effectively use systems to measure the impact, quality, productivity and cost efficacy of interdisciplinary and interagency teams to allow effective leadership and performance management

**5.16** conduct conversations with team members to provide opportunities for positive reinforcement and challenge, and agree any development plans or remedial actions in line with appraisal processes

**5.17** lead the development of a positive learning culture for interdisciplinary and interagency teams

**5.18** use a range of approaches and resources available to educate, support and motivate people, manage talent and succession plan

**5.19** apply a range of leadership strategies that are effective in supporting positive team development and cohesion across disciplines and agencies

**5.20** select, implement and evaluate strategies which are appropriate to the composition of the team, to enable supervision, reflection and peer review

**5.21** recognise 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.

## Platform 6

# Leading improvements in safety and quality of care

All registered nurses with a community nursing specialist practice qualification lead the development and implementation of strategies to improve care, treatment and services, to enhance the health and wellbeing of the specific client group they serve. They are proficient in quality improvement and research methodologies.

They are able to capitalise on their specialist knowledge, skills and experience to mitigate and manage the range of risks, complaints and concerns associated with providing care in diverse community settings. They are able to synthesise the outcomes of risk management activities and use these to develop strategies to promote learning and improvement.

They are able to lead evidence-based quality improvement initiatives. They are able to influence decision-making across the interdisciplinary team and in interagency settings in relation to the wider service and specifically in relation to their intended field of specialist community nursing practice.

## Outcomes

**Registered nurses with this qualification in their intended field of practice, will be able to:**

**6.1** interpret 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

**6.2** 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

**6.3** exercise the knowledge, skills and professional judgement required to balance competing risks and priorities, undertaking quality impact assessments that reflect the balance between safety, quality and least restrictive practices

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

**6.5** use innovative and emerging technology effectively to ensure collection and storage of data to allow analysis and forecasting to inform service improvement and safety plans

**6.6** devise methods of systematically and effectively capturing and evaluating people's lived experiences of care to lead improvements in the quality of service delivery

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

**6.8** initiate and lead a continuous quality improvement programme, selecting an appropriate improvement methodology, collating and presenting results and proposing improvement actions

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

**6.10** present relevant research, quality and audit findings and proposals for care improvement to a range of audiences.

## Platform 7
Care coordination and system leadership

### All registered nurses with a community nursing specialist practice qualification have an extensive 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 understand in detail the functions of the range of different agencies within the community that have a direct or indirect impact on health and wellbeing. They understand the political and economic drivers of each agency, and the resulting opportunities, constraints and risks, which enables them to successfully build appreciative and productive working relationships for the benefit of people, families and communities they work with.

They are able to design and deliver an effective model of person-centred community nursing services, addressing the requirements of the specific client group by integrating within, and maximising the contribution of, other agencies and services. This will include an understanding of those agencies and services beyond their intended field of specialist community nursing practice, to support integration and system wide approaches and collaboration. All registered nurses with a community specialist qualification have the knowledge, skills and attributes to influence and work collaboratively with other agencies and professionals to design and deliver coordinated, sustained and productive change within the specific context in which they work.

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

## Outcomes

**Registered nurses with this qualification in their intended field of practice, will be able to:**

**7.1** critically analyse political and economic policies and drivers that may have an impact on the health, care and wellbeing of local communities

**7.2** understand the economic principles that drive health and social care, and their impact on resource allocation in integrated primary and community care services

**7.3** synthesise epidemiological, demographic, social, political and economic trends to forecast their impact and influence on current and prospective community nursing services

**7.4** build relationships between teams within different systems in health and care, appreciating the value of different approaches, skill sets and expertise

**7.5** maximise effectiveness of different services within the system through collaboration and **co-design**, ensuring that services work seamlessly together to meet the needs of people and communities

**7.6** apply a range of methodologies to drive continuous service improvement within the variety of different organisations and agencies that deliver services

**7.7** proactively lead on the creation and development of effective system networks that enhance communication and decision-making across organisations and agencies

**7.8** demonstrate **cultural competence** and leadership when challenging discriminatory, oppressive cultures and behaviours at a system level

**7.9** develop the skills required to influence the health and social care strategies and policies at a local, regional and national level

**7.10** effectively work in partnership with peers at a strategic level to promote and influence change and improve health outcomes for the people and communities served.

# Glossary

The words in the glossary have been included to explain their specific meaning in the context of these regulatory standards. The meaning might expand on or be slightly more nuanced than the dictionary meaning of some of these words.

**Best interest decision:** a decision made for and on behalf of a person who has been assessed as lacking capacity to make a decision at that time. This is one of the key principles underpinning mental capacity legislation across the United Kingdom.

**Caseload:** a caseload refers to the people served and all the activities involved in supporting people requiring care from community nursing services over a specified period in a specified locality.

**Community assets:** resources that can be used to contribute to developing and improving local health and wellbeing. It may include people and their knowledge, skill, networks and relationships, physical structures, local services, businesses, charities and funds.

**Community nursing:** care provided by nurses in the community including but not limited to nursing care provided where people live, at home or close to home, in adult social care settings, educational settings, primary care, community clinics, outreach centres, health and justice and other community settings or establishments.

**Concordance:** an agreement reached after negotiation between a person receiving care and a healthcare professional that respects the beliefs and wishes of the person, for example, in determining whether the plan of care is being carried out as agreed, or when and how medicines are to be taken.

**Co-design:** in health and care involves the equal partnership of representative professionals, people or groups of people who come together to design care pathways, develop new pathways and revise existing services, models or systems.

**Co-produce:** a partnership approach which brings people together to find shared solutions and involves partnering with people from the start to the end of any initiative or change that affects them.

**Cultural competence:** demonstrating the knowledge, skills and behaviours that are respectful of and responsive to the cultural needs of diverse people and communities when providing health and care services.

**Determinants of health:** includes the social and economic environment, the physical environment and the person's individual characteristics and behaviours.

**Evidence-based care:** care given that reflects up to date evidence in the area, making sure it takes into account the personal abilities, needs and preferences of the person. It also includes the nurse making a personal judgement based on experience, observations and the abilities, needs and preferences of the person when evidence is limited.

**Health literacy:** the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions.

**Holistic assessment:** collection, analysis and sorting of multiple sources of observation and information about a person or people to inform interventions to improve health. The focus is on the whole person, not just a potential or actual illness.

**Nominated person:** in parts of the UK, the role of nominated person exists in mental health/capacity legislation. This is someone that an individual selects to represent them. If the person lacks capacity to nominate, an interim nominated person will be appointed by an approved mental health professional (AMHP) until the person has capacity to make their own nomination. In Scotland the equivalent term is 'Named person'.

**People:** individuals, groups or populations who receive services from nurses, midwives and nursing associates, healthy and sick people, parents, children, families, carers, nominated persons, also including educators and students and others within and outside the learning environment.

**Person-centred:** where the person is at the centre of decision-making, focusing care on the abilities and needs of a person, ensuring that people's preferences, abilities, needs and values guide clinical decisions, and providing care and support that is respectful of and responsive to them.

**Principle of presumption of capacity:** one of the five key principles under the mental capacity legislation of the United Kingdom. The principle states that every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means we can't assume that someone can't make a decision for themselves just because they have a particular medical condition or disability.

**Specialist practice:** surpasses the expectation of the standards of proficiency for registered nurses in areas such as assessment, diagnosis, decision-making, care planning, coordination of care and care delivery specific to a particular person, context, setting or client group.

**Transition of care:** transitions of care are an integral part of a person's journey across health and care systems. Transition of care is recognised to pose risks for a number of reasons. Managing the coordination and transition of people safely and effectively from one place of care to another, or between different professionals, therefore requires effective collaboration to ensure seamless, risk-free, person- centred continuity of care. This may include: transition from children and young people services to adult care services, from primary and community focused care to specialist inpatient care provision, from home to adult social care, from home to hospice care or transfer of care from a professional in one discipline to another professional in a different profession.

**Vulnerable people:** people who may be vulnerable at a particular time and in particular situations (but not in others), due to their personal characteristic(s), situation(s) or neglect, and therefore at a higher risk of potential or actual harm. The type of harm may be emotional, physical, sexual, psychological, material or financial.

# What we do

Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the independent regulator of more than 808,000* nursing and midwifery professionals, we have an important role to play in making this a reality.

Our core role is to **regulate**. First, we promote high professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects a tiny minority of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

To regulate well, we **support** our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to **influence** health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision-making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

nmc
Nursing & Midwifery Council

23 Portland Place,
London W1B 1PZ
+44 20 7333 9333
www.nmc.org.uk
@nmcnews @nmcuk



*Data captured from 30 September 2023.