Competence Framework for Assistant Wellbeing Practitioner (Renal)

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Notes

1) This Competence Framework for the Assistant Wellbeing Practitioner (Renal) (AWP (Renal)) has been informed by the Competence Framework for Psychological Interventions with People with Persistent Physical Health Problems [REF1], and informed by competences within the Healthcare Assistant Practitioner Apprenticeship standard [REF2], Core Standards for Assistant Practitioners [REF3], Competence Framework for Cognitive and Behavioural Therapy [REF4] and Competence Framework for Mental Health Peer Support Workers (MHPSW) [REF5].

   These competency frameworks have been adapted and marked as such using the following rules and markers:

   - Pink highlight: where a competence specific for the AWP (Renal) role has been **added by the authors** of this document (this differs from the above in that here a whole competence has been added, rather than amending wording to suit the renal specialty).
   - Green highlight: where a competence has been added from the **Healthcare Assistant Practitioner Apprenticeship Standard** or the **Core Standards for Assistant Practitioners**.
   - Grey highlight: where a competence has been added from the **APP for MH presentation** (Kay Helliwell (2020; Health Education England).
   - Yellow highlight: where a competence has been **added from the Cognitive and Behavioural Therapy** Competence Framework [UCL; nd].
   - Blue highlight: where a competence has been added from the **Competence Framework for Psychological Interventions with People with Persistent Physical Health Problems**.
   - Red font signifies that the original text has been amended to suit the medical specialty (Renal).
   - Dark green font where a competence from the AHP for MH presentation has been covered in other sections.
   - Light blue text indicates that a competency added by the authors has been informed by the World Health Organisation's **Prevention of mental disorders: Effective interventions and policy options** summary report.

   Any mentions of the practitioner have been changed to "AWP (Renal)" and mentions of the patient group have been changed to "people with kidney disease and their informal carers" (note that these changes have not been marked throughout the document).

2) This Competence Framework is specific for a new role called **Assistant Wellbeing Practitioner (Medical Specialty: Renal)** (working title) which will be referred to as **AWP (Renal)** throughout this document.

3) All competences in this document have been adapted/developed with specific reference to people with kidney disease and informal carers. These are referred to as ‘person’ or ‘people’, unless otherwise specified (for example, when only applicable to one group, such as the kidney patient, but not the other, such as the informal carer).
4) Specific medical competencies detailed in this document are related to the renal speciality, however, these would be adapted when role is applied to another medical specialty.

1. Understanding the values and principles of supporting people with kidney disease and informal carers

Ability to understand and implement the psychologically informed support role in a way that is in line with the values and principles of support

1.1 Values of AWP (Renal)

Ability to:

a) understand the values that underpin support and how they shape the ways in which the AWP (Renal) role works with and supports people
b) understand that the psychologically-informed AWP (Renal) role is rooted in working alongside the person to develop a **trusting relationship**, characterised by:
    - **respect** – being non-judgemental and not making assumptions about or pathologising the person's experiences or beliefs
c) draw on knowledge that support is:
    - **collaborative** – optimised by working as part of a multi-disciplinary team
    - **non-directive** – helping the person to find solutions that work for them (rather than suggesting solutions)
    - **strengths-based** – focusing on and building the person's strengths and their ability to make use of the resources available to them
    - **self-management-focused** – creating hope and building autonomy, empowering the person being supported to define, lead and own their self-management, and enabling them to **identify and work towards life goals** within their communities
    - **integrative –** draws on support provided by the health and social care system
    - **systems-based** – draws on knowledge that family and or friends can be involved in support by providing informal care

1.2 Principles of supporting people with kidney disease and informal carers

a) Ability to draw on knowledge that support is based on the following principles:
    - **building safe and trusting relationships** based on a person-centred approach where the person is placed at the centre of all support being provided
    - providing **collaborative care** where the AWP (Renal) works alongside the person as part of multi-disciplinary teams that surround them
    - respecting **diversity and experience** of each person and particular background or cultural context
    - recognising and placing value on **experiential knowledge held** by the person that can complement, or provide alternatives to, present models

of mental health (for example, medical, nursing, allied health professional, psychological)
- **having awareness** of the range of community and charitable organisations that provides support
- **appreciating** that a family member or friend may be providing informal support or care and may have their own support needs
- enabling the person supported to **exercise choice** about the way in which support is given and received, both directly and at an organisational level (influencing the ways in which support is integrated with and offered through teams)
- **recognising** that on many occasions the person is able to live a full and active life
- supporting the person to have an **appreciation regarding their medical condition** and the impact is has on their daily life
- enabling the person to understand their kidney condition and potential impact
- enabling the person to make use of their own **strengths, skills and strategies** to live better with kidney disease
- **working progressively** to help people learn from their experience and better equip themselves for living well with kidney disease
- understanding and recognising the **communities** that people come from, the communities they choose to be a part of, and the ways in which these have and will shape their experiences
- **working inclusively** by helping people become (re)integrated into their communities or overcome the challenges they may face around this
- building and strengthening **connections** with family, friends, support networks and wider communities
- appropriate use of supervision to ensure boundaries consistent with the role are maintained

2. Knowledge for AWP (Renal)

2.1 Mental health

The AWP (Renal) role uses person-centred and values-based approaches informed by the person being supported and health and social care staff that are not focused on difficulties or diagnoses / diagnostic classifications used by mental health professionals. It is helpful for the role to have a working knowledge of support available, liaise and signpost to mental health services where treatment is indicated or community and voluntary sector organisations and inform their engagement in other aspects of the role.

Mental health difficulties

Ability to draw on a working knowledge of:

a) the mental and physical health difficulties that people they will be working with could experience, and that:
   - mental and physical health conditions **interact with each other**, and that this relationship may vary across individuals
   - mental health difficulties can **affect people of any age**, class, ethnicity, religion, income or chronic kidney disease stage
   - there are **multiple causes** of mental health difficulties and these differ from person to person
     - the multiple causes may not be obvious or clearly known
   - mental health may **change or present itself differently** across a person's lifespan or throughout the journey of a person with kidney disease

b) the relevance of social disadvantage and adversity (and the absence of a valued role in society) on a person's mental health

c) factors that promote wellbeing and emotional strength (for example, being involved in the community, being in employment or undertaking voluntary work, having better social support)

d) risk and protective factors for mental health difficulties, appreciating that they may be individual, social, or environmental in nature

e) the importance of families, informal carers and social networks in relation to mental health difficulties

f) how people may experience a mental health difficulty, holding in mind that such events:
   - are **self-defined**, so how they present will vary from person to person
   - can be a response to difficult or **traumatic experiences**
   - may reflect the person's sense that they are **'out of their depth'**
   - are often characterised by person **seeking urgent help**

g) mental health diagnoses, with the aim of:

- understanding how a **diagnosis or probable diagnosis** is used within the mental health system (even where the AWP (Renal) takes a critical perspective on its use and meaning)
- helping people (who wish to do so) **understand their diagnosis** and its meaning for them
- helping the person **ask questions or discuss** a probable diagnosis (when relevant), where referred to mental health professionals
- encourage professionals to **use plain language** when talking to people about diagnosis or probable diagnosis, avoiding the use of acronyms, technical terms and jargon)

The impact of mental health difficulties on functioning

a) Ability to draw on a working knowledge of the ways in which mental health difficulties can affect functioning and individual development, for example:
   - impact on **daily functioning** and quality of life
   - impact on **family functioning**
   - impact on **social isolation**
   - difficulty in developing and **maintaining intimate, family and social relationships**
   - difficulty **gaining and maintaining employment**, voluntary work or education
   - the way the individual responds to **diagnosis, monitoring and treatment** for chronic kidney disease

Associations between mental and physical health

a) Ability to draw on knowledge that people with mental health difficulties may be more vulnerable to a wider range of physical health conditions (for example, difficulties with weight gain, diabetes and cardiovascular disease)
b) Ability to draw on knowledge that physical illnesses (especially long-term conditions) are a significant risk factor for mental health difficulties, particularly anxiety and depression
c) Awareness that the demands of providing informal care to someone with a kidney disease can place mental or physical challenges on informal carers

Interventions for mental health difficulties

Ability to draw on a working knowledge:

a) that interventions for mental health difficulties can be effective in helping to reduce mental and physical symptoms and improve quality of life
b) of the psychological, social and pharmacological interventions usually offered to people with mental health difficulties, and that:
   - interventions may be offered **independently, sequentially or in combination**

- people accessing mental health services may not have a clear sense of the **intervention options available** to them
- access to **different types of intervention** may be limited by availability and local service provision

c) of the potential physical, psychological or emotional side effects of medications and other treatments prescribed for mental health difficulties

d) of awareness regarding the need to discuss any prescription of medications or other treatments with the person's medical and health care practitioner

e) of the importance of current evidence-based practice within scope of the role

Help-seeking

a) Ability to draw on knowledge of barriers to accessing mental health or health and social care support, such as service provision, professional awareness, fear, stigma and discrimination, including:
   - knowledge that only about **one in eight people** with mental health difficulties is receiving active treatment from any source

2.2 Physiology, health and social care relevant to people with kidney disease

Ability to draw on knowledge of:

a) principles and philosophy of health and social care

b) the physiology, organisation and function of the human body of particular significance for people with kidney disease at different stages of chronic kidney disease

c) different forms of treatment and monitoring for chronic kidney disease and the physical and mental health demands they can place on people

d) the kidney patient pathway between initial diagnosis and treatment, and movement between different forms of treatment for chronic kidney disease

e) the need to discuss, with an appropriately qualified supervisor, how the complex interactions of these areas may be affecting a patient to ensure onward referral

f) provision and promotion of holistic person centred care and support, duty of care and safeguarding of individuals

g) lifespan developments and healthcare needs for people with kidney disease

h) research and development in health and social care sectors to inform and improve quality of care

i) the importance of the strategic environment in health and social care and the implications for the individual

2.3 Core clinical competences to support psychosocial working for people with kidney disease

Knowledge of relationships between life-stage and adjustment to illness

An ability to draw on knowledge that:

a) in younger people the relationship between chronological age and developmental stage is not fixed, and hence there can be considerable

variation in the capacity for understanding illness variation across individuals of the same age

b) in normative developmental terms, positive adjustment to illness can be thought of as the maintenance of positive emotional wellbeing, age appropriate behaviour and developmentally appropriate self-esteem/self-worth at the same time as following (potentially complex) healthcare regimens
c) illness whose onset is perceived as 'age-appropriate' may be easier to adjust to than when the onset is unusual for the person's life-stage

Adolescent and young adult's understanding of illness and its management

An ability to draw on knowledge:

a) of the ways in which their developmental stage impacts on the young person's capacity to understand and manage their illness, for example:
    - **older school-aged children** and adolescents will be capable of understanding their illness and its monitoring and treatment, but concordance with healthcare regimens may be impacted by a number of developmentally-relevant reactions, for example:
        - reactions to a sense that a chronic illness is forever and will adversely impact on their life plans
        - experiencing illness as imposing an increasing sense of difference from their peers
        - difficulty in relating to the longer-term consequences of poor adherence
b) of the impact of long-term renal and mental health conditions on the development of functional independence (for example on personal care, mobility and communication)
c) that chronic illness can:
    - hinder the development and maintenance of **friendships**
    - force an increasing **dependence** on parents or significant others
    - inhibit the development of **independence** in adolescence, as well as impact on that which has already been achieved
    - result in **lower quality of life**
    - lead to **disruption in family** structures
    - lead to higher levels of **depression and anxiety** in comparison to healthy peers
d) of the adverse and long-term cognitive impact of some interventions (for example monitoring and treatment for chronic kidney disease such as dialysis and kidney transplantation)
e) of the impact of chronic illness on education and schooling, for example:
    - arising from the direct **impact of symptoms**
    - impact on **attendance** of regular healthcare appointments
    - impact of illness on **motivation**
    - adverse impact on the development and maintenance of **peer relationships**
    - adverse impact on **achievement** (for example on examination performance)

Adults' and Older Adults' adjustment to chronic illness

Ability to draw on knowledge:

a) that the impact of illness in adults and older adults will depend on their age at first onset, their diagnosis, and how their diagnosis was delivered – for example:
    - onset in **early adulthood** may present a challenge to developmentally normative achievements (such as finding and maintaining employment, developing romantic attachments, or establishing a family), with consequences for the person's sense of self and of their sense of their place in society and their culture
    - with onset in **older age**, disability may threaten previously acquired achievements and roles and so bring with it a series of major losses
b) that fear of impairment leading to disabling dependency is often a worry among older people
c) of the adverse impacts on the self and on relationships with others in older people whose illness leads to disability or dependence on others
d) of the impact of cognitive decline or impairment on the ability to comprehend, adjust to and manage illness

2.4 Local services and sources of mental health and renal care, social care and support in the voluntary, community or statutory sector

a) Ability to draw on a working knowledge of local statutory and non-statutory mental health support options (for example Mind, Samaritans, as well as local community organisations, activities and resources) and kidney-specific support organisations (for example Kidney Care UK, Kidney Research UK, National Kidney Federation) with which AWP (Renal) will engage to help people achieve their personal goals, including:
    - what each organisation, service or resource is **able to offer**
    - **how to access** each organisation or service
    - whether there are any criteria that may be applied to **restrict access**
    - any **limits** (or gaps) in services being provided
b) Ability to draw on knowledge of the relationships between the mental health team the AWP (Renal) is employed in and other statutory and non-statutory services in the local community
c) Ability to build connections with community groups and resources, maintain links with partner organisations, engage with marginalised / hard to reach sections of the community

2.5 Professional, legal and ethical frameworks

The standards of conduct set out below are those expected of all individuals working in a health context. They refer to issues of confidentiality and consent, areas that are described in more detail in other sections of the Competence Framework for AWP (Renal).

a) Ability to draw on knowledge that ethical and (where relevant) professional guidance represents a set of principles that need to be interpreted and applied to unique situations
b) Ability to draw on knowledge of the local codes of ethics and conduct that apply to all professionals in the service, and how these are implemented in relation to:
    - **capacity and consent**
    - **confidentiality**
    - **information sharing**
    - **data protection**

Ability to maintain appropriate standards of conduct

a) Ability to maintain boundaries, for example by:
    - communicating the **limits and boundaries** of the role with the people they support
    - maintaining clear and appropriate **sexual boundaries** with the people they support, as well as their families
    - ensuring that they **do not use their position** to further their own ends
    - **not accepting gifts**, hospitality or loans that may be interpreted as attempting to gain preferential treatment
    - identifying when a **boundary has been crossed** and determining how to respond appropriately
b) Ability to recognise and work within the limits of their qualifications, knowledge, skills and experience, and to:
    - only practise a particular therapeutic approach for which they have appropriate **training and supervision**
    - Seek appropriate advice where concerns with any aspect of practice are experienced
    - where appropriate, **refer to colleagues**, services or organisations with the relevant level of training and skill

Ability to maintain standards of competence

a) Ability to maintain and update skills and knowledge through participation in continuing learning and development
b) Ability to seek opportunities to increase knowledge and skills
c) Ability to judge when they have reached the limits of their responsibility and competence and when to seek advice, management or supervisory support, or assistance from others

2.6 Issues of confidentiality, consent and information sharing

Decisions about issues of confidentiality and consent will be influenced by the person's capacity, but assessing this is a formal procedure that is not part of the

AWP (Renal) role. As such, decision-making that relates to capacity should be based on discussion with (and support from) colleagues and supervisors.

Knowledge of policies and legislation

a) Ability to draw on knowledge of local policies on confidentiality and information sharing, and the ways these are applied when working within and between teams or organisations

Gaining informed consent

a) Ability to give people being supported the information they need to decide whether to proceed engaging with an AWP (Renal), for example:
    - what engagement would **involve**
    - the **potential benefits** of such engagement
b) Ability to invite and actively respond to questions regarding any potential for peer support
c) Ability to draw on knowledge that individuals have a right to withdraw or limit consent at any time:
    - in the event of consent being declined or withdrawn, ability to **respect the individual's right** to make this decision and the ability to seek advice from senior colleagues or a supervisor when required

Knowledge of confidentiality and information sharing

Ability to:

a) draw on knowledge that a duty of confidentiality is owed to:
    - the person to whom the **information relates**
    - any individuals who have **provided relevant information** on the understanding it is to be kept confidential
b) ensure that a person's information is treated as confidential and used only for the purpose for which it was provided
c) draw on knowledge that confidentiality is breached where the sharing of confidential information is not authorised by the person who provided it or to whom it relates
d) draw on knowledge that there is no breach of confidentiality if:
    - **information was provided** on the understanding that it would be shared with a limited range of professionals or for limited purposes, and information has been shared in line with that understanding
    - there is **explicit consent** to the sharing of information
e) draw on knowledge that it is appropriate to breach confidentiality when withholding information could:
    - place the person, the AWP (Renal), other mental and physical health professionals or members of the public **at risk of significant harm**
    - **prejudice** the prevention, detection or prosecution of a serious crime

- lead to an **unjustified delay** in making enquiries about allegations of significant harm to others

f) draw on knowledge that **safeguarding** needs usually take precedence over issues of consent and confidentiality

Sharing information appropriately and securely

a) When decisions are made to share information, the **AWP (Renal):**
   - **shares it only with the person who** needs to know
   - shares it with the **professional providing supervision** for the mental or physical health components of their role
   - ensures that it is **necessary** for the purposes for which it is being shared
   - checks that it is **accurate** and up to date
   - distinguishes **fact from opinion**
   - shares it with **other members** of the collaborative care team
   - ensures that the **person being supported** (or the person who provided the information) is made aware that information is being shared, when it is safe to do so

b) Ability to ensure that information is shared securely and in line with local policies

c) Ability to discuss concerns about disclosure with colleagues (without revealing the person's identity)

Discussing confidentiality

a) Ability to discuss issues of confidentiality with a person
   - in relation to **sharing information** across organisations and services
   - to **secure and record** their consent to share information

b) Ability to ensure that the person being supported is fully aware of the boundaries of confidentiality that apply in the context in which the AWP (Renal) is working, for example:
   - ensuring that the person being supported knows that the AWP (Renal) is **part of a team**, and involved in multi-disciplinary team discussions
   - discussing the person's concerns about **information being passed on** and the impact of these concerns on their relationship with the AWP (Renal)

2.7 Safeguarding procedures

Knowledge

a) Ability to draw on knowledge of local and national safeguarding policies

b) Ability to draw on knowledge that safeguarding concerns can arise across the lifespan, from infancy through to old age

c) Ability to draw on knowledge of the type of abuse and neglect that could trigger a safeguarding concern, such as:
    - **physical abuse**
    - **domestic violence**
    - **psychological abuse**
    - **financial or material abuse** or exploitation
    - **sexual abuse** or exploitation
    - **neglect**
    - **abuse in an organisational context**
d) An awareness of the safeguarding issues that may arise from family systems that surround the person

Application

a) Ability to identify signs or indicators that could flag the need to institute safeguarding procedures
b) Where neglect, abuse or exploitation is suspected, an ability to respond appropriately by:
    - discussing these concerns with the **person being supported**, and explaining (and agreeing) what actions need to be taken
    - raising and **escalating concerns** in line with local safeguarding procedure

2.8 Self-harm and suicide prevention, and procedures for maintaining safety

The competences set out below provide a basic overview of the skills needed to recognise and manage suicidal behaviour and self-harm. More comprehensive detail can be found in the Self-harm and Suicide Prevention competence framework.

The AWP (Renal) is not expected to work independently with someone expressing suicidal thoughts but have an awareness of correct protocols for referral and seeking support from others (both for their own wellbeing and for the wellbeing and safety of the person).

a) Ability to draw on knowledge of factors that contribute to, and increase the risk of, self-harm, self-neglect and harm to others
b) An awareness that self-harm can take the form of medical treatment non-adherence or non-adherence to restrictions placed on different forms of renal replacement therapy such as diet, fluid restriction or medication taken
c) Ability to recognise and respond to expressions of distress and self-harm, and to acknowledge and discuss these feelings in an open and non- judgemental way
d) Where there is evidence that a person may present a significant risk of harm to themselves or others, ability to respond to this in a timely manner by:
    - exploring the **reasons** for the person's acute distress

- determine whether there are any **immediately applicable strategies** that may be helpful, and that the person has the resources to implement them
- if these strategies are ineffective, discussing, explaining and agreeing on the **next steps** with the kidney patient
- drawing on knowledge of **local policies and procedures** for responding to risk, maintaining safety and safeguarding (specifically, the risk of harm to self or risk to others)

e) Ability to use and promote a range of techniques to prevent the spread of infection

Sharing information to maintain safety

a) Ability to judge when it is in the best interests of the person to disclose information, taking into account their wishes and views about sharing information and holding in mind:
   - the **immediacy** of any risk (for example, where there is clear evidence of suicidal intent, such as a plan)
   - that **disclosure is appropriate** if it prevents serious harm to a person

b) Ability (if practically possible) to ensure that the person is informed of communications between the AWP (Renal) and other parties regarding risk

3. Core relational skills

3.1 Understanding **self-management-focused** and person-centred approaches

There are many ways of understanding the meaning of self-management. Given that self-management is person-centred, it varies with each individual based on their own goals, beliefs, experiences and aspirations.

a) Ability to understand the importance of:
    - prioritising the person's **self-management skills** (that focus on their own beliefs, values and goals) over clinical self-management
    - helping the person **lead and take control** of their own self-management
        - ensuring they have the resources and opportunity to become well-informed about their mental and physical health and any care or interventions they receive)

b) Ability to draw on the key principles of personal self-management-focused approaches, namely that:
    - self-management is **self-defined** by the person experiencing mental health difficulty and discussions about self-management and personal goals should be led by them
    - what self-management looks like will **vary from person to person** and that:
        - self-management is about having the knowledge, skills and resources to live a meaningful, satisfying and purposeful life (the life they wish to lead)
        - self-management is unique to each person and will reflect their own goals and aspirations
    - there is a focus on the **person's strengths**, helping them to:
        - foster hope and optimism (a sustainable belief in themselves and a willingness to persevere through uncertainty)
        - identify, define and work towards the life they want to live, and having a sense of autonomy over their life
        - build the skills and strengths to manage challenges and setbacks
        - build their sense of self-esteem and develop a positive identity
        - support their ability to meet challenges in life through self-development and self-management
        - for most people, social inclusion is an important feature of their self-management (as part of a family, friendship group or community, or ability to play a part in society more widely)
    - self-management is a progressive process that takes place over time and may be life-long, and will include learning from setbacks

- recognition that self-management skills may vary if the treatment for chronic kidney disease received by the patient changes

c) Ability to draw on knowledge of factors that can affect a person's self-management, such as:
   - demands of **treatment** or monitoring for the kidney condition
   - **caring** demands
   - **societal factors** (such as housing and educational opportunities)
   - **familial relationships**, traumatic experiences and environmental influences

3.2 Develop and maintain a **supportive relationship with people with kidney disease and informal carers**

Knowledge of factors associated with building a relationship with the supported person

Ability to draw on knowledge of:

a) factors that can make a positive patient- or carer-practitioner relationship more likely, including being:
   - **respectful**
   - **warm and friendly**
   - **open and honest**
   - **trustworthy**
   - **alert and active**
   - **flexible** and allowing the person to discuss issues that are important to them

b) factors that can have a negative effect on the relationship, such as:
   - being **rigid**
   - being **critical**
   - being **distant or aloof**
   - being **distracted**
   - making **inappropriate use of silence**

Developing and maintaining the relationship

Ability to:

a) build trust, develop rapport and be respectful
b) demonstrate warmth, sensitivity and genuine concern, and provide encouragement and support
c) listen and respond to the person's concerns in a manner that is non-judgemental, supportive and sensitive, and that conveys an accepting attitude when they describe their experiences and beliefs
d) accept the person's experiences and concerns as valid, and help them discuss these
e) help the person express any concerns or doubts they have about the kidney or mental health treatment they are receiving, including the person providing

treatment, especially where this relates to mistrust, fear or doubt about the benefits

f) establish the boundaries and purpose of the relationship in the initial meeting, including discussing the limits to confidentiality and information sharing

g) build and maintain relationships with other professionals with health, social care and community backgrounds involved in the treatment or support being provided to the person

Grasping the person's perspective and world view

Ability to:

a) appreciate the person's point of view by having an open and non-judgemental discussion, taking their concerns at face value and accepting their experience as valid

b) understand how the person being supported understands themselves, their experience and the world around them, paying attention to any cultural or spiritual beliefs that are particularly important to them

c) see and understand the other person's distress and express this through the use of empathy

Recognising and addressing threats to the clinical relationship

a) Ability to recognise when there are strains in the clinical relationship and address these, for example:
    - giving and asking for **feedback** in a way that demonstrates a genuine interest in the person
    - discussing the **person's understanding** of the role of the AWP (Renal) and clarifying any misunderstandings
    - inviting the person to **express any negative feelings** about the relationship and discussing possible ways to improve these
        - helping the person explore any fears they have about expressing negative feelings about the relationship between the AWP (Renal) and themselves
    - **acknowledging and accepting responsibility** for any contribution to strains in the relationship

Engagement skills

Ability to:

a) determine a person's readiness to explore options or to try something new, in a manner that builds on their strengths and promotes self-determination

b) draw on knowledge of the potential barriers to engagement and the ability to actively work with the person being supported or with colleagues to address these

Matching the meeting location to the person

Ability to:

a) be open to the possibility of meeting in locations that are not associated with kidney management or mental health services if this is what the person prefers (and if this is possible within the service setting), for example:
    - a **location outside** of that used by the renal speciality
    - a **local community space** such as a library or café
    - meeting in **another quiet space**
b) balance flexibility in the meeting location with the need to maintain personal safety

Managing endings

a) Ability to prepare the person being supported for an ending of psychologically informed support provided, and:
    - **signpost the person** being supported to other resources or sources of support, as required
    - support the person **continue with their self-management** journey after contact with the AWP (Renal) has ended

3.3 Engaging and supporting families

Ability to:

a) draw on knowledge of the significance of families' wider social or community network in planning and providing care and support
b) draw on knowledge that caring for a person with chronic kidney disease will have an impact on families
c) draw on knowledge that difficulties may arise between the kidney patient, informal carer and wider family
d) engage the person's family (when appropriate):
    - to **support** the kidney patient, or be able to speak on their behalf (with their consent) in relation to the care they are receiving
    - to help family members and carers feel comfortable and confident **to ask questions** when they are uncertain or confused
    - to support the people with kidney disease' family, carer, social or community network to **look after their own mental and physical wellbeing** and health and social care needs
e) help families be heard (and responded to), by the team from whom their loved one is accessing support
f) help families access organisations and services that offer information, advice or support relevant to their needs
    - by knowing the scope of available services, the support that they offer, and their service access criteria
g) provide support or information to families to help them navigate the system, policies, processes or legal structures that may affect them

Sharing information about the person with kidney disease with their family, carers or members of their support network

Ability to:

a) share general information on mental and physical wellbeing
b) draw on knowledge of the limits of confidentiality and information sharing
c) draw on knowledge that if the person with kidney diseasedoes not consent, it may not be appropriate to share their information

3.4 Using active listening and communication skills

Knowledge

Ability to:

a) draw on knowledge that communication skills will help AWP (Renal) gain the best understanding of the concerns, needs and strengths of the person they support, helping them to:
    - feel **respected, heard and understood**
    - recognise that their **distress or challenges** have been understood through the expression of empathy
    - **feel connected** to others (and so feel less isolated and alone)
    - **express themselves** and make sense of their experience
    - reflect on and **request the support** that they feel is appropriate to meet their needs
b) understand that behaviours and actions can be a form of communication
    - for example, challenging or aggressive behaviour may reflect high levels of underlying anxiety or fear

Active listening and effective communication

Ability for the AWP (Renal) to:

a) show that they are paying attention to the person being supported, for example through body language:
    - **sitting close** (but not too close)
    - **sitting 'square on'** or next to the person (rather than across a desk)
    - **sitting alongside** the person with kidney disease on haemodialysis where requested
    - adopting an **open posture**
    - maintaining an appropriate level of **eye contact**
b) listen attentively to the person by:
    - **actively listening** to their verbal account and trying to make sense of their experiences, behaviours and feelings, and the social context in which these arise
    - listening to the **tone and pace** of what is said, as well as its content

- helping the person **express themselves** at their own pace (for example, being comfortable with silences if the person is finding it difficult to express themselves)

c) help the person expand on or explore relevant issues by using:
   - **statements** (for example, brief summaries of what has already been said)
   - **questions**
   - **non-verbal prompts**

d) ask:
   - **'open' questions** that require more than a 'yes'/'no' answer and encourage discussion, AND
   - **'closed' questions** that usually have a specific answer and best used to establish factual information

e) judge when questioning is being experienced as helpful and when it is less so
   - for example, where the person is feeling 'grilled'

f) listen to the person with empathy, by:
   - actively trying to **understand their perspective** and the way they understand their situation
   - **reflecting their feelings**

g) convey an empathic understanding of what has been said or conveyed, for example by:
   - **paraphrasing** what has been said (but not repeating word for word)
   - making **short summaries** that try to connect various aspects of what has been conveyed
   - using appropriate **non-verbal behaviour** that is responsive to what has been said (for example, through appropriate facial expression or by nodding)

h) check the person's understanding by asking them to summarise the discussion and any decisions that may have been agreed

i) ask the person whether all the issues they wished to raise have been discussed

j) be mindful about one's own perspective and how this might influence their relationship with the person

k) attend to indications that the person is finding topics distressing or hard to discuss (for example, by noting non-verbal behaviours such as agitation or excessive movement)

l) remain calm while showing empathy and continuing to communicate sensitively with people experiencing distress

m) communicate complex sensitive information to a wide variety of professionals

Overcoming barriers to communication

Ability to:

a) draw on knowledge that where verbal communication is challenging for a person, other forms of communication (such as drawing or writing) may be an effective and appropriate alternative
b) work with the person to identify practical barriers to communication and identify ways to minimise their impact, for example by:
    - asking the person **how best to communicate** with them and how they would like to be communicated with using communication aids
    - adjusting the **complexity of the language** being used
    - managing the **surrounding environment** (for example, within a haemodialysis ward seek to relocate to a different space to assure privacy when possible)
    - managing the **ward environment** if the person wishes to engage in that setting
c) address any difficulties a person has with communicating or expressing themselves by making appropriate adjustments, such as:
    - **listening carefully** and asking the person to clarify or repeat information if it is hard to understand what has been said
    - **allowing time** for them to respond
    - using **simple, straightforward, everyday language**
    - **limiting the number of key concepts** or ideas that are communicated in a sentence
    - using **concrete examples** (rather than abstract ideas)
    - asking **short, simple either/or questions** (but taking care to avoid leading questions)
    - creating a **context for comments** or questions (to help understand the reasons for them)
    - **regularly asking to summarise** or repeat what has been discussed (to check that they have understood accurately)
d) gain an accurate sense of the person's account
e) be aware of (and avoid) any 'filters' they may find themselves imposing, for example:
    - listening in a **judgemental way**
    - **making assumptions** or jumping to conclusions instead of listening carefully

3.5 Working with difference

Working in a culturally competent way depends on valuing diversity, equality and inclusion, respecting the beliefs, practices and lifestyles of people with kidney disease or informal carers who use services, and how these may impact on their physical and mental health or experience of services.

Stance

Ability to:

a) work in a person-centred way (providing care that is led by the person's concerns)
b) treat everyone with dignity, respect, kindness, compassion and consideration
c) equally value all people for their particular and unique characteristics
d) support people who experience physical and mental health difficulties that arise from different social or cultural backgrounds
e) be aware of stigmatising and discriminatory attitudes and behaviours in themselves and others (and be able to challenge these)
f) develop the knowledge and skills to advance mental and physical health equality

Knowledge of the relevance and impact of people's beliefs, practices, demographic factors, identities and lifestyles

Ability to:

a) draw on knowledge that the demographic groups included in discussion of 'different' beliefs, practices or lifestyles are usually those that are or have been subject to disadvantage, discrimination or exclusion
b) draw on knowledge that people can be a member of more than one group or community and that the implications of different combinations of identity and lifestyle factors need to be held in mind
c) maintain an awareness of the potential significance for practice of social and cultural variation across a range of domains, including:
    - **ethnicity, race and culture**
    - **gender, gender identity and sexuality**
    - **religion and belief**
    - **socioeconomic status**
    - **age**
    - **disability**
    - **communication and language**
d) draw on knowledge of the relevance and potential impact of these social and cultural factors on mental and physical health, and on the effectiveness, appropriateness and acceptability of particular psychological approaches

Knowledge of social and cultural factors that may have an impact on access to support

Ability to:

a) draw on knowledge of social and cultural issues that commonly restrict or reduce access to support, for example:
    - **language and communication**
    - **social exclusion and isolation**
    - **mistrust of statutory services**
    - **lack of knowledge** about available services and how to access them

- lack of ability to make necessary **arrangements to cover informal caring duties** where the informal carer need support for themselves
- the **range of cultural concepts**, understanding and attitudes about mental and physical health that affect views about help-seeking, treatment and care
- **stigma, shame or fear** associated with mental and physical health difficulties or diagnoses

b) draw on knowledge of the potential impact of social inequalities and exclusion on the development of mental health difficulties, and on access to and experience of mental health and renal services, resources, support and opportunities

c) draw on knowledge of the impact of factors such as socioeconomic disadvantage or disability on practical arrangements that influence attendance and engagement (for example, transport difficulties, poor health)

d) draw on knowledge of the range of challenges, demands and other conflicts placed on informal carers that may act as a barrier to accessing personal support

Communicate respect for a person and their family

Ability to:

a) draw on knowledge of relevant beliefs, practices and lifestyles where the person from a specific sociodemographic group are regularly seen within a service

b) identify protective factors that are provided through membership of a specific sociodemographic group (for example, the additional support offered by an extended family or community)

c) identify the range of groups and resources in the community that may be helpful for the person

Gain an understanding of the experience of specific beliefs, practices and lifestyles

Ability to:

a) collaborate with people to develop an understanding of their culture and world view, and the implications of any culturally specific customs or expectations for the ways in which challenges or difficulties are described and presented
   - apply this knowledge in order to work with the person in a manner that is **culturally sensitive, culturally consistent and relevant** (and that guards against cultural stereotyping)

b) take an active interest in a person's social and cultural background

c) demonstrate a willingness to learn about their sociocultural perspectives and world view
   - to help **build a trusting relationship**

Demonstrate awareness of the influence of the AWP (Renal)'s own background

Ability for all AWPs (Renal) to:

a) draw on an awareness of their own background, group membership and values, and how these may influence their perceptions of the person they support, the challenges or difficulties they present, and the relationship between the person and the AWP (Renal)
b) reflect on power differences between themselves and the people they support and work to minimise these in order to promote reciprocal and equal relationships

4. Supporting people with kidney disease and informal carers as an AWP (Renal)

4.1 Supporting people with kidney disease and informal carers in their self-management

Ability to:

a) support people in their self-management by helping them to:
   - identify their **strengths, values and aspirations**
   - share their **experiences and feelings**, and make sense of these (and the impact of cultural beliefs and interpretations on their ways of understanding)
   - define **what self-management means** and looks like to them
   - engage in actions that can lead to **personal growth** and development
   - develop a **positive expectation of the future** by promoting hope and belief in life with a long-term physical or mental health condition
   - (re)gain a **sense of autonomy** and choice over decisions that impact on their lives
   - (re)build their **sense of identity** outside of physical or mental health services
   - develop and maintain **positive relationships** (for example, by reconnecting with their loved ones and their communities)

b) help people identify and prioritise their own goals for self-management, by helping them to:
   - identify goals that enable them to re-engage as far as possible with their **previous life routine, workplace, family and community**
   - recognise **activities previously undertaken** that can no longer be engaged with and to support the person replace these activities
   - identify their **hopes, strengths, accomplishments and challenges** so they can achieve their goals
   - identify ways to apply **behaviour change approaches** to address limitations associated with physical or mental health difficulties
   - identify **resources** that will help them achieve their goals and that are outside of physical and mental health services (such as friends, peer groups, support networks, work or community organisations)
   - **celebrate successes** as they move towards achieving personal goals

c) draw on knowledge that while setbacks may occur, maintaining hope and positive expectations can support people to achieve their goals
   - ability to **persevere and continue** to stand by people when they are 'stuck' or finding it difficult to make progress

d) work with people to develop their skills to manage difficult situations, setbacks or challenges that may affect their self-management

Self-determination, self-management and self-care

Ability to:

a) support the person make their own decisions and empower them to build autonomy
b) help the person develop self-determination and self-management skills
    - recognising that each person will find **their own approach** to self-care
c) support self-management and collaboratively discuss care and support options
d) explore with the person how to create a self-care or wellbeing plan (if they choose) that:
    - builds on their **natural strengths**
    - supports their **sense of wellbeing**
    - helps them discover **new areas of interest**
    - increases their **awareness of sources of support** in the community or charitable sectors
e) work with people so they can identify and choose their sources of support, in the form of people, networks, services or resources, that they need to achieve their goals
f) promote and understand the impact of effective health promotion to facilitate healthy lifestyles such as adherence to medical regimens, movement, nutrition and fluid balance

4.2 Help people with kidney disease and informal carers engage in activities that are meaningful to them and give their life a routine

Ability to:

a) help people identify and, where necessary, problem-solve issues or concerns that make it difficult for them to access and engage in activities that are meaningful to them
b) support kidney specific Cognitive Behavioural Therapy (CBT) evidence-informed approaches for the prevention of mental health difficulties
c) help people engage with their previous life routine or adapt to a new life routine alongside monitoring and treatment for chronic kidney disease
d) draw on knowledge that, for many people, engaging in activities that have meaning and purpose can help their self-management by:
    - providing a **sense of structure** or routine to their day
    - helping them **engage with activities** or new activities that bring pleasure
    - helping them **overcome unhelpful behaviours** that can impact on the treatment of and life with chronic kidney disease
    - improving their **sense of wellbeing**
    - improving their **sense of identity, confidence and self-esteem**
    - helping them **interact with others** and build their social and community networks
    - encouraging them to **acquire or develop new skills**

e) help people identify activities that are meaningful to them

4.3 Help people with kidney disease and informal carers develop coping skills

Ability to:

a) work with the person being supported to:
   - discuss their **coping strategies** and identify the external resources available to them (such as family and friends)
   - identify (and reinforce the value of) **existing coping strategies** that the person feels work well
   - identify when (and discuss why) **coping strategies they use do not work well**
   - identify **different coping strategies** that may be more effective
   - consider how to implement skills and strategies that may be **more effective ways of coping** with difficult situations
   - identify any **potential barriers** to implementing new coping strategies

b) support people to develop the skills to reflect on and review their coping strategies over time

4.4 Collaboratively discuss psychosocial care and support options

Ability to:

a) explore with the person how they might discuss issues or concerns they have regarding different forms of kidney monitoring, treatments, or intervention options with a health professional
b) engage the person in a collaborative discussion of the care and support options or choices open to them
c) direct the person to appropriate members of their multidisciplinary team or sources of information about care and support options in a way that helps them:
   - have a clear understanding of the **care and support options** open to them (that is, the organisations, services and support available to them, and the way these are usually accessed)
   - raise and discuss **queries or concerns**
   - decide **what is best for them**
d) determine when the person's decision to try a particular approach or intervention:
   - is based on a **collaborative choice**
   - represents an **active choice** (rather than a choice that they experience as imposed on them)

4.5 Enable patient engagement with individual care and self-management plans

The AWP (Renal) does not have a formal responsibility to draw up and monitor care and self-management plans, but can work with the multi-disciplinary team and contribute to their development and use, depending on the service they work in.
Ability to:

a) work with people collaboratively, to participate in the development of their care, self-management or wellbeing plans
b) discuss a person's care or self-management plan with them, including any personal goals or objectives that would benefit from input from the AWP (Renal)
c) help people develop an advance directive or statement (where appropriate) as part of their care plan or crisis plan (setting out their wishes regarding how they would like to be helped in any future crises)

4.6 Facilitate access to care and sources of support

Signposting is a form of self-help whereby information about accessing organisations and services that are relevant to the meet the needs and goals of patients is provided. Taking steps to make it likely that people will access these is an important part of this process.

Identifying sources of support

Ability to:

a) draw on knowledge of available sources of support, for example:
    - local **voluntary, community and charitable sector** organisations or groups offering both emotional and practical support (including housing or financial) or advocacy
    - **national websites and helplines**
b) inform the person about relevant mental health services and support referral in the event they demonstrate elevated levels of symptoms associated with common mental health difficulties
c) engage with community or charitable organisation that can support transition of the person back to work or inform ways to engage with professionals regarding adaptations to accommodate return
d) ensure that information about sources of mental health treatment or support:
    - is **up to date**
    - **accurately** describes the type of support that is on offer
e) draw on knowledge of social activities, resources or programmes within local communities and to help people with kidney disease or informal carers access and engage in them, for example:
    - **peer support** programmes or groups
    - **informal carer** support groups
    - **employment advisors**
    - **charities** offering practical or emotional support
    - **supported community engagement**

- **group-based community activities** (including religious, sport or leisure activities)
- **social participation interventions**
- **voluntary work programmes or activities**
- **life-skills programmes**
- **employment interventions or programmes**, such as Individual Placement and Support (IPS)
- support from **local social prescribers** and link workers

f) convey information about organisations and services, to help the person make informed choices about the options they wish to pursue
   - identify **statutory, community or charitable sector** organisations and services that are accessible to a person
   - consider **particular needs** that may make use of the statutory, community or charitable sector difficult to engage with (for example travel to or using the premises)

g) help the person consider the type of support that matches their needs and situation based (for example) on:
   - their **goals**
   - their **expressed preferences**
   - the type of **kidney difficulties** or treatments received
   - the **nature and severity of their distress**
   - their **willingness to access services**

h) discuss with the person the reach, responsibilities and limits of organisations and services, to identify those that are both suited to their needs and acceptable to them

Facilitating access to mental health services

Ability to:

a) facilitate access to an appropriate mental health service through administrative or practical help (for example, by accompanying a person to an initial appointment or meeting)

b) draw on knowledge of the potential challenges that people may face when trying to access mental health services, such as:
   - **practical challenges** such as attending appointments
   - **difficulties managing** provision of informal care provided
   - issues such as **stigma**

c) help people use common problem-solving approaches to address these challenges

d) introduce and support a kidney-specific CBT-informed problem-solving prevention approach

Signposting

Ability to:

a) draw on knowledge that signposting aims to help a person independently access sources of support that are relevant to their circumstances and goals that they may not be aware of
b) draw on knowledge that signposting can help address the environmental determinants of mental health by encouraging the person with kidney disease to make use of services that provide practical support
c) pass on contact information in a way that makes it likely to be remembered and used, for example:
    - **written** rather than verbal
    - using the **medium most likely to be accessed** by the person (for example electronically via social media or an app, or printed media)
d) establish that a person is willing and able to access the organisation, service or support
e) follow up with the person to see if they have accessed the organisation, service, group, activity or programme, or whether they need a different type or level of support
f) support referral to Improving Access to Psychological Therapies or equivalent for the treatment of common mental health difficulties.

4.7 Support transitions in care for the person with kidney disease

AWPs (Renal) are not expected to organise transitions in mental or physical health care (for example type of monitoring or treatment for chronic kidney disease) but can have a role in supporting people through the process of transition.

Ability to:

a) draw on knowledge that transitions in care (between different types of monitoring and treatment for chronic kidney disease, within and across organisations) can be distressing, and may be times of greater risk for the person, and that:
    - **anticipating the ending of an intervention**, relationship or time with a service can lead to strong feelings and distress
b) support the person during the transition or transfer of care, for example helping to check whether they:
    - are given as much **notice by the service** as is practically possible
    - **understand why** the transition or transfer of care is taking place
    - can **express their opinion** on the transition or transfer of care
    - are informed about the **timescale** of the transition
    - are informed about the **services** that will be on offer
    - know **what information** will (and will not) be communicated to the new service, and that they are given the opportunity to discuss any concerns
c) discuss a person's feelings about the transition, and to work with them to:
    - discuss their **concerns and feelings**

    - identify **issues** that may make a transition or transfer of care problematic
    - identify and overcome **barriers** that make it less likely that they will stay in contact with the new service (for example, anxiety or anger about moving to a new service, upset over loss of contact with valued professionals)

d) draw on knowledge that people may need extra support and preparation to successfully navigate transitions or transfers of care, including by:
    - where appropriate, helping the person develop **skills in independence, assertiveness and self-advocacy**
    - where possible, **providing continuity of support** during the transition

e) where there are concerns that a transition is not progressing well, to raise these by escalating any issues to an appropriate colleague or supervisor

4.8 Developing and maintaining a supportive environment

Ability to:

- develop competency to provide a supportive environment that can facilitate effective interpersonal relationships
- tolerate the patient's distress with compassion
- recognise the distressing nature concerning some experiences reported by the kidney patient and their informal carers
- sit with and listen to another's distress whilst maintaining own wellbeing, and seeking support to do this when necessary

5. Working with teams and promoting people's rights

5.1 Work as part of a multidisciplinary team

The AWP (Renal) will be supported by, and integrated into, the renal specialism and work collaboratively with psychological health provision and relevant health, social care and charitable organisations

Ability to:

a) draw on knowledge that working effectively as a team is important as it can have a positive impact on the experience of people using renal, mental health and community-based health and social care services

b) Work within a **collaborative care team** to maximise the sharing of information regarding patient treatment and management

c) draw on knowledge of the multi-disciplinary team's remit, shared goals, values, culture and practice

d) draw on knowledge of the roles and responsibilities of other multi-disciplinary team members

e) work as part of the renal service or other organisation while retaining the perspective and ethos of support for the person

f) work effectively with multi-disciplinary colleagues to:
   - **enhance existing services** and the care and support they offer
   - **identify and resolve potential conflict** or disagreement regarding the support or care provided to a person
   - improve their **knowledge and understanding** of the AWP (Renal) role and:
     - how they fit within the team
     - the values and principles underpinning support

g) be aware of team dynamics that challenge effective working within the team, for example, when:
   - there are **unhelpful power relationships**
   - the AWP (Renal) role is **not recognised** as a distinct and valued position
   - AWP (Renal) roles are **not given the same status** as those of other members of the team
   - **tensions develop** because of the dual role of the AWP (Renal)
     - being a member of the team and having a supportive relationship with the person being supported)

h) consider how best to respond to these challenges, usually through initial and ongoing discussions with (and support from) a psychological and/or nominated renal service supervisor, and holding in mind basic conflict resolution strategies, such as:
   - presenting a case **calmly and clearly**
   - identifying when (and when not) to challenge **problematic team behaviours**
   - focusing on the **problem** (rather than on personal issues)

- listening to the **point of view** of other team members
- identifying **potential strategies** for resolving issues

i) raise concerns about unsafe staff practice by following the service's policies and procedures

j) proactively make recommendations to improve the quality of service delivery

k) allocate work to and support the development of others

Communication with others in the team

Ability to:

a) communicate effectively with the multi-disciplinary team (both verbally or in writing) about the support they are currently providing to people with kidney disease (based on a 'need to know' basis), and to:
   - **record** what information has been shared, with whom and for what purpose
   - **seek advice** (for example, from a supervisor) when in doubt about sharing information

b) discuss challenges to team communication (with a supervisor) and to consider how these can be best managed, for example by:
   - identifying **when** (and when not) to challenge problematic team behaviours
   - presenting a case **calmly and clearly**
   - focusing on the **problem** (rather than on personal issues)
   - focusing on the **future rather than the past**
   - listening to the **point of view** of other multi-disciplinary team members
   - **problem solving** (identifying potential strategies for resolving the issues)

c) support the multi-disciplinary team with the organisation, implementation and coordination of clinical tasks (including Social Prescribing & Care navigation)

Documentation

Ability to:

a) understand how work is documented in the setting in which the AWP (Renal) is working, and to maintain a record of contacts with the people they support (in line with service guidelines and policies)

b) understand that in statutory (and many other) settings an up-to-date record of progress for each person being supported should be entered into the patient's clinical record (usually after each contact with the person being supported)

c) write or enter into an electronic system a record of progress that:
   - is **person-centred**, providing a sense of regarding the experience of the informal carer
   - reflects on the person's **wellbeing**
   - addresses the **goals and objectives** set out in the person's care plan (where possible)

- is **concise, legible, written** in a style that is accessible, and signed and dated
- summarises the **activities** that have taken place to date with each person being supported
- identifies any **significant issues** or concerns that have arisen

Care meetings

a) Ability to contribute to meetings on planning, coordinating, maintaining and evaluating a care or care plan for a person

5.2 Work within a collaborative care model

Working with other organisations or services

Ability to:

a) draw on knowledge that collaborating with other organisations or services will directly benefit the person's care and wellbeing
b) identify and connect with organisations or services that are already involved with a kidney patient, informal carer, or their family members (where appropriate), and:
    - **identify the roles and responsibilities** of other organisations and services in relation to the range of care and support a person can access
c) contribute to meetings with other organisations or services to support the planning and coordination of care received by a person
d) recognise challenges when working with other organisations and services (including those that reflect differences in values and principles)
e) work with colleagues, a supervisor or team leader to plan how these challenges can be managed

Communication with other organisations and services

Ability to:

a) recognise when it is appropriate to share information with other organisations or services
    - **share relevant information** with the appropriate agencies (based on the principle of 'need to know')
b) maintain effective communication (both written and verbal) with professionals in other organisations when it is relevant to the treatment, care and support for the person
c) identify potential barriers to effective communication and, where possible, develop strategies to overcome these

5.3 Offer a personalised perspective to different groups of professionals

Ability to:

a) offer a self-management and person-centred perspective, for example working with staff to:
    - **help them understand** the AWP (Renal) role and remit
    - **improve their awareness** of the importance of treating people with dignity, respect, kindness and consideration
    - **discuss** (and possibly address) their attitudes and perceptions about mental health and renal care
    - **improve their understanding** of self-management-focused approaches (and especially the distinction between personal self-management, clinical self-management and service-defined self-management)
        - understanding the importance of people defining, owning and leading their own self-management (rather than having self-management defined for them by professionals or the service)
    - **explore ways to work** in a self-management-oriented way with people
    - help them **avoid unhelpfully technical language** or jargon
    - understand the **importance of co-production** (involving people with kidney disease, lived experience of renal failure, or mental health difficulties in planning, developing, delivering and evaluating services), social inclusion and equality
b) help physical and mental health professionals, organisations and services keep well-informed about the perspectives and concerns of people being supported, for example through:
    - developing **guidance for staff** on how to talk with people with kidney disease or informal carers in a person-centred and self-management-oriented way about diagnosis, medication or interventions
    - **reviewing and updating risk assessment** documentation to support co-produced safety plans developed with people
c) support co-production in service development and evaluation, and:
    - an ability to **work with services** to co-produce and co-deliver staff training
d) work with staff to make reasonable adjustments and ensure that environments are culturally sensitive and free from discrimination

5.4 Promote the rights of people with kidney disease and informal carers being supported

Ability to:

a) draw on knowledge of an individual's right to manage their own health and wellbeing
b) help people:
    - **navigate the services** and organisations with which they are in contact

    - **understand the choices** and options they may have over the care they receive
    - be aware of **their rights** in the physical and mental health care system
    - **understand the policies**, processes or legal structures that might affect them
c) amplify the voice of the person they are supporting, so that they:
    - **feel listened to**
    - **have their voice heard**, especially with regard to decisions about their care
d) help people raise and discuss questions and concerns about their care with relevant professionals (for example, regarding their diagnosis, medication or interventions related to physical or psychological management)
    - an ability to help people **plan** (and rehearse) how they could raise concerns about their care (for example, with whom and in what settings)
e) speak on a person's behalf to promote their inclusion and rights in situations such as multi-disciplinary team meetings, with organisations and services, and with family members (where necessary) by:
    - ensuring people are **involved in jointly developing their care plan**, and that they remain involved in further discussions about their care
    - **providing people with the skills and knowledge** to advocate for their own rights
    - **facilitating access** to health and social care services, other organisations, information, or alternative sources of support, such as advocacy services
f) work with people being supported to address challenges with, or barriers to, accessing organisations and services, or infringements of their rights
g) listen to complaints or concerns from people about their care or treatment and respond in a prompt, open and constructive way, by:
    - helping them **think about possible next steps**, and what actions they would like to take
    - seeking **advice or support from a supervisor** or team leader regarding the appropriate next steps
    - following the service's **complaints procedures** (for example, referring concerns to independent mediators where appropriate)

6. Self-care and support

6.1 Ability for the AWP (Renal) to reflect on their own self-management and self-care

Self-care cannot take place in isolation: organisations need to have systems in place that are responsive to an individual's needs and that enable staff to agree on, and implement, appropriate adjustments that accommodate these needs.

This means that the AWP (Renal) should be able to identify the people they would need to talk to in order to ensure they receive the right support.

Ability for the AWP (Renal) to:

a) maintain a focus on self-management, self-care and their own health and wellbeing by:
   - working to their **strengths**
   - engaging in strategies such as **stress management**, using wellness and self-management plans, and seeking support from others when needed
   - **anticipating challenges** by responding to, and managing, experiences that trigger upset or early warning signs
   - appreciating ways to **enhance their own resiliency** by adopting CBT approaches

b) identify and manage any barriers to self-management or self-care, or to seek support from others

c) judge when:
   - their work is creating **unhelpful levels of emotional distress** and to put in place appropriate self-care
   - an ability to consider whether their experience of distress may be linked to **social, environmental or personal factors** (such as difficulties in their own self-management)
   - **work-related stress** may impact on their effectiveness, how they behave at work and on other members of the multi-disciplinary team
   - they have **reached the limits of their responsibility** or competence, and when to seek advice, management or supervisory support, or assistance from others

d) monitor and reflect on people's emotions or challenges that arise as a result of their work and role, for example:
   - **issues arising** directly from their work with people they support
   - **conflict** within the multi-disciplinary team, or unhelpful organisational pressures

e) monitor and reflect on the impact of any challenges, and so judge when support or supervision is necessary, in order to:
   - help them **maintain their own wellbeing**
   - identify **potential solutions**

- ensure that decisions about the **best way forward** are taken based on careful reflection (for example, whether to persist, adapt or stop a course of action)
- continue **working effectively** and to maintain everyday activities and responsibilities

6.2 Make effective use of supervision

Supervision is understood differently in different settings. Here, it is defined as an activity focused separately on both the physical and psychological role components that gives the AWP (Renal) the opportunity to review and reflect on their work with a clinical renal professional, psychological professional and, as the role develops, a senior AWP (Renal). This includes talking about areas they might experience as difficult or distressing, at times with colleagues in group supervision. This definition distinguishes supervision from line management. The AWP (Renal) may require two types of supervision, one for psychological competencies and one from a member of the renal team to ensure that the role is appropriately embedded in the service.

a) Ability to hold in mind that the main purpose of supervision is to:
   - support the **delivery of support** in line with the values and principles espoused in the AWP (Renal)
   - offer **active support** and encouragement to the AWP (Renal)
   - enhance the **quality of psychologically-informed support** and care provided by the AWP (Renal)
   - share **good practice** and positive outcomes
   - encourage **reflection about the impact** of the work on the AWP (Renal) support role, and identify potential solutions to negative impacts or challenges

Working collaboratively with the supervisor

Ability to:

a) work with the supervisor to agree the content and structure of supervision (for example, agreeing the areas that need to be discussed, being clear about the respective roles of supervisor and supervisee, the goals of supervision and any contracts that specify these factors)
b) make the supervisor aware of any previous work or experience and identify current learning or training needs
c) engage with the supervisor as an active participant
d) present an honest and open account of the work being undertaken, including reflections on the emotional impact of the work
e) focus on the issues that seem most important and relevant (aiming to select and concentrate on these)

Engage in self-appraisal and reflection

a) Ability for the AWP (Renal) to:
    - be **open and realistic** about their capabilities and to share this self-appraisal with the supervisor
    - reflect on and use **feedback from the supervisor** to further develop the skills for accurate self-appraisal, and to apply self-reflection in future work
    - formulate personal beliefs, thoughts or behaviours and present these at supervision for discussion

Engage in active learning

a) Ability to follow through suggestions regarding relevant reading or additional training made by the supervisor or other members of the renal multi-disciplinary team, and incorporate this learning into their practice

Ability to use supervision to reflect on developing personal and work roles

Ability to:

a) use supervision to discuss the personal impact of the work, especially where this reflection is relevant to self-care and to maintaining the likely effectiveness of the work
b) use supervision to reflect on the impact of the work in relation to sharing their lived experience and their development as an AWP (Renal)

6.3 Recognise and adopt ways to promote and maintain personal resilience

Ability to:

a) judge when they are experiencing unhelpful levels of stress and to prioritise taking appropriate steps to relieve this
b) confidently raise concerns regarding challenges to personal resiliency
c) identify the most appropriate person to initially offer support and guidance

7. Using psychologically informed approaches to support people with kidney disease and informal carers

7.1 Support engagement with self-management approaches

Ability to:

a) encourage people to make use of psychological approaches to support their self-management
b) identify when it may be helpful for a person make use of a psychological approach
c) help the person understand the potential value of engaging with mental health services when appropriate
d) outline the rationale for using psychological approaches and answer any questions or concerns, ensuring that the person:
    - understands the **rationale** for using a particular psychological approach and how it might help them
    - indicates whether (or not) this is an **approach that may be of interest**
    - indicates their **willingness to engage** with (and try out) these strategies
e) work with the person to monitor and review the utility of the strategies being used and, if necessary, to adapt, change or stop the way they are working together
f) respond to, and discuss with the person, any feedback regarding the strategies being used (whether this is given directly or indirectly)
g) discuss and work together to problem-solve any difficulties the person may be experiencing with making use of the approach

Supporting people with kidney disease and informal carers in crisis

Ability to:

a) support people experiencing a mental or physical health crisis, by:
    - keeping in mind the **values** possessed by the person
    - using **active listening skills** to provide a sense of safety and reassurance
    - **working with others** to find or create safe spaces for the person
    - using **knowledge of local resources**, services and support to connect or signpost people to the appropriate service
b) help people recognise when they are in crisis that may represent a risk to themselves or others and need urgent management
c) encourage people experiencing a mental or physical health crisis to seek appropriate support
d) present concerns regarding risk to the multi-disciplinary team and/or collaborative care team

e) appreciating the challenges associated with the informal carer role for people with kidney disease that may make it difficult for them to manage a mental or physical health crisis
f) immediately action risk protocols in the event the person is at imminent risk to themselves or others
g) provide continuity in support whilst the physical or mental health crisis is being managed

7.2 Work with people with kidney disease and informal carers in groups

Ability to:

a) support organisation and running of groups, follow-up of did not attend rates (DNAs) and gathering of service user feedback.
b) lead and deliver psychoeducational (and other types of) groups
c) promote and raise awareness regarding peer-led groups
d) promote availability of psychoeducation or groups to enhance self-management
e) work with colleagues in the renal specialty, health and social care, community and voluntary sector organisations to plan groups, such as thinking about:
    - **practicalities** (for example, setting)
    - **content of sessions** (including resources and materials required)
    - **roles and responsibilities** of staff involved in the group programme
f) contribute to establishing an environment that is physically and emotionally safe, for example by:
    - discussing **ground r**ules (for example, the importance of confidentiality and respect for others)
    - drawing attention to any **breaches** of the ground rules
    - helping all group members to **participate**
g) engage with group members and build a positive relationship with each individual
h) utilise groups to facilitate social links between group members
i) support people to take a lead running groups if they desire
j) be alert to group dynamics, such as the formation of sub-groups, or the impact of individual relationships on the rest of the group
k) match the content and pacing of sessions to the needs and views of group members
l) explore and address any barriers to participation in the group, such as:
    - **physical health difficulties**
    - related to **aspects of kidney monitoring and treatment**
    - **practical barriers** (for example, transport, caring responsibilities for the kidney patient, childcare)
    - **social and emotional barriers** (for example, anxiety around talking in a group, aspects of treatment for the kidney difficulty or worry about stigma restricting the topics the person is willing to discuss)

- **historical factors** (for example, previous negative experience of groups)

m) promote and encourage regular attendance, while not stigmatising those who fail to attend sessions

n) plan for and reflect on potential challenges to the group, such as:
   - **disruptive behaviour**
   - **persistent lateness**, absence or non-engagement
   - members who **dominate a group** (to the exclusion of others)
   - **high levels of distress**

7.3 Support the use of digital interventions by the person with kidney disease and informal carer

Ability to:

a) draw on knowledge of digital interventions that people with chronic kidney disease and mental health needs can use to support themselves

b) draw on knowledge of the various formats that can be used to access digital interventions, for example:
   - **mobile phone apps**
   - **websites**
   - **video or telehealth** options for 'virtual' therapy or meetings (such as Attend Anywhere, Zoom or FaceTime)

c) support people's use of digital interventions to improve or monitor their kidney condition, mental wellbeing, self-help and self-management, for example by:
   - helping them overcome any **technical or practical barriers** to using kidney disease information platforms, prevention approaches, and interventions (such as not being familiar with using apps or having limited access to a computer, tablet or phone)
   - identifying when they are having **difficulty using or engaging** with the kidney disease information platforms or digital intervention, and helping to problem-solve these, for example:
     - explaining the rationale
     - helping to clarify goals and tasks
     - identifying (and addressing) challenges to maintaining motivation

7.4 Supporting psychological practice for people with kidney disease and informal carers

The AWP (Renal)'s main responsibility and duty is to undertake defined clinical or therapeutic interventions appropriately delegated by a Registered Practitioner.

Assessment

a) Ability to undertake a brief CBT four areas assessment regarding mental health

- ability to gain an overview of the persons **current life situation, specific stressors and social support**
    - paying particular attention to the interaction between kidney monitoring and treatment and psychological difficulties
- ability to present action taking regarding **psychological management** as part of the renal multi-disciplinary team
- ability to obtain a general idea of the **nature of any mental and physical health difficulty** being experienced
- ability to appreciate the **range of difficulties** experienced by informal carers and how this can impact on the support they provide to the kidney patient
- ability to assess and act on **indicators of risk** (of harm to self or others)
    - to know when to seek advice from others
    - to determine when to activate appropriate risk protocols
- ability to gauge the person's **motivation for a psychological intervention**
- ability to **discuss treatment options** with the person, making sure that they are aware of the options available to them, and helping them consider which of these options they wish to follow

Monitoring and evaluation

Ability to:

a) undertake basic physiological measurements as part of an assessment of an individual's healthcare status
b) collaboratively administer psychometrically sound brief mental health screening measures for common mental health difficulties
c) interpret brief mental health screening measures and, where appropriate, introduce and support referral into community mental health services
d) support CBT indirect prevention-focussed approaches
e) support or undertake exposure techniques delegated by a registered practitioner
f) provide holistic assessment of individual programmes of care and discuss modification to individualised care plans with other members of the multi-disciplinary team
g) use appropriate technology and equipment for the role including data entry
h) collate people's feedback, following up with experience questionnaires for service quality assurance processes

The use of low-intensity exposure techniques for kidney specific procedural anxiety

Ability to:

a) explain the rationale for exposure, in particular its use as a way of helping a person learn to tolerate (rather than rigidly to avoid) fear and anxiety cued by:
    - **situational stimuli** associated with kidney treatment
    - **interoceptive (somatic) stimuli**
b) introduce the concept of hierarchical exposure and to help the person construct a hierarchy of feared situations for both kidney-specific and interoceptive items, and their combination
c) work with the person to implement exposure in a manner which maximises the probability of benefit, in terms of its structure (for example number of situations faced, duration and pacing)
    - helping the person **identify and circumvent** any covert avoidance or the use of safety behaviours
d) identify, plan and implement interoceptive, in vitro and in vivo exposure to help patients learn that some physiological sensations can be induced behaviourally and / or cognitively
e) identify when it would be helpful to involve significant others in exposure, and to plan and implement this
f) help the patient follow-up any therapist-directed exposure with self-directed exposure
g) help the patient review exposure experiences

7.5 Help people with kidney disease and informal carers develop problem-solving skills and enhance resiliency

Ability to:

a) explain the rationale for problem solving
b) introduce and support problem solving-specific prevention approaches based on CBT
c) help the person select problems, on the basis that these are both relevant and important for them and are ones for which achievable goals can be set
d) help the person specify the problem(s), and break down larger problems into smaller (more manageable) parts
e) identify achievable goals with the person, bearing in mind their resources and likely obstacles
f) help the person:
    - generate **possible solutions**
    - select their **preferred solution**
    - plan and **implement preferred solutions**
    - evaluate the **outcome of implementation**, whether positive or negative
    - **test beliefs or assumptions** that might get in the way of problem solving

- maintain a focus on encouraging the person to arrive at their own solutions (rather than making suggestions as to what these might be and so risking imposing these on the person)

8. Meta-competencies for the AWP (Renal)

Ability to balance the various roles of the AWP (Renal) (for example providing support, promoting people's rights, facilitator, supporting interventions). Under the direction of a supervisor or line-manager supervision, the AWP (Renal) is expected to manage own work and case load and implement programmes of care in line with current evidence, taking action relative to an individual's health and care needs.

8.1 Attitudes, values and style of interaction

a) Ability for an AWP (Renal) to be aware of their own values, and reflect on the ways that these values might affect (positively and negatively) the people they work with

8.2 Engagement and intervention

Ability to:

a) judge when it is best to refocus on goals seen as potentially relevant or manageable / achievable by the person they are supporting, rather than continuing to explore other issues, which could lead to disengagement
b) judge when caring, social and cultural barriers to engagement may be relevant and need to be taken into consideration
c) judge when to continue focusing on working with difficulties and when to step back, based on the level of engagement with a person
d) identify and respond to implicit or explicit indicators that a person is at risk of disengaging from the interaction, for example by:
    - responding to and openly **discussing explicit feedback** that expresses concerns about important aspects of the conversation or proposed course of action
    - responding to **implicit feedback** that indicates concerns about important aspects of the discussion (for example, feedback through comments, non-verbal behaviour or significant shifts in responsiveness)
    - identifying when it seems **difficult for people give 'authentic' feedback** (for example responding with what they think the AWP (Renal) wishes to hear) rather than expressing own view and discussing with them
e) balance flexibility and consistency when providing care and support, and delivering interventions
f) judge when to offer self-disclosure and to decide what would be helpful to disclose and what should be held back

g) appreciate occasions where a person may choose to disengage from a psychologically informed approach but wish to continue receiving general support or benefit from a supportive relationship

8.3 Support

Ability to:

a) match the intensity and timing of support to the needs of the person, and to judge whether and when to increase or decrease the level of response
b) judge when to offer support to the person or when to foster independence and their ability to self-manage

8.4 Respond to feedback

Ability to:

a) demonstrate awareness regarding different ways to collect formal feedback on practice or care provided
b) discuss and respond to explicit and implicit feedback from patients and/or their supervisor and line manager about the care they deliver
c) detect and respond to implicit feedback that indicates that a person has concerns about the care, support or interventions they receive (for example, non-verbal behaviours, verbal comments or changes in behaviour or responsiveness)
d) present patient feedback for discussion with the line manager and/or supervisor
e) make any necessary changes to practice to address feedback

We welcome any feedback on the framework

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