Virtual Ward and Urgent Community Response Capabilities Framework

Foreword

To support our workforce to develop and build confidence and capability to provide safe and quality services, NHS England commissioned Skills for Health to develop a core skills and capabilities framework for urgent community response and virtual wards. This framework is key to informing workforce education, training and career progression as well as informing local workforce models.

The framework provides a standard and greater clarity on the scope of practice for nurses, allied health professionals and support workers in multi-disciplinary teams working within virtual wards and urgent community response teams in the community.

This framework builds on existing good practice and sets out the **core skills and capabilities** for health and care professionals working in these teams.

The framework describes the new skills and capabilities required to enable effective and efficient use of new technologies and digitalisation. This informs the management of care safely at home or in the community, when clinically appropriate to do so. In addition, it sets out the core capabilities to inform personalised care and supporting people to become more active partners in their own health and wellbeing.

We hope this framework will help support teams to confidently deliver these crucial services, ensuring that skills and training needs are well understood and planned for and that staff are developed to safely and effectively deliver care to patients and communities.

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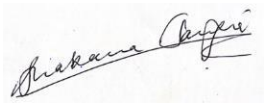

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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.
- Given regard to the need to reduce inequalities between patients in access to and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

Introduction and background

THE NHS Long Term Plan (2019) promised the possibility of ‘care closer to home’ with a boost to out of hospital care with significant financial investment and new models of care delivery. The possibility of this delivery model was tested during the COVID-19 pandemic, by developing urgent care at home services.

As a result of the pandemic, there has been a period of rapid innovation and transformational change in service delivery. This has included a rapid acceleration of the use of digital technology in healthcare, and an expansion of virtual wards. Urgent Community Response (UCR) has played a key role in integrated personalised care to reduce hospital admission and recognise the importance of Home First interventions. This, amongst others, has formed part of the dynamic and innovative changes to service delivery, which require our workforce to work in new ways.

In December 2021, the 2022/23 priorities and operating guidance set out the requirement for systems to improve the responsiveness of Urgent and Emergency Care (UEC) and build community care capacity – keeping patients safe and offering the right care, at the right time, in the right setting through the development and expansion of virtual wards, including Hospital at Home services.

Virtual wards

A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards, including Frailty and Acute Respiratory Infections (ARI) virtual wards, support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home or place of residence. This includes allowing the patient to be cared for at home, or to go home sooner.

Virtual wards should be led by a named registered consultant practitioner i.e., doctor, nurse, allied health professional or primary care GP with knowledge and capability in the relevant specialty or model (Frailty and Respiratory care).

Urgent Community Response services

Two-hour UCR teams provide assessment, treatment, and support to people over the age of 18 in their own home or usual place of residence who are experiencing a health or social care crisis and are at risk of hospital admission within two to 24 hours. Assessment and care should start within two hours, where clinically appropriate, of the referral being received, with short-term interventions typically lasting under 48 hours. Teams are expected to work in an inter-disciplinary way, and often consist of registered nurses, advanced clinical practitioners, physiotherapists, occupational therapists, support staff, social workers and paramedics, with support from other relevant professionals including GPs and geriatricians, all of whom will require the digital capability to ensure safe assessment and monitoring of virtual care.

All 2-hour UCR services, however configured, are expected to provide crisis care for the following nine conditions/needs as a minimum:

- Falls
- Decompensation of frailty

- Reduced function/deconditioning/reduced mobility
- Palliative/end-of-life crisis support
- Urgent equipment provision to support a person experiencing a crisis/at risk of hospital admission
- Confusion/delirium
- Urgent catheter care
- Urgent support for diabetes
- Unpaid carer breakdown which, if not resolved, will result in a healthcare crisis for the person they care for.

All parts of England will provide a 2-hour UCR, 12 hours a day, 7-days a week with ongoing scaling and workforce development required in the coming years to achieve expected impact for patients and services.

Workforce skills and capabilities

At a local level, Virtual wards and UCR teams are working together to support the needs of patients in the place they call home. In response to this news way of working, we recognise that a framework for skills and capabilities is required to inform the upskilling and development of our workforce. This framework has been developed with 11 core capabilities and specific capabilities unique to both services.

The framework has been developed nationally; however, it will be implemented in accordance with local service models and needs.

Return to contents page

Who is this framework for?

The framework will be of particular interest to teams delivering virtual wards and UCR and other organisations supporting these services.

Current and future workforce

The framework sets out clear expectations about the requirements for effective and safe practice. It provides clarity about characteristics and requirements to practice at each tier and sets out a structure of core capabilities required in practice at each tier.

It can be used as the basis for formal or informal appraisal, alongside a training needs analysis, comparing current skills and knowledge with required skills and knowledge.

The framework can assist staff in the development of a portfolio of evidence of capability.

Service commissioners

The framework sets out clear expectations of practice, supporting commissioners of services to specify minimum standards for employment.

The core capabilities support workforce forecasting and development to meet local needs and foster a mutual understanding and expectation of staff working in services.

Employers

The framework enables employers and managers to demonstrate that the staff they employ/manage meet the core capabilities and that staff development plans are in place alongside appropriate supervision to ensure the safety of those who use the services.

This framework underpins and supports the need for continuing professional development of staff to ensure their practice is safe, effective, remains up-to-date and supports the process of quality assurance to ensure the safety and effectiveness of care.

The framework can be used as part of appraisal processes and to review and recognise how capabilities are shared across teams.

Supervisors

The framework can support supervisors by providing a clear structure and standards against which practitioners can be assessed.

Education and training providers

The framework can inform those who design, deliver and quality assure training and development opportunities to focus on these core capabilities that learners need to develop. This in turn will guide the content of educational activities and the use of appropriate teaching, learning and assessment strategies.

Use of this framework also supports organisational and system-wide effectiveness and efficiencies by encouraging the delivery of education and training that is focused on developing core capabilities, and optimises opportunities for inter-professional learning; focused on outcomes-based curricula which equip individuals with the attributes required to meet the needs of health and social care services.

In so doing, it will help to increase consistency in knowledge and skills development, prevent unnecessary duplication in education and training delivery, and strengthen skill mix and teamworking.

Patients, people who use services, carers, and the public

The framework should enable patients, people who use services, carers and the wider public to better understand the role played by virtual ward and urgent community care teams within the wider healthcare team, as well as the expected quality of service provision. In addition, the framework can be useful for people such as patient or lay representatives including those in-patient participation groups, or holding positions on organisational boards, or in other roles such as co-production of services, education or system development.

Return to contents page

Structure of the framework and capabilities

Capabilities

The framework articulates the **core capabilities** necessary for well-led, compassionate, and responsive care.

For the purposes of this framework, we are using the following definition of capabilities:

Capabilities are the attributes (skills, knowledge, and behaviours) which individuals bring to the workplace. This includes the ability to be competent and beyond this, to:

- *Manage change*
- *Be flexible*
- *Deal with situations which may be complex or unpredictable and escalate/refer appropriately to ensure patient safety*
- *Continue to improve performance. (Skills for Health 2020)*

Therefore, 'capability' can be more than 'competence.' To be competent is to consistently perform to defined standards required in the workplace – usually focused on the outputs of work and observable performance.

Competence tends to describe practice in stable environments with familiar problems, whereas 'capabilities' describe the ability to be competent, and beyond this, to work effectively in situations which may be complex and require flexibility and creativity.

In practice, the terms 'capability' and 'competence' are both widely used in educational and workforce development literature, and they have often been used interchangeably, with little clear distinction between the two.

Both capability and competence:

- Are about 'what people can do'
- Describe knowledge, skills, and behaviours
- Can be the outcome of education, training, or experience.

For the purposes of this framework, we are using the term 'capabilities' as this describes the ability to be competent and to work effectively in situations which may require flexibility and creativity.

Terminology

It is acknowledged that there is some complexity around the use of language in relation to individuals who receive care and services. The term 'patient' is used within the **core capabilities**; however, within the section on **urgent community response**, the term 'service user' is used, recognising that individuals other than the 'patient' will be supported as part of the service offered and in recognition of care and services being delivered by multiple parts of the integrated care system. Within the framework, individuals within the **virtual ward** are referred to as 'patients', as this is a safe and appropriate alternative to receiving care within a hospital setting.

Structure of the framework

The framework contains 11 core capabilities common to the delivery of high quality, personalised care in the virtual ward and within urgent community response services; 4 capabilities specific to the delivery of care within urgent community response services; and 4 capabilities which relate specifically to the delivery of care within the virtual ward. The capabilities are numbered for ease of reference. This does not indicate a prescribed pathway, process, or hierarchy.

The capabilities described within the framework are defined at 3 tiers; this does not align to staff grading.

The framework is incremental, in that tier 2 and tier 3 assume that people possess the knowledge and skills at preceding tiers, thus reducing the need for repetition.

The capabilities are written to enable employers and others to contextualise the capabilities appropriately to suit the environment in which their services operate and the job roles they use. It is for employers with their employees to agree a scope of practice and a job plan. To help with the utilisation of the framework, indicative roles have been identified which sit alongside each tier of practice; however, this is for guidance/reference only.

It is important to note that all members of the workforce must be aware of their own capabilities and should escalate/refer appropriately to ensure the safety of individuals.

The context in which the workforce operates will vary; therefore, it is not possible for this framework to prescribe/mandate the levels of supervision for each tier of practice. In all eventualities **the safety and wellbeing of individuals must be paramount.**

Further explanation of the 3 tiers is presented in the table on the page below.

Tier	Tier descriptor	Indicative roles
Tier 1	All staff who work in the virtual ward and urgent community response teams. This tier will be relevant to health and social care staff in a variety of roles.	• Administrator (health and social care) • Healthcare support worker • Social care worker • Nurse • Allied health professional • Doctor • Clinical lead
Tier 2	This tier is particularly relevant to independent and autonomous practitioners. Staff in this tier will provide direct care and services to patients, make decisions relating to patient care, work within their scope of practice and take accountability for the care and services they provide. They may need to seek support from others where more complex decisions on care and management need to be made, beyond their scope of practice.	• Nurse • Allied health professional • Pharmacist • Social worker
Tier 3	This tier is most relevant to those staff with clinical and professional accountability and responsibility for the whole care of the patient, including escalations within the system. Staff working within this tier will be responsible for managing service, system risk and flow, as well as leading teams, and manging care and specialist services at the highest level.	• Advanced clinical practitioners (leading the system) • Senior clinician • Consultant

Return to contents page

Community health services virtual ward and urgent community response capabilities framework

'Core' capabilities

Capability 1. Communication and consultation skills			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Communicate clearly and coherently, taking into account the needs of the patient.	x	x	x
b) Acknowledge and respond to communication promptly, actively listening to the personal views, beliefs and spiritual views of patients, their informed choices, and their individual goals.	x	x	x
c) Adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to the patient's communication and language needs, preferences, and abilities (including levels of spoken English and health literacy) and use accessible information.[1]	x	x	x
d) Introduce self using "hello my name is" or similar, and clearly explain the role and function of your service and obtain consent for any interventions.	x	x	x
e) Ensure that the environment is as conducive as possible to effective communication, evaluating and remedying situations, circumstances or places (during home visits, care home visits or in emergency situations) which make it difficult to communicate and have strategies in place to overcome these barriers.	x	x	x
f) Identify any communication barriers with individuals and take the appropriate action.	x	x	x

[1] Accessible Information Standard (2016) Making health and social care information accessible https://www.england.nhs.uk/ourwork/accessibleinfo/

g) Clarify points and check that you and others understand what is being communicated.	x	x	x
h) Establish lines of communication including use of technology which enables non face-to-face communication with individuals in other locations in times of need or emergency e.g., phone, video, email, remote or group consultation as appropriate, depending on the patient and carers' preferences and abilities.	x	x	x
i) Maintain confidentiality of information where appropriate to do so, adhering to confidentiality principles.	x	x	x
j) Reflect on communication strategies and skilfully adapt these to ensure they foster an environment of patient empowerment, including taking steps to ensure patients, families and carers are enabled to use technology.	x	x	x
k) Convey information and address issues in ways that avoid jargon and assumptions; respond appropriately to questions and concerns to promote understanding with verbal, written and digital information that is realistic, balanced and honest, and provide advice which can empower better-informed choices and foster higher quality shared decision-making *with* patients, their families and carers, rather than for them.	x	x	x

For further details on core communication and relationship building skills, see https://www.personalisedcareinstitute.org.uk/

Capability 2. Practising holistically to personalise care and promote wellbeing			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Explore and act upon day-to-day interactions with patients to encourage and facilitate positive changes in behaviour and action that seeks to prevent illness, promote supported self-care, health and recovery, including (but not limited to) good nutrition and fluid intake, smoking cessation, reducing alcohol intake and increasing exercise, that will have a positive impact on the health and wellbeing of people, communities and populations i.e., 'Making Every Contact Count'[2] and signpost additional resources.	x	x	x
b) Work collaboratively with the wider multi-disciplinary team to promote physical and mental wellbeing for all individuals as appropriate.	x	x	x
c) Advise on sources of relevant local or national self-help guidance, information and support including coaching.	x	x	x
d) Understand and be able to describe the factors affecting the health and wellbeing of a community (e.g., equity, income, education, environment).	x	x	x
e) Recognise and foster the importance of social networks and communities for the patient and where applicable their carers/families in managing long-term health conditions, such as working appropriately with social prescribers, link workers, health coaches, statutory and voluntary organisations, and support groups. Signpost to voluntary, community and social enterprise organisations and community resources as appropriate.	x	x	x

[2] https://www.makingeverycontactcount.co.uk/

f) Respond appropriately to the impact of psychosocial factors on the presenting problems or general health such as housing issues, work issues, family/carer issues, lack of support, social isolation and loneliness, and consider in the context of local social prescribing services.	x	x	x
g) Support patient self-care and self-management and work in such a way that is non-judgmental and respects the rights, privacy, and dignity of individuals, promoting choice and independence as applicable[3].	x	x	x
h) Enable and support individuals to assert their views, control their own lives and make informed choices about the services and care they receive. Awareness of and support to individuals in the management of Personal Health Budgets (PHB) and related supply of care and services.	x	x	x
i) Evaluate how a patient's preferences and experience, including their individual cultural and religious background, can offer insight into their priorities, wellbeing and managing their own care after discussions with the patient and their family/carers.	x	x	x
j) Develop and promote shared decision-making and shared management/personalised care/support plans with people, individualised to meet their needs and personal goals in partnership, where appropriate, with other health and social care providers and with family, carers, and voluntary organisations where applicable.		x	x
k) Understand the Mental Capacity Act.	x	x	x
l) Undertake an assessment of mental capacity, within scope of practice, or refer, as appropriate.		x	x
m) Evaluate the implications of lack of capacity, and apply in practice, the relevant legislation for informed consent and shared decision-making (e.g., mental capacity legislation).		x	x

[3] Self-management for long-term conditions: Patients' perspectives on the way ahead (2005) The King's Fund https://www.kingsfund.org.uk/publications/self-management-long-term-conditions

n) Use evidence-based strategies to enhance behaviour change through coaching techniques and other local strategies.		x	x
o) Collaborate with individuals, families and carers, organisations, and systems in developing, implementing and evaluating services for a healthy community, which could include (but is not limited to) safeguarding, health promotion and prevention.			x

Capability 3. Families and carers as partners in care			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Work with families and carers to ensure that patients receive the necessary care, keeping them updated, and consider how local professionals can work together to support this process.	x	x	x
b) Understand what support, services and resources are available for families and carers, including practical and emotional support services, and support them to access them.	x	x	x
c) Support families/carers to make well-timed decisions, which are in the best interests of their relative where appropriate, such as those who have impaired capacity or where a lasting power of attorney is in place.	x	x	x
d) Recognise the impact of the presenting problem on family and carers as well as on the patient, including any resulting stress, and the potential impact on carers of providing care at home.	x	x	x

Capability 4. Working with colleagues and in teams			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Work effectively and respectfully within and across multi-disciplinary health and social care teams and across organisations. Maintain a knowledge and understanding of the wider primary, community and secondary care, voluntary sector services and teams, and refer independently using professional judgement.	x	x	x
b) Advocate and utilise the expertise and contribution to patients' care of all allied health and social care professionals and work collaboratively within the multi-professional team to optimise assessment, diagnosis and integrated management and care for people.	x	x	x
c) Work within and across a complex systems environment of multi-specialty teams and different pathways, managing the complexity of transition from one team to another or membership of multiple teams and cross organisational and professional boundaries.		x	x
d) Be able to bring out the best in multi-professional teams with different skills, empowering the team to make decisions in accordance with their expertise.			x
e) Initiate effective multi-disciplinary team activity as a lead member and understand the importance of effective team and/or organisation dynamics. (This may include, but is not limited to, evidence-based practice with monitoring processes such as audit/quality improvement, significant event review, shared learning and continuous professional development).			x

Capability 5. Information gathering and interpretation			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Record all pertinent information gathered concisely and accurately for clinical management, and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance.	x	x	x
b) Undertake appropriate assessment and formulate an appropriate plan of care jointly with individuals, including psychosocial history to provide some context for patients' issues.		x	x
c) Explore and appraise people's ideas, concerns and expectations about their symptoms and condition, and whether these may act as a driver or form a barrier.		x	x
d) Understand and apply a range of consultation models appropriate to the clinical situation and appropriately across physical, mental, social and psychological presentations.		x	x
e) Synthesise information from the history taken, taking account of factors which may include the presenting complaint, existing complaints, past medical history, genetic predisposition, medications, allergies, risk factors and other determinants of health to establish differential diagnoses.		x	x
f) Incorporate information on the nature of the patient's needs, preferences, and priorities from various other appropriate sources, e.g., third parties, previous histories, and investigation.		x	x
g) Undertake systematic clinical examination of complex, incomplete, ambiguous, and conflicting information gathered from history-taking and/or examination, distilling and synthesising key factors from the appraisal, and identifying those elements that may need to be pursued further.		x	x

h) Deliver diagnosis and test/investigation results (including sad and difficult news) sensitively and appropriately in line with local or national guidance, using a range of media such as spoken word and diagrams to ensure the patient has understanding about what has been communicated.		x	x

Capability 6. Clinical examination and procedural skills			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Ensure the place of examination gives the patient privacy and respects their dignity (and comfort as far as practicable).	x	x	x
b) Recognise the need for a systematic approach to clinical examination, identify and interpret signs accurately, and facilitate access to an appropriate chaperone, where required.		x	x
c) Apply a range of physical assessment and cognitive clinical examination skills appropriately, systematically, and effectively, including for delirium and dementia, and escalate or refer as appropriate.		x	x
d) Undertake appropriate monitoring for the individual and clinical situation, recognising the deterioration of an individual's physical and mental health, and intervene, escalate, or refer as appropriate.	x	x	x

Capability 7. Making a clinical diagnosis and ongoing clinical risk management[4]			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Make a differential diagnosis in a structured way using a problem-solving methodology informed by an understanding of probability based on prevalence, incidence, and natural history of illness to aid decision-making.			x
b) Synthesise the expertise of multi-professional teams across organisations and professional boundaries to aid in diagnosis where needed.			x
c) Interpret findings and results using advanced diagnostics skills and undertake appropriate interventions, including urgent referral/escalation as in life threatening situations, or further investigation, treatment, or referral, considering clinician limitations and patients' wishes.			x
d) Monitor and review hypotheses in light of additional information and think flexibly around problems, generating functional problem lists and safe treatment plans, acknowledging patient autonomy.			x
e) Recognise limitations in evidence, data, and situation, and when taking mitigating actions to manage risk appropriately. Recognise and acknowledge the concept of prognostic uncertainty and, where that exists, consider this in discussions with patients, their families and/or carers when exploring options, and discuss treatment expectations and scenarios for preferred anticipatory management.			x

[4] Practitioners should have a knowledge and understanding of the 9 clinical conditions specified within the Community health services two-hour urgent community response standard guidance in meeting the requirements of Capability 7.

f) Arrange appropriate follow up that is safe and timely to monitor changes in the patient's condition in response to treatment and advice, recognising the indications for a changing clinical picture and the need for escalation or alternative treatment as appropriate.		x	x
g) Evaluate outcomes of care against existing standards and patient outcomes and manage/adjust plans appropriately in line with best available evidence.		x	x
h) Vary the management options responsively according to the circumstances, priorities, needs, preferences, and benefits for those involved, with an understanding of local service availability and relevant guidelines and resources, ensuring that risks are understood and the rationale for decisions clearly documented.		x	x
i) Safely prioritise problems in situations using shared agenda setting where the patient presents with multiple issues.		x	x
j) Undertake a comprehensive geriatric assessment (CGA) for people living with moderate or severe frailty.		x	x
k) Simultaneously manage acute and chronic problems, including for patients with multiple morbidities, and those who are living with frailty,[5] adopting an anticipatory care approach to both identify and manage current and future issues, including physical, emotional, mental, and psychosocial.		x	x
l) Manage interface with care provision which may be needed out of hours.		x	x

[5] Health Education England, NHS England and Skills for Health (2018), Frailty: A /Framework of Core Capabilities

Capability 8. Prescribing treatment and administering medication			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Adhere to own prescribing competency legal framework appropriate to role, scope of practice and training for prescribing or medication administration.	x	x	x
b) Facilitate a range of non-medicinal interventions, such as lifestyle changes and social prescribing.	x	x	x
c) Promote personalised shared decision-making to focus on medications that address the outcomes/needs that matter most to the patient and support adherence where appropriate, leading to concordance.		x	x
d) Critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental wellbeing and healthcare provision; working with pharmacy team members as appropriate and necessary.		x	x
e) Keep up-to-date and apply the principles of evidence-based practice, including clinical and cost-effectiveness and associated legal frameworks for prescribing. Follow Royal Pharmaceutical Framework guidelines (e.g., medicines optimisation).		x	x
f) Understand the importance and principles of individualising medication decisions, reducing problematic pharmacy and the positive impact of de-prescribing on overall health wellbeing and functioning (e.g., following STOPP/START principles) where risks of harm may outweigh benefit to the patient and/or where medications are no longer conferring overall benefit and/or may not be in line with the preferred priorities of the patient.		x	x
g) Advise patients on adherence to medicines, with expected benefits and limitations, and inform them impartially of the advantages and disadvantages in the context of other management options.		x	x

Guidance on medication review produced by the British Geriatric Society can be located here: https://www.bgs.org.uk/resources/6-cga-in-primary-care-settings-medication-review. Further competencies on prescribing produced by the Royal Pharmaceutical Society can be located here: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf?ver=2019-02-13-163215-030

Capability 9. Leadership, management, and organisation			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Be well organised with consideration for patients and colleagues, carrying out all aspects of work in a timely manner, demonstrating effective time management within the constraints of the service.	x	x	x
b) Respond positively when services are under pressure, acting in a responsible and considered way to ensure safe practice.	x	x	x
c) Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit).	x	x	x
d) Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working.	x	x	x
e) Actively seek and be positively responsive to feedback and involvement from patients, families, carers, communities, multi-disciplinary colleagues and across organisational and professional boundaries in the co-production of service improvements.	x	x	x
f) Be an advocate for patient engagement to inform service improvement.	x	x	x

g) Demonstrate receptiveness to challenge and preparedness to constructively challenge others across organisational and professional boundaries, escalating concerns that affect patients, families, carers, communities and colleagues' safety and wellbeing when necessary.	x	x	x
h) Undertake appropriate management duties for a team(s).	x	x	x
i) Demonstrate the impact of practice on service function and effectiveness, and quality (i.e., outcomes of care, experience, and safety).	x	x	x
j) Manage patient feedback, including compliments and complaints, acting on identified learning or improvements aligned to professional standards and applicable local policy.		x	x
k) Critically and strategically apply advanced clinical expertise across professional, service, organisational and professional boundaries, influencing clinical practice to enhance quality; focus on high value-based care to reduce unwarranted variation, and promote the sharing and adoption of best practice.			x
l) Demonstrate leadership, resilience, and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others.			x
m) Lead new practice and service redesign solutions with others in response to monitoring, feedback, evaluation, data analysis and workforce and service need, working across organisational and professional boundaries and broadening sphere of influence.			x
n) Lead actively on developing practice in response to changing population health need, engaging in horizon scanning for future developments and to add value (e.g., new treatments and changing social challenges).			x
o) Negotiate own and others' scope of practice within legal, ethical, professional, and organisational policies, governance, and procedures, with a focus on managing risk and upholding safety.			x

p) Lead on, and work, in partnership across other professions, services and organisational boundaries to plan how to put strategies for improving health and wellbeing into effect, to ensure own role is impactful and such impact can be measured.			x
q) Continually develop practice in response to changing population health need, engaging in horizon scanning for future developments (e.g., health inequalities, impacts of genomics, new treatments and changing social challenges).			x

Capability 10. Education and development			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Develop, review and update development plans in the light of performance.	x	x	x
b) Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities.	x	x	x
c) Actively seek to share best practice, knowledge, and skills with other members of the team.	x	x	x
d) Act as a role model by inspiring, empowering and enabling others as well as through own positive behaviours.	x	x	x
e) Identify any gaps between the current and future requirements of practice.	x	x	x
f) Be able to support practice development by acting as a mentor and/or clinical assessor as appropriate.		x	x
g) Facilitate collaboration of the wider team and support peer review processes to identify individual and team learning, and support them to adopt this.		x	x

h) Enable the wider team to build capacity and capability through work-based and inter-professional learning, and the application of learning to practice; creating and facilitating a positive learning environment.			x

Capability 11. Research and evidence-based practice			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Maintain awareness of and work to local, regional, and national policies, procedures and best practice.	x	x	x
b) Utilise the findings of research and/or guidelines to inform own practice.	x	x	x
c) Be able to understand research findings and apply that knowledge in work to improve care; utilising evidence-based practice.		x	x
d) Disseminate best practice research findings and quality improvement projects through appropriate media and fora (e.g., presentations and peer review research publications).			x
e) Critically engage in research/quality improvement activity, adhering to good, ethical research practice guidance, so that evidence-based strategies are developed and applied to enhance quality, safety, productivity and value for money.			x
f) Evaluate and audit own and others' clinical practice, selecting and applying valid, reliable methods; then act on the findings by critically appraising and synthesising the outcome and using the results to underpin own practice and to inform that of others.			x
g) Take a critical approach to identify gaps in the evidence base and its application to practice, alerting appropriate individuals and organisations to these and how they might be addressed in a			x

safe and pragmatic way. This may involve acting as an educator, leader, innovator and contributor to research activity and/or seeking out and applying for research funding.			
h) Lead on quality improvement initiatives/projects – sharing outcomes and leading change.		x	x
i) Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review to monitor and review community services.			x
j) Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical, and other active researchers.			x

Urgent community response 'specific' capabilities

Capability 1. Dealing with referrals and ensuring assessment			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Understand relevant patient pathways and implement relevant procedures and protocols for contacting service users, practitioners, carers, and agencies.	x	x	x
b) Promote the urgent community response service, advocating its benefits and the positive impact it has for individuals, carers, and populations.	x	x	x
c) Recognise the risk and acuity involved with each referral and manage appropriately.		x	x
d) Determine the suitability of the service user to access the urgent community response service, enabling access to those who meet the criteria for acceptance, and signposting the referrer to alternative options for those who do not, ensuring optimal outcomes for individuals.		x	x
e) Determine the priority of the needs of the service user from the referral information provided by the referrer and confirmation of the need for assessment.		x	x
f) Identify the practitioners, services, equipment, and other resources and benefits available to help.		x	x
g) Identify and agree what type of referral action should be taken.		x	x
h) Establish any specific requirements to achieve effective assessment of the health and wellbeing needs of the service user.		x	x
i) Establish and confirm the roles and responsibilities of the practitioners who will be involved in the holistic assessment.		x	x

j) Agree with members of the inter-disciplinary team how to co-ordinate assessments to make best use of practitioners' time and expertise, and take account of any interrelationships between various aspects of the assessment.		x	x
k) Ensure arrangements for the assessments are consistent with the priority of the service user and specific requirements.		x	x
l) Agree the methods and timing for reviewing the outcomes and reports of the assessment with the service user, those involved in their care and the inter-disciplinary team.		x	x

Capability 2. Prioritising care and outcomes			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Focus on the expressed personalised goals, priorities, well-informed choices, and the outcomes that matter most to the service user.	x	x	x
b) Respect and empower personal autonomy and informed choices.	x	x	x
c) Discuss as necessary assessment results with the service user, families, and members of the inter-disciplinary team to: • agree the outcomes (having discussed them previously with the service user and embracing their personalised chosen goals) • identify any risks to the service user • identify potential actions • document plan and any risk mitigation.		x	x

d) Discuss, share, and explore the outcomes of the assessment with the service user, as well as family/carers in a way that empowers them to make well-informed choices for their management.		x	x
e) Explore the possible options for actions that could be taken and provide the service user, family/carer with a rationale for them, to empower their well-informed preferences on which action they would choose what they may feel is best for them.		x	x
f) Agree the actions to be taken with the service user based on the results of assessments/ investigations and other relevant factors (including their personalised goals, preferences, and priorities).		x	x
g) Produce referrals to other practitioners that contain all the necessary information and are presented clearly and logically, taking into account: • the priority status of each service user being directed towards further assessment, treatment, and care, based on available details • the availability of the appropriate service providing the required further assessment, treatment, and care.		x	x
h) Be alert to any changes in the needs of the service user, or the availability of the required service, and reprioritise people as appropriate to ensure optimum service delivery.		x	x
i) Ensure that the needs of the service user who requires further assessment, treatment, and care from one or more health and care providers have been taken into account, arranging further service provision in an appropriate and logical sequence.		x	x

Capability 3. Enabling care and/or therapy interventions			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Identify any risks to the delivery of the care plan, including any tensions or conflicts between practitioners or organisations, and develop strategies to manage these.	x	x	x
b) Recognise the timeliness of interventions and the need for ongoing monitoring, and respond accordingly.	x	x	x
c) Understand the benefits of digital tools that aid in the monitoring of care and safely deploy such tools in the environment of the service user.	x	x	x
d) Identify and evaluate any deterioration in the condition of the service user and take appropriate action or report to others where appropriate.	x	x	x
e) React appropriately to restore or maintain health and physiological status when the outcomes from monitoring the service user, or reporting by them, show a deterioration in their condition, using appropriate interventions.	x	x	x
f) Evaluate the extent to which the care plan is meeting its agreed purpose and goals, in collaboration with the practitioners involved.		x	x
g) Agree modifications to the care plan with the service user and practitioners involved, taking the necessary action to implement these.		x	x
h) Agree the date and process for the next review of the care plan with the practitioners involved.		x	x

Capability 4. Transfer of care			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Communicate appropriately with other health and care providers during and following transfer of care regarding the progress of service user changes to the care plan; details of transfer from the pathway and relevant transfer to other required service(s), teams or support networks where applicable.	x	x	x
b) Provide post-transfer information and support to the service user and significant others before the transfer of care happens.	x	x	x
c) Identify the destination of the service user and assess the available resources in line with their needs.		x	x
d) Arrange any required follow up arrangements with the service user, including community services and out-patient appointments.		x	x

Virtual ward ‘specific’ capabilities

Capability 1. Referral			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Know and understand the admission (inclusion and exclusion) criteria and main referral routes into the virtual ward to adhere to the referral pathway, in accordance with the standard operating procedure (SOP) for the service.	x	x	x
b) Recognise the risk and acuity involved with each referral and manage appropriately.		x	x
c) Effectively co-ordinate care/service delivery into virtual ward pathways, in accordance with agreed response times for the service.	x	x	x
d) Respond appropriately to referrals from, including but not limited to, GPs, members of the multi-professional integrated care team, allied health professionals, hospital staff, community nurses, care homes, social care staff and pharmacists, and identify and agree the referral action to be taken, ensuring the patient and/or their family/carer is informed.		x	x
e) Conduct a holistic assessment, utilising clinical judgement and diagnostic reasoning, within scope of professional practice, to determine that the patient meets the admission criteria for the virtual ward.		x	x
f) Manage patient/family/carer expectations with respect to patients not being medically fit and back to baseline when referred/discharged to a virtual ward.		x	x

Capability 2. Assessment and personalised care/management planning			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Conduct remote triage of patients and undertake, in accordance with the SOP for the service, an initial screening to assess patient suitability for the virtual ward environment, including home access issues, KeySafe location, safety of home environment, impact on family and/or carer(s), cultural and/or language sensitivities.		x	x
b) Undertake clinical risk assessment in the absence of face-to-face review.		x	x
c) Explain the processes and procedures, including use of digital devices, to patients deemed suitable for admission to a virtual ward, and gain their consent for monitoring and/or treatment.		x	x
d) Develop a personalised management plan (including documented and agreed criteria for discharge) in partnership with the patient, their family and/or carer(s), to ensure full understanding of the requirements of being cared for in a virtual ward, and to enable the patient, their family and/or carer to make an informed decision about their ongoing care and treatment.		x	x
e) Discuss and agree a personalised discharge plan with the patient, their family and/or carer(s).		x	x
f) Discuss and agree a personalised escalation plan with the patient, their family and/or carer(s), ensuring that the plan contains key contacts, times, and telephone numbers.		x	x
g) Establish the patient's competence and willingness in engaging with remote monitoring. Give information and set expectations as to what is required by the patient or their carer.	x	x	x
h) Assess the patient's (or carer's) competence in monitoring their health status and uploading data, if there is a requirement for the use of remote monitoring devices.		x	x
i) Recognise any family and/or carer stress and increased burden associated with the provision of acute care at home and manage appropriately.		x	x

j) Understand the potential inequality impacts on patients with differing levels of digital literacy and access to technology.		x	x
k) Facilitate the provision of support for the patient, their family and/or carer to use technology whilst receiving care from the virtual ward e.g., wearables, pulse oximeters, blood pressure monitors.	x	x	x

Capability 3. Technology enabled monitoring			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Ensure chosen monitoring technology is appropriately aligned to the situation/care pathway and to the priorities of the patient, their personalised goals, and choices – including comfort and wellbeing monitoring, where applicable.		x	x
b) Discuss and agree monitoring arrangements with the patient, including ensuring timely delivery of appropriate monitoring equipment. The importance of timely submission of data for those patients that are not being continuously monitored should be discussed and agreed.	x	x	x
c) Ensure the patient is aware of monitoring parameters and when to seek help, as per SOPs, understands how, and, is able to self-monitor their condition using the device(s) provided in line with the agreed monitoring plan, with appropriate support if required.	x	x	x
d) Provide the patient with written information which specifies support/contact details of where to seek technical support whilst receiving care on the virtual ward.	x	x	x
e) Effectively utilise specialist software (i.e., a clinical dashboard) to report results in a timely manner to the clinical team.		x	x

f) Enable effective communication approaches in non face-to-face situations e.g., remote consultation, either via phone or video conferencing.		x	x
g) Utilise video conferencing, as and when deemed a safe and appropriate method of assessment, to conduct a visual assessment of the patient and their general condition.		x	x
h) Undertake a 'virtual visit,' utilising telephone monitoring to gain current health status of the patient, arrange a home visit if required, ensuring the appropriately skilled practitioner attends to carry out required interventions.		x	x
i) Identify and evaluate any deterioration in a patient's condition and take appropriate action, or escalate to others where appropriate, adhering to established escalation pathway.		x	x
j) Understand local processes to access technology support if errors/connectivity issues occur with devices in and out of hours.		x	x

Capability 4. Leadership			
The practitioner must:	**Tier 1**	**Tier 2**	**Tier 3**
a) Be able to effectively manage teams remotely.		x	x
b) Establish and maintain a safe remote team environment in which team members can access opportunities to discuss concerns about patients and are encouraged to support and challenge.			x
c) Work with the differing skills within multi-disciplinary teams and empower members of the team to make independent decisions in accordance with their scope of practice, knowledge, skills, and expertise.		x	x

d) Understand data reporting and contribute to the evaluation required to support local organisation, integrated care system, regional/national virtual monitoring, and policy development.			x
e) Understand information governance and legal safeguards for sharing patient data together with their proportionate application.	x	x	x
f) Be able to capture patient feedback and outcomes and apply quality improvement (QI) methods to iterate, learn from and scale up, and/or develop an existing or new virtual ward.		x	x
g) Be able to grow and nurture the development of a newly emerging patient-centred virtual ward, through innovation, change management and systems thinking.			x
h) Support the workforce with the implementation of new ways of working and changes to delivery of clinical care.			x

Return to contents page

Appendix 1. How the framework was developed

Development of the framework was guided by a project expert reference group representing key stakeholders, including virtual ward and urgent community response practitioners, clinicians, and professional bodies.

A wider stakeholder list was also established to include a more diverse range of organisations and individuals that wished to be updated on the development of the framework, and to provide comments or feedback as part of the consultation process. Individuals were able to register their interest on a project web page.

Initial desk research was undertaken to identify key references, resources and significant themes or issues for consideration – further references and resources continued to be identified during the project (see Appendix 3. Bibliography and Appendix 4. Clinical skills).

Initial iterations of the framework were developed based on the findings of the desk research and consultation with the project steering group. In June, a wider online consultation survey was conducted with a total of 214 respondents. Based on analysis of these survey outcomes, further amendments and refinements were undertaken, leading to a final meeting of the project expert reference group on 27 July 2022.

Return to contents page

Appendix 2. Acknowledgements

This capabilities framework was commissioned by the Community Transformation Workforce team, NHS England.

The project expert reference group was co-chaired by Dr Esther Clift, Consultant Practitioner, Frailty and Geraldine Rodgers, Director of Nursing for Leadership & Quality, Nurse Fellow for Older People. Project management was provided by Rosemarie Simpson, Andrew Lovegrove and Dawn Probert (Senior Consultants at Skills for Health).

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Return to contents page

Appendix 4. Core clinical skills

Below is a range of core clinical skills that healthcare staff could be expected to be familiar with in the context of the capabilities contained within this framework.

The application of the core clinical skills **will be determined by the scope of the role** of the individual member of staff and the context in which they operate, and would form part of their job plan, as agreed between them and their employer.

The core clinical skills have been aligned to a suite of appropriate national occupational standards (NOS), which are statements of the standards of performance for individuals when carrying out functions in the workplace, together with specifications of the underpinning knowledge and understanding. NOS are developed for employers by employers through the relevant sector skills council or standards setting organisation. For more information on NOS please see here: https://www.skillsforhealth.org.uk/info-hub/national-occupational-standards-overview/

Whilst this list is not intended to be exhaustive or exclusive, the NOS are aligned to the national 2-hour operational and clinical guidance (NHS England, 2021) and support the delivery of the 9 clinical conditions which are expected for all UCR services.

The 9 conditions are:

- Falls
- Decompensation of frailty
- Reduced function/deconditioning/reduced mobility
- Palliative/end-of-life crisis support
- Urgent equipment provision to support a person experiencing a crisis/at risk of hospital admission
- Confusion/delirium
- Urgent catheter care
- Urgent support for diabetes
- Unpaid carer breakdown which, if not resolved, will result in a healthcare crisis for the person they care for.

NOS title and weblink

Respond to referrals of individuals with health conditions	https://files.ukstandards.org.uk/pdfs/SFHCHS59.pdf
Plan inter-disciplinary assessment of the health and wellbeing of individuals	https://files.ukstandards.org.uk/pdfs/SFHCHS52.pdf
Investigate and diagnose an individual presenting for emergency assistance as the result of a fall	https://files.ukstandards.org.uk/pdfs/SFHEC11J.pdf
Lead the implementation of inter-agency services for addressing health and wellbeing needs	https://files.ukstandards.org.uk/pdfs/SFHGEN125.pdf
Assess an individual's health status	https://files.ukstandards.org.uk/pdfs/SFHCHS39.pdf

Obtain case history	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS168/obtain-case-history
Interpret the findings of healthcare investigations	https://files.ukstandards.org.uk/pdfs/SFHCHS83.pdf
Establish a diagnosis of an individual's health condition	https://files.ukstandards.org.uk/pdfs/SFHCHS40.pdf
Establish an individual's functional capabilities in the context of an emergency presentation	https://files.ukstandards.org.uk/pdfs/SFHEC10.pdf
Establish an individual's functional capabilities in the context of long-term conditions clinical management	https://files.ukstandards.org.uk/pdfs/SFHCMA2.pdf
Agree courses of action following assessment to address health and wellbeing needs of individuals	https://files.ukstandards.org.uk/pdfs/SFHCHS45.pdf
Determine a treatment plan for an individual	https://files.ukstandards.org.uk/pdfs/SFHCHS41.pdf
Prioritise individuals for further assessment, treatment, and care	https://files.ukstandards.org.uk/pdfs/SFHEUSC07.pdf
Refer individuals to specialist sources of assistance in meeting their healthcare needs	https://files.ukstandards.org.uk/pdfs/SFHCHS99.pdf
Prioritise individuals for treatment and care	https://files.ukstandards.org.uk/pdfs/SFHTEL1.pdf
Manage a patient caseload which achieves the best possible outcomes for the individual	https://files.ukstandards.org.uk/pdfs/SFHCMI1.pdf
Develop and sustain working relationships with colleagues and stakeholders	https://www.ukstandards.org.uk/en/nos-finder/CLDAL16/develop-and-sustain-working-relationships-with-colleagues-and-stakeholders-
Co-ordinate, monitor and review service responses to meet individuals' needs and circumstances	https://files.ukstandards.org.uk/pdfs/SFHCHS231.pdf
Provide information and support to carers of individuals with long-term conditions	https://files.ukstandards.org.uk/pdfs/SFHCHS58.pdf
Enable carers to support individuals	https://www.ukstandards.org.uk/en/nos-finder/SFHGEN20L/enable-carers-to-support-individuals-legacy
Implement a treatment plan	https://files.ukstandards.org.uk/pdfs/SFHCHS225.pdf
Monitor and assess patients following treatments	https://files.ukstandards.org.uk/pdfs/SFHCHS47.pdf
Support individuals at the end of life	https://files.ukstandards.org.uk/pdfs/SCDHSC0385.pdf

Evaluate the delivery of care plans to meet the needs of individuals	https://files.ukstandards.org.uk/pdfs/SFHCHS53.pdf

Provide intermediate life support	https://files.ukstandards.org.uk/pdfs/SFHEC17.pdf
Support people with mental health needs in crisis situations	https://files.ukstandards.org.uk/pdfs/SFHMH21.pdf
Obtain and test capillary blood samples	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS131/obtain-and-test-capillary-blood-samples
Obtain venous blood samples	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS132/obtain-venous-blood-samples
Undertake routine clinical measurements	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS19/undertake-routine-clinical-measurements
Set up equipment to monitor physiological function	https://files.ukstandards.org.uk/pdfs/SFHCHS224.pdf
Insert and secure urethral catheters	https://files.ukstandards.org.uk/pdfs/SFHCC02.pdf
Care for individuals with urethral catheters	https://files.ukstandards.org.uk/pdfs/SFHCC03.pdf
Undertake personal hygiene for individuals who require additional support to care for themselves	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS11/undertake-personal-hygiene-for-individuals-who-require-additional-support-to-care-for-themselves
Support individuals to manage continence	https://www.ukstandards.org.uk/en/nos-finder/HSCCLD211/support-individuals-to-manage-continence
Undertake treatments and dressings related to the care of lesions and wounds	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS12/undertake-treatments-and-dressings-related-to-the-care-of-lesions-and-wounds
Assess the healthcare needs of individuals with diabetes and agree care plans	https://files.ukstandards.org.uk/pdfs/SFHDiabHA1.pdf
Help an individual using insulin therapy to manage their diabetes; understand the effects of food, drink, physical activity and medication on their health and wellbeing	https://files.ukstandards.org.uk/pdfs/SFHDiabTX03.pdf
Help an individual understand the effects of food, drink and exercise on their diabetes	https://files.ukstandards.org.uk/pdfs/SFHDiabHA5.pdf
Manage pain relief for an individual	https://files.ukstandards.org.uk/pdfs/SFHCHS164.pdf

Carry out extended feeding techniques to ensure individuals nutritional and fluid intake	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS17/carry-out-extended-feeding-techniques-to-ensure-individuals-nutritional-and-fluid-intake
Perform routine electrocardiograph (ECG)	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS130/perform-routine-electrocardiograph-(ecg)-procedures
Perform intravenous cannulation	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS22/perform-intravenous-cannulation
Carry out intravenous infusion	https://files.ukstandards.org.uk/pdfs/SFHCHS23.pdf

Administer medication to individuals	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS3/administer-medication-to-individuals
Support individuals to take their medication as prescribed	https://files.ukstandards.org.uk/pdfs/SFHGEN135.pdf
Deliver subcutaneous treatments using syringe drivers or infusion devices	https://files.ukstandards.org.uk/pdfs/SFHCHS49.pdf
Assess bladder and bowel dysfunction	https://files.ukstandards.org.uk/pdfs/SFHCC01.pdf
Undertake tissue viability risk assessment for individuals	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS4/undertake-tissue-viability-risk-assessment-for-individuals
Undertake agreed pressure area care	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS5/undertake-agreed-pressure-area-care
Fit healthcare equipment, device, product and/or system to meet clinical and individual needs	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS223/fit-healthcare-equipment%2C-device%2C-product-and-or-system-to-meet-clinical-and-individual-needs
Select assistive devices or assistive technology to meet an individual's needs	https://files.ukstandards.org.uk/pdfs/SFHCHS140.pdf
Enable individuals to use assistive devices and assistive technology	https://www.ukstandards.org.uk/en/nos-finder/SFHCHS239/enable-individuals-to-use-assistive-devices-and-assistive-technology
Implement interventions with older people at risk of falls	https://files.ukstandards.org.uk/pdfs/SFHOPF5.pdf
Implement programmes and treatments with individuals who have restricted movement/mobility	https://files.ukstandards.org.uk/pdfs/SFHCHS135.pdf

Prepare a discharge plan with individuals	https://files.ukstandards.org.uk/pdfs/SFHCHS122.pdf
Work with others to facilitate the transfer of individuals between agencies and services	https://files.ukstandards.org.uk/pdfs/SFHGEN123.pdf
Discharge and transfer individuals from a service or your care	https://files.ukstandards.org.uk/pdfs/SFHGEN28.pdf
Support individuals to access and use services and facilities	https://www.ukstandards.org.uk/en/nos-finder?Title=Support+individuals+to+access+and+use+services+and+facilities&dateFrom=&dateTo=&suite=&occupation=&soccode=&developedby=&validity=&noscategory=&sortOrder=DateApprovedDescending
Work in partnership with carers to support individuals	https://files.ukstandards.org.uk/pdfs/SCDHSC0387.pdf
Provide advice and information to individuals on how to manage their own condition	https://www.ukstandards.org.uk/en/nos-finder/SFHGEN14/provide-advice-and-information-to-individuals-on-how-to-manage-their-own-condition

Below are links to further resources:

Health Education England e-learning programme for virtual wards, relevant to staff at all Tiers
https://www.e-lfh.org.uk/programmes/virtual-wards-enabled-by-technology/

Personalised Care Institute
https://learn.personalisedcareinstitute.org.uk/login/index.php

Royal College of Nursing subject guides
https://www.rcn.org.uk/library/Subject-Guides/pain

- https://www.rcn.org.uk/clinical-topics/bladder-and-bowel-care/RCN-Bladder-and-Bowel-Learning-Resource#introduction
- https://www.rcn.org.uk/library/Subject-Guides/end-of-life-care
- https://www.rcn.org.uk/Professional-Development/Principles-of-nursing-practice
- https://www.rcn.org.uk/clinical-topics/Older-people

The Hearing Aid Podcasts
http://thehearingaidpodcasts.org.uk/

Wessex Academic Health Science Network
Urgent Community Frailty Response Service Toolkit

Return to contents page

Appendix 5. Implementation support

The following information is provided to help further people's understanding of the utility of the framework and how to get the most out of it.

Implementation support – staff, people, and teams

This framework will support staff, people, and teams by:

- Setting out clear expectations of each level of practice.
- Supporting appraisal.
- Supporting staff to identify their development needs.
- Supporting the development of teams.

The framework sets out clear expectations for staff about the requirements for effective and safe practice. It provides clarity about requirements at each level of practice.

Staff can use this framework to better understand their and the wider workforce's development needs. It can help them understand how to maximise the contribution of the existing workforce, identify opportunities for new ways of working and, where appropriate, identify the need for new roles.

This framework can be used to review and recognise how existing capabilities are individually and collectively being used across a team and/or area of care.

The framework can be used as the basis to conduct formal or informal appraisal and training needs analysis, comparing current capabilities with those identified in the framework. This framework can also be used to support career progression and development in a challenging environment and engagement in continuing professional development.

Staff using this framework need to collaborate with their employers to:

- Identify where their existing job sits on the core capabilities framework.
- As part of the performance review/appraisal process identify and evidence their capability.
- Identify gaps in capability.
- Agree a programme of development to address any 'gaps' and/or to identify career development opportunities.

This framework will assist staff in the development of a portfolio of evidence of capability and can be used to support revalidation requirements.

Implementation support – employers

The framework will:

- Enable employers to demonstrate that staff meet the required capabilities.
- Demonstrate there are development plans in place to ensure that they are proactively working to achieve those capabilities.
- Ensure learning and development can be targeted and focused on the needs of the service and the workforce.

The framework underpins the continuing professional development of staff to ensure their practice remains up to date, safe and effective, and it supports the process of quality assurance to ensure the safety and effectiveness of their role.

The framework enables employers to consider objectively how their current workforce's performance aligns to the capabilities and ensure any workforce development is based on service need/outcomes.

Employers would need to undertake the following for each of their existing jobs in their setting:

- Identify which jobs align to which tier of the framework.
- Use the capabilities as the basis for individual performance management e.g., supervision/review/appraisals etc.
- Use any capability 'gaps' as the basis for continuing professional development.
- Use the evidence gathered in performance reviews/appraisals etc. as the basis for a training needs analysis to inform the allocation of training resources.

This framework also provides potential benchmarking of service provision at an organisational level and for employers to identify appropriate/further development.

Implementation support – education

The framework will enable education and learning providers to inform the design and delivery of appropriate education, training, and development programmes, including identifying learning outcomes.

This will ensure that learning and development provision contributes to the full range of knowledge to support the capabilities required to make individuals safe and effective members of the workforce.

The framework will inform those who design and deliver training and development opportunities to focus on the key capabilities that learners need to achieve and maintain. This in turn will guide the content to be included and the use of appropriate learning and teaching strategies.

Use of this framework also supports organisational and system-wide effectiveness and efficiencies by encouraging the delivery of education and training that is focused on developing core capabilities, and optimises opportunities for inter-professional learning; focused on outcomes-based curricula which equip individuals with the attributes required to meet the needs of the population.

In so doing, it aims to increase consistency in knowledge and skills development, prevent unnecessary duplication in education and training delivery, and strengthen skill mix and teamworking.

Education and learning providers would need to work in partnership with employers to:

- Ensure learning outcomes are aligned to identified capabilities within the framework.
- Ensure learning outcomes are measurable and objective to ensure learners can demonstrate identified capabilities.
- Promote learning as a means of enabling a culture of multi-professional working that is focused on meeting the outcomes of patients, citizens, and the wider population.

Return to contents page