NHS England

The Centre for Advancing Practice

Advanced Practice Community Rehabilitation Physical Activity for People with Long-term Conditions Capably Framework

Endorsed 2022

Publication reference:

Endorsement by NHS England's Centre for Advancing Practice

This framework has met the Centre for Advancing Practice's criteria for endorsement as a multi-professional capability and curriculum framework and is ready for delivery.

It will be kept under regular periodic review to ensure that it remains current and responsive to changing population, patient, service delivery and workforce needs.

Further information on the Centre's approach to area specific capabilities is available here: https://advanced-practice.hee.nhs.uk/

Note:

Minor edits to this document have been made to reflect changes in links.

This document has been rebranded in line with NHS England branding guidelines.

Minor amendment in language from Credential to area specific capability.

No other changes to this document have been made.

Contents

Introduction

Developing and retaining the advanced practice workforce is a strategic priority for the NHS. The NHS Long-Term Plan recognises the potential contribution of advanced a practitioners to meeting short-term and long-term workforce demands, while the NHS People Plan is heavily supportive of scaling up and delivering new roles and models of advanced level practice. NHS England (formally Health Education England) is leading this agenda by working collaboratively across the health and care system to develop safe and effective advanced practice capability and capacity, including in support of new models of care.

Area specific capabilities are designed to be delivered as an integral part of Centre-accredited advanced practice master's degrees, as well as for practitioners to take up once they have gained an advanced practice master's degree (where this will usefully build on their prior advanced practice learning and fits with workforce development and service delivery needs).

Area specific capabilities specifications articulate the advanced practice capabilities required for the current and future workforce to deliver safe and effective services within particular areas of practice. By strengthening opportunities for career development in clinical roles, they should also support the retention of highly valued and skilled staff and facilitate workforce transformation, all with a focus on achieving public and patient benefit.

Current information on the Centre for Advancing Practice and its approach to Area specific capabilities can be found at the following: Advanced Practice (hee.nhs.uk).

Community rehabilitation: physical activity for people with long-term conditions

Intended level of learning

Level 7

Aim

This area specific capability describes the advanced practice capabilities required to transform rehabilitation for people living with long-term conditions (LTCs). It includes a population health management approach, building on local community assets and leading a wider rehabilitation workforce to offer an integrated and sustainable model. It also describes the capabilities required to deliver personalised holistic rehabilitation, taking a bio-psychosocial approach that builds on a critical understanding of behaviour change and psychological therapies.

It sets out advanced-level practice that involves exercising a high degree of autonomy, and complex decision-making and that is underpinned by level 7 (Master's level) learning.

Pre-requisites

To meet the demands of this area specific capability framework, practitioners need to hold current registration with their professional UK regulatory body, as required for the practice of their profession.

Practitioners also need to have a current scope of practice and role and to work in a practice environment that enables them to engage with the full demands of the area specific capability framework. This includes through their having access to the workplace-based supervision, learning and assessment arrangements set out in this document and being supported to engage with the full requirements of advanced practice (across the four pillars), as set out in the Multi-professional framework for advanced practice in England (2017).

Co-requisites

This area specific capability framework should be undertaken by practitioners either as an integral part of undertaking a full advanced practice MSc programme or following their successful completion of such a programme (or demonstration of the educational equivalence of this via the Centre for Advancing Practice's ePortfolio (supported) route).

This integrated or sequential approach ensures that practitioners fully meet the capabilities set out in the Multi-professional framework for advanced practice in England (2017) across the four pillars of practice: clinical, education, leadership and management and research.

Intended volume of learning

This area specific capability framework has a notional volume of learning of circa 350 hours. For practitioners who have already completed an advanced practice MSc degree, it should

normally take up to 12 months to complete, based on their being full-time employees and their learning being integrated into their usual pattern of work.

For practitioners who undertake the area specific capability framework as an integral part of working towards advanced level practice, it will form a component part of an advanced practice MSc programme. This will take two to three years, based on practitioners being full-time employees and their learning being integrated into their usual pattern of work.

For practitioners who have undertaken relevant prior learning that has currency and enables them to demonstrate fulfilment of some of the capabilities (in line with providers' academic regulations), there should be appropriate flexibility for them to complete the area specific capability framework within a reduced timeframe.

Key learning outcomes

On successful completion of the area specific capability framework, practitioners should have demonstrated that they can do the following in community rehabilitation (physical activity for people with long-term conditions):

1. Critically appraise a range of communication and consultation skills that enable a personalised holistic approach to community rehabilitation, recognising the absolute imperative to enable people with long-term conditions to feel empowered in the decision-making process and to make positive behaviour changes.
2. Evaluate optimal approaches to effective multi-disciplinary team-working, including the wider rehabilitation workforce, and apply such approaches to enable best practice in the context of changing roles, new models of care and integrated care pathways.
3. Critically appraise the impact of interventions within their own practice, and that of the wider team, on the wider determinants of health and health equality for individuals and populations.
4. Critically apply the knowledge and skills required to lead assessment, screening and stratification to ensure individuals' engagement in the appropriate rehabilitation intervention and to facilitate a self-management approach.
5. Critically apply their knowledge and skills to lead, evaluate and modify a rehabilitation programme that combines physical activities, opportunities for behaviour change, lifestyle education, environmental and activity adaptation, including in terms of managing high levels of risk, uncertainty and complexity and informed by a critical engagement and interpretation of available evidence and data.

Scope of this area specific capability framework specification

The population targeted by the capabilities described in this area specific capability framework are living longer but not necessarily well. More people in middle age (estimates between 15% and 30% of the UK population) are living with more than two long-term conditions. Research findings identify that low levels of physical activity and higher levels of sedentary behaviour are also much more common in people with long-term conditions.[1]

This area specific capability framework describes the leadership capabilities required to transform rehabilitation for this population, taking a population health management approach, building on local community assets, and leading a wider rehabilitation workforce to offer an integrated and sustainable model of care. The area specific capability framework also describes the capabilities required to deliver personalised holistic rehabilitation, taking a bio-psycho-social approach that builds on an advanced practice understanding of behaviour change and psychological therapies.

The approach outlined in this area specific capability framework is not intended to replace condition- specific rehabilitation. However, there are three components of rehabilitation that are applicable to almost all long-term conditions: physical activity, psychosocial support and personalised education.[6] In addition, this approach to working with people with long-term conditions focuses on building individuals' knowledge, understanding and confidence to live well with a long-term condition(s) and to be hopeful for the future, while also taking a proactive approach to secondary prevention, with a view to stopping or slowing the progression of poor health to complexity, frailty and disability.

The area specific capability framework has been developed with input from a diverse expert steering group, with members drawn from across the health, leisure and fitness sector and including people with lived experience.

The capabilities set out in this area specific capability framework comprise the following:

- Capabilities that are specific to advanced practice in progressing community physical activity approaches for people living with long-term conditions.
- More generic capabilities that are relevant to all primary and community care-based advanced practice, including for progressing community physical activity for people with long-term conditions.

It is the combination of the area-specific and generic capabilities that is key to safe and effective advanced practice in community rehabilitation for physical activity for people with long-term conditions. For clarity, the area-specific and generic capabilities are presented in tables in thematic clusters under shared thematic headings.

[1] Vancampfort D, Stubbs B, Ai K (2017) *Physical chronic conditions, multimorbidity and sedentary behaviour amongst middle-aged and older adults in six low- and middle-income countries.* International Journal of Behavioural Nutrition & Physical Activity. 2017;14:1-13. URL https://ijbnpa.biomedcentral.com/articles/10.1186/s12966-017-0602-z

The generic capabilities should be developed and assessed through their integration with the area-specific capabilities. They should therefore form a common thread through practitioners' development of the area-specific capabilities, rather than the generic and area-specific capabilities being addressed separately.

The capabilities in this framework are also mapped to the capabilities set out in the Multi-professional framework for advanced practice in England (2017) This is indicated in the righthand column of the capability tables.

Capabilities

1. Personalised and collaborative working - including preventative & population health

Area-specific capabilities (ASC)	MPF (2017)
ASC 1.1 Personalised and collaborative working 1. Create the opportunity for people with complex health needs to explore, reflect and engage with a way forward, sharing and checking understanding of the scale of health change possible and the full range of options available. 2. Support people with complex health needs to engage and explore personal goals, the consequences of their actions and inactions on these goals, and their health status and independence relevant to their condition(s). 3. Demonstrate a critical understanding of the use of tools, techniques and strategies to enhance the understanding of health-related information when communicating with people, including those with lower levels of health or digital health literacy and those with specific health or cultural needs (e.g. disability, illness, language, diet or other factors). 4. Demonstrate a comprehensive understanding of the role of evidence in shared decision-making and communicate and interpret evidence in a meaningful way to enable informed joint decisions about care management. 5. Critically analyse enablers and barriers to people's participation in physical activity taking account of the multiple dimensions of health, comorbidities, health literacy, activation, the role of family/carers and the social determinants of health. 6. Critically evaluate and apply an understanding of the relationship between health literacy, social determinants of health and health inequalities to enhance people's opportunities for physical activity. 7. Explore and appraise theories and application of behaviour change models, the social model of disability, and determinants of health, activity and environmental adaptation, including:	1.1, 1.2, 1.5, 1.8, 1.9, 1.10, 1.11 2.1, 2.2, 2.3 2.5, 2.6, 2.7, 2.9 3.3 4.2, 4.3

8. Motivational Interviewing. 9. Making Every Contact Count.[2] 10. Health coaching and supporting behaviour change. 11. Personalised care in all settings (including remote and virtual) and at all times. 12. Lead and advocate for the use of consistent language and terminology across health, social care and the fitness and leisure sector that is relevant and accessible to all. 13. Synthesise understanding of how working alongside local partners can encourage a local 'system' approach that can connect services and integrate support around people to help them attain their goals. 14. Appraise and enable the transformative links between community physical activity approaches and other disciplines, services and providers, including those relating to medicine, pharmacology, psychology and sociology, and approaches to social prescribing. 15. Evaluate the complex relationship between physical, social, cultural and economic environments; how to adapt and change environments and their impact on community physical activity approaches; and the need for population level analysis. 16. Demonstrate the ability to critically analyse, identify and utilise the health characteristics of the local population, including cultural, occupational, epidemiological, environmental, economic and social factors, including in support of those who experience health inequalities. 17. Synthesise understanding of longer-term conditions and complex patterns of social inequalities across groups and communities and build strong team engagement and understanding that is beneficial across the lifespan and across different populations. 18. Using population health data, proactively work with local partners (including fitness and leisure sector organisations) to offer a sustainable approach to long-term engagement in all forms of graded and adapted physical activity. 19. Instigate work with teams, people with lived experience, key stakeholders and communities (including fitness and leisure sector	

[2] Health Education England (undated) *Making Every Contact Count*. http://www.makingeverycontactcount.co.uk/

organisations) to build health literacy, activation and equity of access to care, education and support (including via virtual platforms). 20. Co-design services with people with lived experience and key stakeholders that are based on population health data and health needs assessment. 21. Role model leadership skills to improve services and performance using appropriate leadership theories, behavioural change approaches and service improvement methodology. 22. Lead and advocate for reasonable adjustments to meet individuals' needs in planning, developing and delivering services. 23. Actively engage a range of people with long-term conditions, their families, carers and networks in evaluating services, applying the principles of equality, diversity and anti-discriminatory practice and actively promoting advanced practice-related research projects. 24. Critically analyse and evaluate the impact of interventions within their own practice and that of the wider team on the health and wellbeing of the targeted populations, taking account of the cultural, occupational, epidemiological, environmental, economic, and social factors and those who experience health inequalities.	
Generic capabilities (GC)	MPF (2017)
GC 1.1 Communication and consultation skills 1. Critically appraise communication strategies and optimise communication approaches appropriately using skills such as active listening (e.g. frequent clarifying, paraphrasing and picking up verbal cues, such as pace, pauses and voice intonation). 2. Reflect on advanced communication strategies and skilfully adapt these to ensure communication strategies foster personal empowerment. 3. Autonomously adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to people's communication, cultural and language needs, preferences and abilities (including levels of spoken English and health literacy).	1.4, 1.5 2.2

4. Adapt communication approaches based on contextual demands, drawing on a broad range of approaches to broaden and deepen their influence on others. 5. Communicate in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate individuals' care. 6. Evaluate and modify situations, circumstances and places that make it difficult for individuals to communicate effectively and deploy appropriate strategies to overcome these barriers. 7. Communicate effectively with individuals who require additional assistance to ensure an effective interface with practitioners, including the use of accessible information. 8. Recognise when individuals and their families/carers may have competing agendas and facilitate shared agenda-setting using a triadic consultation approach. 9. Consult in a highly organised and structured way, with professional curiosity as required. 10. Enable effective communication approaches to non-face-to-face situational environments (e.g. phone, video, letters email or remote consultation). 11. Manage, enable and support individuals (including where applicable, carers and families) effectively, respectfully and professionally, especially when there are conflicting priorities and opinions. 12. Elicit psychosocial history/factors to provide some context for individuals' problems/situation. 13. Advocate for individuals and/or support individuals' empowerment when required.	
GC 1.2 Practising holistically to personalise care and promote population and person health 1. Actively explore and act upon day-to-day interactions with individuals to encourage and facilitate changes in behaviour such as smoking cessation, reducing alcohol intake and increasing activity that will have a positive impact on their own health and wellbeing, as well as	1.4, 1.7, 1.9, 1.10 2.5, 2.6, 2.9 3.3

communities and populations (e.g. Making Every Contact Count[3] and signpost additional resources). 2. Actively explore implement and evaluate approaches/strategies that positively influence health outcomes for individuals, populations and systems. 3. Critically appraise the impact that a range of social, economic, and environmental factors can have on health outcomes for individuals and, where applicable, their family and carers. 4. Recognise the wider determinants of health, including (but not limited to) the impact of psychosocial factors on individuals' presenting problems or general health, such as housing issues, work issues, poverty, discrimination, abuse, family/carer issues, lack of support, social isolation, and loneliness. 5. Actively engage individuals in shared and informed decision- making about their care and advanced planning by: 6. Supporting them to express their own ideas, concerns and expectations and encouraging them to ask questions. 7. Explaining in non-technical language all available options (including doing nothing). 8. Exploring with them the risks and benefits of available options, discussing the implications of each, how options relate to them as individuals and supporting their understanding as much as possible. 9. Supporting them to decide on their preferred way forward. 10. Supporting them to explore the consequences of their actions and inactions on their health status and the fulfilment of their personal health goals. 11. Supporting them to self-manage their care where at all possible and where appropriate. 12. Develop and promote shared management/personalised care/support plans with individuals to meet their specific needs, including, where appropriate, in partnership with other health and social care providers and with carers/family members and voluntary organisations, where applicable.	

[3] Health Education England (undated) *Making Every Contact Count*. http://www.makingeverycontactcount.co.uk/

13. Evaluate how individuals' preferences and experience, including their individual cultural and spiritual background, can offer insight into their priorities, wellbeing and managing their own care. 14. Evaluate how the vulnerabilities in some areas of individuals' lives might be overcome by promoting resilience in other areas. 15. Recognise and foster the importance of social networks and communities for people and, where applicable, their carers/families in managing long-term health conditions (e.g. linking with statutory and voluntary organisations and support groups). 16. Work collaboratively across agencies and boundaries both to improve individuals' health (and other) outcomes at a personal level and to improve health outcomes and reduce health inequalities at a population/system level. 17. Advise on and refer individuals appropriately to (including but not limited to) psychological/occupational therapies and counselling services, in line with their needs and wishes, taking account of local service provision. 18. Advocate for and contribute to personalised approaches in the management and development of services. 19. Evaluate the implications of, and apply in practice, the relevant legislation for informed consent and shared decision-making (e.g., mental capacity legislation[4] and the Fraser Guidelines[11]).	
GC 1.3 Working with colleagues and in teams 1. Advocate and utilise the expertise and contribution of other health and social care professionals to individuals' care and work collaboratively within the multi-professional team to optimise assessment, diagnosis and integrated management and care for people. 2. Work effectively within and across teams, managing the complexity of transition from one team to another or membership of multiple teams. 3. Initiate and lead effective multi-disciplinary teams and understand the importance of effective team dynamics, including (but not limited to)	1.1, 1.2, 1.3, 1.9 2.1, 2.2, 2.3, 2.8, 2.11 3.4, 3.5, 3.7, 3.8

[4] HM Government (2005) *Mental Capacity Act.* https://www.legislation.gov.uk/ukpga/2005/9/contents
[11] Care Quality Commission (2022) *Fraser Guidelines.* https://www.cqc.org.uk/guidance-providers/gps/gpmythbuster-8-gillick-competency-fraser-guidelines

service delivery processes, research, audit and quality improvement, significant event review, and shared learning and development. 4. Synthesise a deep and systematic knowledge and understanding of wider health and social care and voluntary sector services and teams to make informed independent referrals, using professional judgement, mentoring, and ensuring patient and public involvement.	
GC 1.4 Maintaining an ethical approach and fitness to practise 1. Lead and advocate for practice that promotes the rights, responsibilities, equalities and diversity of individuals, including (but not limited to) acting as a role model in promoting individuals' rights and responsibilities and ensuring others do the same. 2. Critically reflect on how personal values, attitudes and beliefs might influence professional behaviour. 3. Critically evaluate and reflect on ethical/moral dilemmas encountered during practice and that may impact on care.	1.1, 1.2, 1.3 2.2, 2.3, 2.4, 2.10, 2.11 3.2, 3.8

2. Assessment of needs and physical activity approaches

Area-specific capabilities (ASC)	MPF (2017)
ASC 1.1 Assessment of needs 1. Explore and appraise how to assess people, groups and communities, their environments and their biopsychosocial determinants of health in highly complex and unpredictable contexts and using ethical, evidence-informed assessment across a continuum of care, age and setting. 2. Explore and critically appraise the range of generic and specific outcome measures that may be of benefit in providing a more detailed understanding of people and their needs. 3. Lead in triaging and coordinating referrals from health, social care and fitness/leisure sector, self-referral and re-referral, screening the appropriateness and priority of referrals. 4. Lead the team in delivering comprehensive baseline assessments, including the use of outcome measures, to personalise, grade and adapt the physical activity prescription to optimise individuals' health and wellbeing, ensure safe exercising and facilitate personal, relevant goal setting. 5. Critically recognise and analyse when a baseline assessment is outside the normal parameters and facilitate further clinical assessment, management and/or referral. 6. Critically appraise and triangulate all evidence from interview, observation and standardised measures to ensure the most accurate assessment is made of individuals, their chosen physical activity and the environment around them. 7. Lead the team to facilitate conversations to start individuals' engagement in their long-term commitment to positive behaviour change, addressing the need to grade and adapt activities and environments to ensure individuals' accessibility. 8. Demonstrate a critical understanding of a range of relevant decision support tools[5] and resources to assess individuals' readiness to	1.4, 1.5, 1.6, 1.11

[5] NHS England (2022) *Decision support tools.* https://www.england.nhs.uk/personalisedcare/shared-decisionmaking/decision-support-tools/

change (using patient activation measures) and adopt appropriate behavioural change strategies to agree short- and long-term goals with individuals. 9. Review and/or optimise medicines and other interventions relevant to individuals receiving assessment, including how medicines and other interventions are used, their side effects and their impact on individuals' participation. 10. Identify new, innovative ways to assess, pinpoint and resolve underlying issues that result in individuals' decreased levels of activity (e.g. reduced functional ability and independence, loss of ability to cope and social isolation, work stress and sickness absence, mental health crises and multiple, cumulative social stressors).	
Generic capabilities (GC)	MPF (2017)
GC 2.1 Information gathering and interpretation 1. Structure consultations so that individuals and/or their carer/family (where applicable) are encouraged to express their ideas, concerns, expectations and understanding. 2. Use active listening skills and open questions to effectively engage and facilitate shared agenda-setting. 3. Undertake general history-taking and focused history-taking (including physical and psychosocial history) to elicit and assess for red flags. 4. Synthesise information to establish a differential diagnosis, taking account of all relevant factors relating to the presenting complaint, condition or circumstance, existing factors, past medical history, genetic predisposition, medications, allergies, risk factors and other determinants of health. 5. Incorporate information on the nature of individuals' needs preferences and priorities from various other appropriate sources (e.g. third parties, previous histories and investigations). 6. Critically appraise 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.	1.4, 1.5

7. Provide diagnosis and test/investigation results, (including bad news) sensitively and appropriately in line with local or national guidance, using a range of media (e.g. the spoken word and diagrams) to seek to ensure individuals understand what has been communicated. 8. Apply a range of care consultation models appropriate to the clinical situation and appropriately across individuals' physical, mental and psychological presentations in line with personal scope of practice. 9. Explore and appraise individuals' ideas, concerns and expectations about their symptoms and condition and whether these may act as a driver or form a barrier.	
GC 2.2 Examination and procedural skills 1. Critically understand and adapt practice to meet the needs of different groups and individuals, including adults, children and those with particular needs (such as cognitive impairment, sensory impairment or learning disability[6]), working with chaperones, where appropriate in line with personal scope of practice. 2. Apply a range of assessment and/or clinical examination techniques appropriately, systematically and effectively as clinically indicated within the context of the situation and manage any risk factors, such as suicidal ideation, promptly and appropriately.	1.4, 1.5, 1.8
GC 2.3 Making a diagnosis 1. Consider all the relevant evidence from individuals' history, baseline observations and tests, and clinical examination. 2. Make use of clinical interpretations and reports to make justifiable assessment of the nature, causes and prognosis of individuals' health condition/health status. 3. Formulate a differential diagnosis based on subjective and, where available, objective data. 4. Revise hypotheses in the light of additional information and think flexibly around problems to generate functional and safe solutions.	1.1, 1.2, 1.3, 1.6, 1.8

[6] Health Education England and Skills for Health (2019) *Advanced Clinical Practice: Capabilities framework when working with people who have a learning disability and/or autism*. www.skillsforhealth.org.uk/learningdisabilityandautismframeworks

5. Discuss diagnoses with individuals to enable them to think through the implications and how these can be managed. 6. Recognise when information/data may be incomplete and take mitigating actions to manage risk appropriately. 7. Extrapolate, interpret and synthesise evidence from individuals' history, baseline observations, assessments, tests, and investigations in order to make a diagnosis. 8. Synthesise the expertise of multi-professional teams to aid in diagnosis where needed. 9. Target further investigations appropriately and efficiently following due process and with an understanding of investigations' respective effectiveness, validity, reliability, specificity and sensitivity and the implications of their limitations. 10. Exercise clinical judgement and select the most likely diagnosis in relation to all information obtained, including the use of time as a diagnostic tool where appropriate.	

3. Participation in activity for individuals, groups and communities

Area-specific capabilities (ASC)	MPF (2017)
ASC 1.1 Participation in activity for individuals, group and communities 1. Integrate and apply evidence-informed approaches in the presentation of health promotion and preventative care programmes, including by working in partnership with individuals to utilise behaviour change activity and environmental adaptation principles to promote and support individuals with continuing participation in physical activity. 2. Proactively seek innovative, transformative solutions/interventions that are community-based and population-driven to prevent, maintain and improve community physical activity approaches, including through deploying anticipatory skills for proactive, complex interventions and health promotion. 3. Demonstrate comprehensive advanced knowledge of participation in activity (including of indications and contraindications, expected benefits and limitations, how to grade/adapt/adjust all available interventions) to manage individuals' conditions. 4. Lead the team in embedding the principles of self-management and patient activation (including goal setting) across the whole patient pathway and in recognising the importance of exploring problem-solving skills to improve individuals' long-term self-management and quality of life. 5. Lead the team so that individuals have a co-produced, personalised physical activity programme with the aim of increasing their physical and mental fitness and overall daily energy expenditure and decreasing their sedentary behaviour. 6. Advocate for applying the relevant legislation in ways that enable people to maintain their desired activities and their safety, including through using positive risk-taking where appropriate. 7. Critically evaluate the use of social prescribing to connect people to community groups and services, enabling people to manage their own health and wellbeing and develop their skills and confidence. 8. Critically analyse evidence demonstrating that aerobic and resistance training result in clinically meaningful improvements in whole body	1.7, 1.8, 1.11

endurance and strength respectively that, when applied to person-centred goals, can help people to become more active.

9. Critically evaluate how continuous or interval aerobic training can provide equivalent benefits to endurance performance.
10. Identify key components of an exercise programme that may focus on:
    a. Access.
    b. Time/intensity/frequency.
    c. Structure.
    d. Content – exercise and education (to include all relevant risk factor management).
    e. Self-management.
    f. Transition/integration.
11. Critically analyse a wide range of comprehensive community physical activity approaches that target the person, their physical, social and attitudinal environment (e.g. assistive technology, carer support and tackling discrimination), support their engagement in their chosen activities (e.g. grading and adapting activities) and rebuild lost skills and confidence.
12. Demonstrate a comprehensive knowledge of the role of digital technology to support individuals' engagement and adherence to engagement in physical activity (e.g. apps and wearables).
13. Understand the potential benefits and limitations of digital interactions and how to take account of individuals' needs and abilities in adapting interactions on a digital platform.
14. Critically evaluate a range of health outcomes to reduce individuals' sedentary behaviour, including:
    a. Confidence to self-manage (self-efficacy).
    b. Optimising well-being following surgical outcomes.
    c. Commitment to physical activity.
    d. Return to work (e.g., vocational approaches, including the *AHP Health and Work Report* [7]).
    e. Return to usual, personally relevant roles, routines and activities.

[7] Allied Health Professions Federation 2022. *The Allied Health Professions (AHP) Health and Work Report.* http://www.ahpf.org.uk/AHP_Health_and_Work_Report.htm

15. Lead the team to empower people, groups and communities to build their confidence, enhance feelings of control and make informed choices about plans for physical activity, using collaboration and reassurance where extra support is required.
16. Integrate and utilise the *AHP Health and Work Report* process and help people to remain or enter work by using focused interventions that address their work ability, the demands of their job and working environment and advise on and develop return to work.[8]
17. Role model the presentation of accurate, detailed and comprehensive reports to others that include (but are not limited to) the following:
    a. Levels of occupational performance in the context of everyday living/working and capacity to develop new skills and strategies.
    b. The outcome of assessments (e.g. work ability).
    c. The feasibility of independent living or return to work.
    d. Specific, tailored recommendations regarding the level of support needed to carry out chosen occupations in chosen places, such as living at home or returning to a particular job.
18. Critically evaluate plans and ensure people receive on-going assessment and a regular review of their goals, with adjustments agreed, reiterated and documented where required.
19. Formulate and prioritise a range of options for individuals in line with the best available evidence, exploring the risks, benefits and consequences of options and confidently supporting positive risk-taking.
20. Explore and appraise alternative approaches to increasing individuals' intrinsic motivation, undertaking goal setting, problem-solving and behaviour change conversations, including in contexts of high complexity and significant risk.
21. Demonstrate a comprehensive understanding of how offering choice, promoting partnership-working, and supporting shared decision-making may improve uptake and individuals' long-term engagement in physical activity.

[8] Allied Health Professions Federation 2022. *The Allied Health Professions (AHP) Health and Work Report.* http://www.ahpf.org.uk/AHP_Health_and_Work_Report.htm

22. Use advanced clinical reasoning to address any cardiac, musculoskeletal, respiratory, mental health or other misconceptions and illness perceptions that lead to individuals' increased disability and reduced engagement. 23. Lead the team in ensuring the comprehensive utilisation of a range of health outcomes that measure individuals' progress in relation to baseline measures. 24. Develop and promote services with interventions that are designed to support behaviour change, activity and environmental adaptation using behaviour change and other relevant techniques tailored to individuals.	
Generic capabilities (GC)	MPF (2017)
GC 3.1 Clinical management 1. Safely prioritise problems in situations using shared agenda setting where individuals present with multiple issues. 2. Implement shared management, personalised care and therapeutic intervention/support plans in collaboration with individuals, and where appropriate carers, families and other healthcare professionals, ensuring the absolute focus is on personalised care. 3. Arrange appropriate follow-up that is safe and timely to monitor changes in individuals' 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. 4. Identify when interventions have been successful and complete episodes of care with individuals, offering appropriate follow-on advice to ensure that they understand what to do if situations or circumstances change. 5. Vary the management options responsively according to individuals' circumstances, priorities, needs and preferences, as well as the risks and benefits for those involved, with an understanding of local service availability and relevant guidelines and resources. 6. Evidence and evaluate individuals' outcomes of care against existing standards and manage and adjust plans appropriately in line with the best available evidence.	1.5, 1.7 4.2

7. Utilise evidence gathered to inform personal practice and to work across teams/organisations/systems to use outcome evidence to effect positive changes in practice. 8. Ensure safety-netting advice is appropriate and that individuals understand when and how to seek urgent or routine review. 9. Support individuals who might be classed as frail and work with them utilising best practice.	
GC 3.2 Managing complexity 1. Manage acute and chronic problems simultaneously, including with individuals who have multiple health conditions (physical, mental and psychosocial) and who are frail. 2. Manage both practitioner and people's uncertainty and expectations. 3. Communicate risk effectively to individuals and involve them appropriately in management strategies. 4. Consistently encourage improvement and rehabilitation and, where appropriate, recovery. 5. Critically engage with the complexities of working with individuals who have multiple health conditions (physical, mental and psychosocial). 6. Recognise the inevitable conflicts that arise when managing and caring for individuals with multiple problems and take steps to adjust and prioritise care appropriately.	1.2, 1.3, 1.4, 1.8
GC 3.3 Prescribing treatment, administering drugs/medication, pharmacotherapy 1. Safely prescribe and/or administer therapeutic medications, treatments and therapies relevant and appropriate to scope of practice, including (where appropriate) by applying an understanding of pharmacology and considering relevant physiological and/or pathophysiological changes and allergies. 2. Facilitate and or prescribe non-medicinal therapies such as psychotherapy or lifestyle changes (social prescribing). 3. Advocate for personalised shared decision-making to support adherence leading to concordance.	1.5, 1.7

4. Apply a range of available options other than drug prescribing (e.g. not prescribing, promoting self-care and advising on the purchase of over-the counter medicines). 5. Prescribe/promote non-medicinal treatments that may include (but are not limited to) talking therapies, activity, dietary changes and lifestyle workplace/home changes/adaptations. Where a Non-Medical Prescriber (NMP): 6. Critically analyse polypharmacy, evaluating pharmacological interactions and the impact on physical and mental wellbeing and healthcare provision. 7. Practise in line with the principles of antibiotic stewardship and antimicrobial resistance using available national resources. 8. Appropriately review individuals' response to medication, recognising the balance of risks and benefits that may occur, taking account of context, what matters to individuals, their experience, the impact for them and their preferences in the context of their life, as well as polypharmacy, multimorbidity, frailty[9] and individuals' existing medical issues (e.g. kidney or liver issues and/or cognitive impairment). 9. Confidently explain and discuss risks and benefits of medication with individuals using appropriate tools to assist as necessary. 10. Advise individuals on medicines management, including concordance and the expected benefits and limitations and inform them impartially on the advantages and disadvantages in the context of other management options. 11. Support individuals to only take medications that they require and deprescribe, where appropriate. 12. Keep up-to-date and apply the principles of evidence-based practice, including clinical and cost-effectiveness and associated legal frameworks for prescribing.	

[9] Health Education England, NHS England and Skills for Health (2018) *Frailty: A Framework of Core Capabilities.* www.skillsforhealth.org.uk/frailty-framework

Learning, supervision and support

Introduction

Practitioners undertaking this area specific capability framework need to have a scope of practice, role and practice environment that provides them with structured, supportive opportunities for relevant, safe and effective workplace-based supervision and learning that enables them to engage fully with the demands of both the specific capabilities set out in this specification and those of advanced practice more broadly.

They also need to commit to engage with the required learning arrangements and assessment requirements to do the following:

- Meet the learning outcomes.
- Develop and demonstrate the defined area-specific and generic capabilities.
- Integrate all components of learning in their progression and development.
- Engage in learning and development activities that reflect the demands of advanced/level 7 learning (e.g. in terms of engaging with complexity, ambiguity and risk and critically engaging with the evidence base).

At all times, practitioners must place the wellbeing and safety of people above all other considerations and take responsibility for recognising and working within the limits of their personal scope of practice and competence.

Emphasis is on the further development and refinement of practitioners' decision-making to manage increasing levels of complexity, ambiguity and risk, including on when to seek assistance and advice from others. Practitioners are expected to take responsibility for their own learning and to be proactive in initiating appointments with their supervisors (see below) to plan, undertake and receive feedback on their learning and development.

Formal teaching and learning

Education providers and those providing workplace-based supervision and learning are expected to use this area specific capability framework to plan learning, teaching and assessment strategies to maximise the quality and integration of educational opportunities in academic and workplace settings.

Practitioners can develop their professional knowledge, skills, and behaviours to achieve the capabilities set out in this specification through engaging with a variety of learning and teaching activities and critically reflecting on their own development and feedback from others.

Learning and teaching activities can include, but are not limited to, the following:

- Teaching sessions including lectures and small group teaching.
- Case presentations.

- Engagement in research and quality improvement projects.
- Skills simulation.
- Joint specialty meetings.
- Independent learning, including the critical appraisal of research and other evidence-based practice resources.
- Structured reflection on learning.
- Participation in management and multidisciplinary meetings.
- Recommended online resources.

Other learning activities can support practitioners' engagement with the area specific capability framework, providing that they clearly align with the learning outcomes and area-specific and generic capabilities set out in this specification. Delivery of all components requires collaboration between education providers, local service providers and practitioners. Whether practitioners are employed or on placement, local service providers retain full responsibility for all aspects of clinical governance in the workplace, in line with the specific responsibilities set out in locally made collaborative agreements.

Self-directed learning

Practitioners are expected to take a proactive approach to their own learning and development as part of engaging with the area specific capability framework and including through engaging with multi-professional team-working, learning and collaboration. Practitioners are responsible for:

- Engaging with opportunities for learning.
- Initiating assessments and appraisal meetings with their supervisors.
- Undertaking self- and peer-assessment.

Practitioners are encouraged to take the opportunity to learn with their peers (including at a local level) through engaging in peer-to-peer learning, review and discussion.

Practitioners are also expected to undertake self-directed learning in line with personal learning needs to meet the learning outcomes and capabilities. This includes through engaging critically with learning and development materials and evidence-based publications, and their critical reflection on their own learning progression and practice.

Practitioners should maintain a portfolio of evidence of their learning and development as they progress through the area specific capability framework. They should use their portfolio as a medium for critical reflection on their learning and practice in ways that are in keeping with the demands of level 7/advanced practice learning and development.

Reflective practice is an important part of self-directed learning and of continuing professional development. It is an educational exercise that enables practitioners to explore, with rigour, the complexities, and underpinning elements of their actions to refine and

improve them. Verbal reflection is a useful activity for practitioners to engage in to aid their learning and development.

Writing reflectively also adds to the oral process by deepening practitioners' critical understanding of their practice and their learning from this. Written reflection offers different benefits from verbal reflection. These a record for later review; a reference point to demonstrate development; and a starting point for shared discussion. Whatever the mode of reflection, it is important that it takes place and that there is a record of it having taken place, whether or not the specific subject or content of the reflection is recorded.

Practitioners are expected to use feedback from their supervisor to inform their on-going focuses for their further professional development, across the four pillars of advanced practice.

Workplace-based learning

Workplace-based learning should provide the majority of practitioners' experiential learning opportunities, working with their supervisors and/or other experienced clinicians. These settings should provide learning opportunities relating to liaising with other practitioners, working closely with the multidisciplinary team, making referrals (as appropriate), and discharge planning and follow-up.

Continuous systematic feedback and reflection are integral to learning from practice and should be assisted by workplace-based supervision and assessments. The practitioner should be required to keep evidence of their workplace-based learning activity and further development in their portfolio.

The following arrangements should be in place to support practitioners' workplace-based learning:

- Access to online learning facilities and libraries, including e-resources.
- Induction to local policies, procedures, and arrangements comparable to senior decisionmakers.
- Access to electronic patient records consistent with their level of training and in line with all data security requirements and protocols.
- Use of resources to enable safe and effective learning.
- Access to storage for confidential training records.
- Access to appropriate local training.

Workplace-based supervision

Workplace-based supervision is fundamental to the delivery of safe and effective training. It takes advantage of the experience, knowledge and skills of expert practitioners and ensures practitioners' interaction with experienced practitioners.

Supervision is designed to ensure safety by encouraging safe and effective practice and professional conduct. Learning must be supervised appropriately, depending on practitioners' experience and learning and development needs, case mix and workload to ensure the delivery of high-quality, safe patient care. As practitioners progress, their level of supervision should be tailored to facilitate their increasing independence, as is consistent with safe and effective personalised care.

Those involved in the workplace-based education supervision of practitioners must have the relevant qualifications, experience, and training to undertake the role. Specialist skills and knowledge are usually taught by senior or advanced level practitioners, whereas the more generic aspects of practice can also be taught by the wider multidisciplinary team.

Workplace-based coordinating education supervisors

Workplace-based coordinating education supervisors are required for practitioners. They must be appropriately trained assessors with delegated authority. They may be senior practitioners or experienced advanced practitioners who have the necessary skills, knowledge, and experience to oversee practitioners' clinical activity and learning. They need to be familiar with the area specific capability framework and local arrangements for its delivery and take-up. This includes the precise arrangements for practitioners' supervision, learning and assessment and providing good-quality, constructive feedback and for ensuring that practitioners are enabled to develop their capability safely and effectively.

Practitioners' portfolios should include their reflections on their learning experiences and progress and a record of their learning agreement meetings, supervision reports and workplace-based assessments, including the outcomes of these.

Workplace-based education supervisors' main responsibilities are to use the evidence held within practitioners' portfolios (including the outcomes of assessments, reflections and learning agreements) to inform appraisal meetings. Supervisors are also expected to update and verify practitioners' record of progress.

Further information

Health Education England has published guidance for Workplace Supervision for Advanced Clinical Practice (2021)[10]. This sets out detailed guidance for the workplace supervision of registered health professionals undertaking advanced practice education. This includes on the following:

- Identifying the specific advanced practice demands (including competence and capability) in the context of the different regulated professions and practitioners' individual scope of practice.

[10] Health Education England (2021) *The Centre for Advancing Practice, Workplace Supervision for Advanced Clinical Practice: An integrated multi-professional approach for practitioner development.* Supervision - Advanced Practice (hee.nhs.uk)

- Approaches to learning and development, including developing and agreeing and individual learning plans.
- An integrated multi-professional approach to workplace-based supervision, including the recommended roles of coordinating education supervisors and associate workplace supervisors, as well as employer responsibilities.

Indicative assessment strategy

Introduction

A key element of practitioners' preparation for advanced level practice in f community rehabilitation for working with people with long-term conditions is the formal assessment of their fulfilment of the outcomes and capabilities set out in this document. The purpose of the assessment strategy outlined here is to define the principles for a proportionate, robust, and consistent approach to practitioner assessment. This includes the following:

- The integration of academic and workplace-based learning in how the capabilities are assessed.
- Formative assessment leading to summative assessment.
- The integration of practitioners' critical reflection on their learning and development within the assessment approach.
- Evidence of practitioners' critical engagement in evidence-based practice.
- Practitioners' development of a portfolio of evidence.
- A proportionate approach to assessment and avoidance of over-assessment.
- Consistency in assessment, including in the quality of feedback and 'feed forward' received by practitioners.[11]

It is recognised that employers and education providers may already have established assessment processes in place that achieve an integrated approach to workplace-based and academic assessment. It is not the intention for this area specific capability framework to add another 'layer' of assessment if this is not needed. Rather, it is to support education providers and employers ensure that their approach to assessment aligns with and fulfils this strategy and that the assessment load remains proportionate for all parties.

The assessment strategy is designed to allow practitioners to demonstrate their fulfilment of the learning outcomes and capabilities set out in this area specific capability framework. This is with a focus on practitioners' delivery of high-quality care to meet population/patient needs within the specific service delivery model in which they have a role and within their individual scope of practice.

The assessment approach should have both formative and summative aspects. Workplace based assessment elements must be carried out by workplace-based supervisors in the clinical setting. They should ensure the safe ongoing progression of practitioners' learning to meet the requirements of advanced level practice and assess practitioners' integration of learning to demonstrate their fulfilment of the multi-faceted nature of advanced practice capabilities.

[11] Jisc (2016) Guide: *Feedback and Feed Forward*. Feedback and feed forward | Jisc

Approaches to assessment

The achievement of each capability must be demonstrated through sufficient, valid, proportionate evidence. that is in line with the demands of level 7 learning and practice. The reliability of the assessment process can be increased through triangulating and integrating written, observational, and oral evidence. The evidence should also integrate workplace-based and academic assessment.

The emphasis within evidence of practitioners' fulfilment of the learning outcomes and capabilities must be on quality and not quantity. However, it is acknowledged that assessment drives learning, and practitioners should be encouraged to seek assessment and feedback on their performance and 'feed forward' to inform their on-going learning and development.

The number of formative assessments undertaken prior to a summative assessment is not stipulated. All elements of assessment should contribute to practitioners' learning and development.

Types of assessment

Examples of types of assessment evidence that can be used either formatively or summatively include, but are not limited to, the following:

Supervisor report

This is designed to help capture the opinions of experienced practitioners who have supervised practitioners. Supervisors are asked to comment on practitioners' knowledge, skills and behaviours and various important aspects of their performance in support of their learning progression.

Self-assessment

As part of the multi-clinician report, practitioners undertake self-assessment that encourages the analysis of their existing knowledge, level of ability and preferred learning style. Within this analysis, reflection on self, performance, task, and suitability is encouraged to explore, develop, and evaluate practitioners' capability, including their interpersonal skills.

Multisource feedback

This is used to gather feedback on generic skills, such as communication, leadership and teamworking, alongside assessing practitioners' behaviours. Feedback is sought both from people who practitioners care for and colleagues with whom they work, including their manager, peers, junior staff, administrators, and other health and care professionals.

Case-based discussion

A case-based discussion is an interview conducted by workplace-based supervisors that is designed to assess practitioners' knowledge, reasoning and decision-making that is focused

on written case records. It enables either formative or summative assessment and feedback to be documented to support practitioners' learning.

Direct observation of procedural skills

The direct observation of procedural skills is used to assess practitioners' clinical and professional skills in performing a range of diagnostic and interventional procedures. Assessors do not have to be practitioners' workplace-based supervisors. Assessors provide written feedback for the practitioners' portfolio and verbal developmental feedback. Practitioners may already be proficient in the capability being observed. This must be recorded in their portfolio and approved by a suitably qualified/competent assessor.

Service-user survey

Service-user surveys are aimed at triangulating feedback that practitioners receive in undertaking an episode of care. They cover interpersonal and professional skills, behaviours and attitudes, including to ensure any episode of care is person-centred.

Practitioners' record of progress in their portfolio

Practitioners are expected to keep and develop a portfolio of evidence to demonstrate their achievement of the capabilities set out in this area specific capability framework.

Practitioners should use their portfolio to gather evidence on their progress, assessments, and appraisals. This includes through the following:

- Recording their learning activities and feedback from others.
- Capturing their own critical reflection on their learning progression.
- Articulating their critical engagement with, and use of, the evidence base in their learning and practice.

Practitioners are expected to add self-assessment ratings to record their view of their own progress. The aims of this self-assessment are as follows:

- To provide the means for reflection and evaluation of current practice.
- To inform discussions with supervisors to help both gain insight and assist in developing personal development plans.
- To identify shortcomings between practitioners' experience and capabilities and the areas defined in this area specific capability framework to guide and plan their future clinical exposure and learning and development focuses.

Assessors

Assessors should be advanced practitioners or other senior health or care professionals who are appropriately qualified and skilled in assessment and have delegated authority.

Assessors should undertake both formative and summative assessments. They must be competent in the area they are assessing and be familiar with the standard of, and approach

to, the assessment required, in line with the capabilities and assessment strategy set out in this area specific capability framework.

Workplace-based coordinating educational supervisors should use the capabilities in this area specific capability framework as the basis of their discussion with practitioners. This includes to inform the identification of practitioners' learning needs and the formulation of their learning development plans.

Both supervisors and assessors must have a good knowledge of the learning outcomes and capabilities set out in this area specific capability framework and use them to structure how they perform their role in relation to practitioners' learning.

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Appendix 2: How this area specific capability framework was developed

Development was guided by a project steering group to provide appropriate multi-professional expertise and cross-sector representation (see Appendix 3.

Acknowledgements). A wider reference group was also established. This was open to any individual or organisation, including voluntary organisations, seeking to be informed about the project and/or engage in the consultation process. Representation included patients, carers, and families with relevant lived experience to ensure the patient voice and co-production throughout the process.

Initial desk research identified key references, resources and significant themes or issues for consideration derived from contemporary research and evidence-based practice – further references and resources continued to be identified during the project (see Appendix 1. References and bibliography).

Several iterations of the document were developed and refined, based on the findings of the desk research and in consultation with the project steering group. Through engagement with the steering group, any differences of view were moderated and addressed through enacting a consensus-building approach.

An indicative assessment strategy was developed for the area specific capability framework, working closely with education and service providers to ensure the area specific capability framework is deliverable within universities' advanced practice MSc programmes, as well as meeting the requirements of NHS England's Centre for Advancing Practice.

Subsequently, a full draft of the document was made available for wider consultation. The draft document and a link to an online survey were hosted on a Skills for Health project web page. This was disseminated widely through the project steering group, group members' networks, and contacts and with the wider reference group. Based on analysis of these survey outcomes, further amendments and refinements were undertaken, leading to a final meeting of the project steering group and submission of the document to NHS England's Centre for Advancing Practice for independent review and endorsement as an area specific capability framework.

A summary of the development activity and timeline is provided in the table below.

Development activity	Timeline
Initial research and project steering group established	May - June 2020
Steering Group meetings to review iterations of the draft document	13 January, 10 February, 17 March and 26 May 2021
Task and finish group meeting to review indicative assessment strategy	7 January 2021
Consultation, including online survey	25 February to 21 March 2021
Analysis of consultation findings	April 2021
Revisions to document, taking account of consultation findings	May – June 2021
Submission of document to the Centre for Advancing Practice for progression through Centre endorsement process	August 2021
Edits to document in response to initial Centre 'scanning' against Centre endorsement criteria	October 2021
Consideration of document by Centre independent reviewers	November 2021
Reviewer feedback submitted to Centre's Endorsement Panel	December 2021
Submission of Panel recommendation to Centre's Education Assurance Group	January 2022
Centre endorsement conferred subject to the fulfilment of specified conditions	January 2022
Conditions fulfilled and Centre endorsement ratified by Education Assurance Group	June 2022
Document finalised as a Centre-endorsed area specific capability framework	June – September 2022

Appendix 3: Acknowledgements

The development of this credential specification was commissioned by Health Education England (HEE) now NHS England.

The project steering group was chaired by Ruth ten Hove, HEE credential lead and assistant director, Chartered Society of Physiotherapy. Project management was provided by Sharon Wilton, technical consultant, and Colin Wright, senior consultant, of Skills for Health.

Membership of the project steering group is listed below.

Name	Title / Organisation
Ruth ten Hove **(chair)**	HEE credential development lead. assistant director, Chartered Society of Physiotherapy
Sharon Aldridge-Bent	Director of nursing programmes (leadership) Queen's Nursing Institute
Steve Aspinall	Chief executive, British Association of Sport Rehabilitators and Trainers
Angela Busuttil	Consultant clinical psychologist and professional lead, clinical health psychology, Sussex Partnership NHS Foundation Trust
Kenny Butler	Head of health & wellbeing development, UK Active
Rebecca Chester	Consultant nurse for people with learning disabilities at Berkshire Healthcare NHS Foundation Trust
Aynsley Cowie	Consultant physiotherapist, NHS Ayrshire and Arran
June Davis	Rehabilitation lead, Macmillan Cancer Support
Chris Foster	Head of learning and development, UK Active
Name	**Title / Organisation**
Sally Hinton	Executive director, British Association for Cardiovascular Prevention and Rehabilitation (BACPR)
Marc Holl	Professional head of physiotherapy & clinical development lead, Nuffield Health
Sandy Jack	Professor of anaesthesia and critical care medicine, University of Southampton
Kate Jackson	Interim head of personalised care (clinical, workforce & quality), NHS England
Anna Lowe	Programme manager, National Centre for Sports and Exercise Medicine, Sheffield Hallam University
Zoe Merchant	Specialist occupational therapist and programme lead,-GM

	Prehab4Cancer and Recovery Programme Greater Manchester
Suhaliah Mohamed	Professional development lead for allied health professionals (AHPs), East London NHS Foundation Trust
John Moore	Consultant in respiratory & intensive care medicine, Manchester University NHS Foundation Trust
Olivia Revitt	Cardiorespiratory physiotherapy lecturer/practitioner, University of Leicester Subject matter expert, Health Education England
Colin Robertson	Executive director, Underground Training Station Foundation
Deborah Robinson	NHS, Lived experience
Sally Singh	Head of pulmonary and cardiac rehabilitation, University Hospitals of Leicester NHS Trust
Sharon Wilton	Technical consultant, Skills for Health
Colin Wright	Senior consultant (frameworks), Skills for Health

Finally, we want to thank those who took part in the online consultation survey.

Appendix 4: Glossary of terms

Term	Definition
Augmentative and Alternative Communication (AAC)	The communication methods used to supplement or replace speech or writing for those with impairments in the production or comprehension of spoken or written language.
Advanced care planning	The voluntary process of discussion between an individual and their care providers to make clear the individual's wishes regarding their ongoing care in the context of anticipated deterioration of their health with loss of capacity to make decision or communicate wishes in the future.
Capability	The ability to perform or achieve certain actions or outcomes. Capabilities are flexible and adaptive in a wide range of real-life, complex settings (as opposed to competencies). Capabilities also reflect the extent to which learners can generate new knowledge and continue to improve their performance.
Care co-ordination	The deliberate organisation of care activities for the person between two or more participants (including the person themselves) involved in their care to facilitate the appropriate delivery of health care services.
Community	Any setting that is not a tertiary referral hospital.
Co-production	A way of working that involves health and care service users, carers and communities in equal partnership, and which engages groups of people at the earliest stages of service design, development and evaluation.
Competencies	A set of defined, discrete knowledge, skills, behaviours and attitudes that are learned and assessed in specific situations. These terms are often used interchangeably.
Evaluation	The process of judging or calculating the quality, importance, amount, or value of something.
Exercise	Exercise is physical activity that is planned, structured, and repetitive for the purpose of conditioning the body. Exercise consists of cardiovascular conditioning, strength and resistance training, and flexibility.
HbA1c	Glycated haemoglobin test: Measuring the glycated form of haemoglobin to obtain the three-month average of blood sugar
Health coaching	An approach based on helping people gain and use the knowledge, skills and confidence to become active participants in their care so that they can reach their self-identified health and well-being goals.
Health inequalities	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age.

Health literacy	People having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use, and navigate health and social care information and services.
Holistic assessment	Comprehensive assessment that takes account of physical, psychological, emotional, spiritual, lifestyle, socioeconomic position, cultural background.
Integrated care systems	In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. ICSs have evolved from Sustainability and Transformation Partnerships (STPs).
Learning outcomes	The detailed knowledge, skills, and behaviours that a learner will be expected to achieve and demonstrate on completion of training.
Long-term conditions	Conditions for which there is currently no cure, and which are managed with drugs and other treatment and lifestyle advice.
Making every contact count (MECC)	An approach to behaviour change that utilises the millions of day-today interactions organisations and staff have with people to support them in making positive changes to their physical and mental health and well-being[12].
Motivational interviewing	Motivational Interviewing (MI) uses a guiding style to engage people, clarify their strengths and aspirations, evoke their own motivations for change and promote autonomy in decision making. MI is based on these assumptions: • How we speak to people is likely to be just as important as what we say. • Being listened to and understood is an important part of the process of change. • The person who has the problem is the person who has the answer to solving it. • People only change their behaviour when they feel ready not when they are told to do so. • The solutions people find for themselves re the most enduring and effective.
Patient activation	‘Patient activation’ describes the knowledge, skills, and confidence a person has in managing and taking action regarding their own health and care. The words of this definition are now more commonly used than the term “patient activation” itself.
Personalised care	Personalised care is a partnership approach that helps people make informed decisions and choices about their health and wellbeing, working alongside clinical information. The approach takes account of the person’s co-morbidities, is sensitive to their biopsychosocial needs and meets their preferences and choices.

[12] Health Education England (undated) *Making Every Contact Count*. http://www.makingeverycontactcount.co.uk/

Physical activity	Physical activity is any body movement that works muscles and uses more energy than when resting. Walking, running, dancing, swimming, yoga, and gardening are examples of physical activity. Exercise is a type of physical activity that is planned and structured.
Quality improvement	The use of methods and tools to continuously improve quality of care and outcomes for people.
Rehabilitation	A set of interventions needed when a person is experiencing, or is likely to experience, limitations in everyday functioning due to ageing or a health condition, including chronic diseases or disorders, injuries, or traumas[13].
Screening	The purpose of screening is to detect early disease or risk factors for disease in a population. It is a way of identifying apparently healthy people who may have an increased risk of a particular condition. Screening is not diagnostic. Screening for: • red flags refer to clinical features that help to identify the presence of potentially serious conditions. Such conditions include tumours, infection, fractures, and neurological damage. • Yellow flags are psychosocial indicators suggesting increased risk of progression to long-term distress, disability, and pain. • Blue flags are indicators as to whether an individual is able to meet the demands of their job.
Self-efficacy	This is about a person's confidence in undertaking a particular behaviour and their beliefs about their capabilities. Self-efficacy beliefs are cognitions that determine whether health behaviour change will be initiated, how much effort will be made, and how long the change will last in the face of obstacles and failures.
Shared decision-making	A collaborative process through which people are supported to understand and make decisions about their care, based on evidence-based, good quality information and their personal preferences.
Social determinants of health	The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national. and local levels.
Social prescribing	Connecting people to non-medical sources of support in their local community that may help meet particular needs, or that can help to prevent worsening health for people with existing long-term conditions and reduce costly interventions in specialist care[14].
Triadic consultation approach	A way of appreciating the input of people other than the patient in terms of gathering information and formulating a care plan and other interventions

[13] World Health Organisation (2020) Rehabilitation https://www.who.int/news-room/fact-sheets/detail/rehabilitation

[14] Coalition for Collaborative Care (2016), Personalised care and support planning handbook. https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf

Appendix 5: Exercise assessment and outcome measures

Assessment

Assessment of individuals should be completed at baseline prior to enrolling them into a community exercise programme. Baseline assessment enables accurate prescription of exercise and also records a variety of measures to ensure individuals are safe and appropriate to engage in the intervention.

- Blood Pressure
- Heart rate
- Blood glucose
- Blood lipids
- Oxygen saturation.

Outcome measures

Outcome measures are tools used to access individuals' current status. The results of a test are used to objectively determine the baseline function of individuals at the beginning of treatment. Once treatment has commenced, the same tool can be used to determine individuals' progress and the treatment efficacy.

Outcome measures should be included in the baseline assessment. Health-related quality of life measures should be included, as well as physiological ones.

Outcome measures that may be beneficial include, but are not limited to, the following:

- Visual analogue scale - measures a characteristic or attitude that is believed to range across a continuum of values and cannot easily be directly measured. https://www.sciencedirect.com/topics/medicineand-dentistry/visual-analog-scale
- Borg Rating of Perceived Exertion (RPE) is the 6-20 scale and measures patient effort. https://academic.oup.com/occmed/article/67/5/404/3975235
- Borg Breathlessness is a 0-10 scale. https://www.physiopedia.com/Borg_Rating_Of_Perceived_Exertion
- EQ-5D - is a standardised measure of health-related quality of life. https://euroqol.org/euroqol/
- FACIT – Functional assessment of chronic illness. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC317391/
- HADS – Hospital anxiety and depression scale. https://academic.oup.com/occmed/article/64/5/393/1436876
- Exercise capacity – submaximal tests, e.g. the Incremental Shuttle Walk Test (ISWT), 6MWT and a step test. https://thorax.bmj.com/content/63/9/775

- BARTHEL - an ordinal scale used to measure performance in activities of daily living. https://www.physio-pedia.com/Barthel_Index
- Patient Activation Measure (PAM) – relating to individuals' knowledge, skills, and confidence in managing their own wellbeing. https://ihj.bmj.com/content/2/1/e000032
- NUTRITION https://www.bapen.org.uk/screening-andmust/must/introducing-must
- STRENGTH- 30 seconds sit to stand/Oxford scale/Dynamometer. https://www.sralab.org/rehabilitation-measures/30-second-sit-stand-test
- MoCA – Montreal measure of cognitive impairment. https://www.verywellhealth.com/alzheimers-and-montreal-cognitiveassessment-moca-98617