NHS England

The Centre for Advancing Practice

Advanced Practice Community Rehabilitation - Healthy Ageing framework

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Publication reference:

Area specific capability specification endorsed by the Centre for Advancing Practice

This NHS England commissioned document has met the Centre for Advancing Practice's criteria for endorsement as an area specific capability specification 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.

Advanced Practice Community Rehabilitation - Healthy Ageing framework 1

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 is for practitioners able to engage with the demands of advanced practice and lead diagnostics for recovery and rehabilitation in a multi-professional team to support people to age well.

It sets out advanced-level practice that involves exercising a high degree of autonomy and complex decision-making and 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 clinical practice in England (2017).*[1]

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 clinical 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

[1] Health Education England (2017) Multi-professional framework for advanced clinical practice in England Multi-professional framework for advanced practice in England (2017) - Advanced Practice (hee.nhs.uk)

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 credential 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 credential providers' academic regulations), there should be appropriate flexibility for them to complete the credential within a reduced timeframe.

Key learning outcomes

On successful completion of the credential, practitioners should have demonstrated that they can undertake the following in community rehabilitation (healthy ageing):

1. Critically appraise and apply a range of communication and consultation skills that enable a personalised approach to community rehabilitation and support people to age well, recognising the absolute imperatives to empower individuals and others in the decision-making process and to enable a personalised and self-managed approach.
2. Evaluate optimal approaches to effective multi-disciplinary team-working 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 advanced practice intervention measures within their own practice on the wider determinants of healthy ageing and health equality for individuals and populations.
4. Critically apply the knowledge and skills required to elicit and record an accurate clinical history, clinical examination and successfully interpret clinical diagnostic results for a range of health conditions relevant to ageing.
5. Undertake appropriate and timely holistic clinical assessment and diagnosis at advanced practice level, including by managing high levels of risk, uncertainty, and complexity and by critically engaging with and interpreting available evidence and data.
6. Synthesise the goals and priorities of individuals with clinical need to initiate, evaluate, and modify rehabilitation treatment/therapy and care, leading complex decision-making where appropriate.

Scope of this area specific capability framework

This is designed to develop the capabilities required of practitioners leading diagnostics for recovery and rehabilitation within a multi-professional team and to support people to age well.

The scope includes any community or home-based location where people may be experiencing decompensation of health conditions or are recovering after a significant event, but probably not in a tertiary hospital setting. People who may benefit from the interventions of practitioners working at advanced practice level with the capabilities set out in this credential specification may be living with moderate to severe frailty.

The area specific capability framework was developed using an iterative process, with input via a project steering group comprising clinical experts in the field from a range of professions and people with lived experience. Content was benchmarked to the current evidence base for the interventions identified. The credential specification was refined through rounds of consultation with expert groups, such as the British Geriatric Society Community Rehabilitation Special Interest Group and professional bodies. It was then taken through an open consultation exercise conducted by Skills for Health. Account was taken of the feedback received and the content agreed by the project steering group.

Marie Stern, a patient representative and member of the project steering group, commented:

From the patient perspective, I am very impressed. It would make a huge difference to people and could be life-changing for, say, an elderly person recovering from an illness or accident on top of other conditions. When I think of my parents and grandparents after strokes and heart attacks, I can see that co-ordinated care as proposed here would have given them a much better quality of life.

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

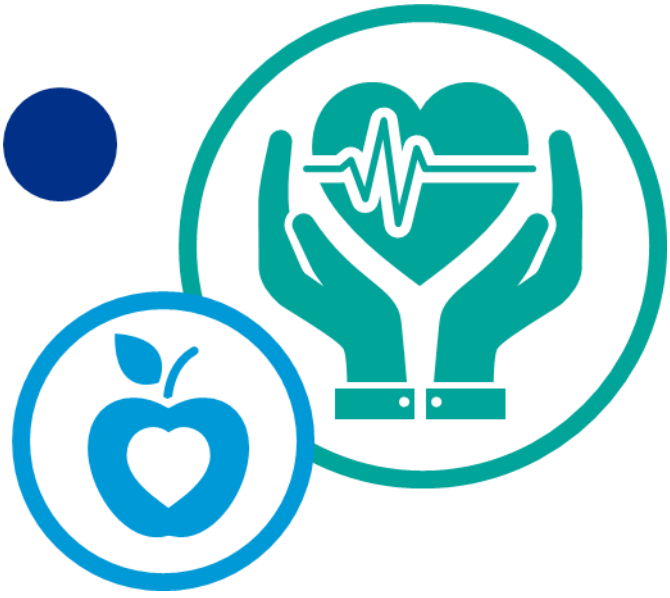
- Capabilities that are specific to advanced practice in community rehabilitation for healthy ageing.
- More generic capabilities that are relevant to all primary and community care-based advanced practice, including community rehabilitation for healthy ageing.

It is the combination of the area-specific and generic capabilities that is key to safe and effective advanced practice in community rehabilitation for healthy ageing. For clarity, the area-specific and generic capabilities are presented in tables in thematic clusters under shared thematic headings.

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 clinical practice in England (2017).*[2] This is indicated in the righthand column of the capability tables



[2] Health Education England (2017) *Multi-professional framework for advanced clinical practice in England.* Multi-professional framework for advanced practice in England (2017) - Advanced Practice (hee.nhs.uk)

Capabilities

1. Clinical practice

Area-specific capabilities (ASC)	MPF (2017)
ASC 1.1 Area-specific capabilities 1. Promote awareness of the effectiveness of rehabilitation interventions amongst people/patients, health and social care professionals and commissioners. 2. Apply advanced clinical reasoning to formulate and deliver community-based rehabilitation interventions based on comprehensive assessment, interpretation of investigation results, planning and monitoring of people with complex needs. 3. Apply advanced skills in the completion of Mental Capacity Act[3] assessments for people where their ability to consent to treatment is in question. 4. Undertake a range of complex rehabilitation interventions, applying a high degree of skill across more than one setting within the community. 5. Integrate structured graded exercise aimed at components of fitness necessary for therapeutic rehabilitation. 6. Provide specific advice and guidance on changing, adapting or managing the physical and social environment to ensure individuals' physical safety, comfort and emotional security. 7. Facilitate behaviour change using evidence-based approaches such as motivational interviewing, health coaching and supporting self-management, during the rehabilitation intervention. 8. Support individuals to engage and explore personal goals around their health status and independence that are relevant to their condition, recognising the value of the therapeutic relationship. 9. Apply the principles of health and wellbeing across a range of conditions, including but not limited to keeping active and social engagement. 10. Appropriately use self-management techniques, including technologies (e.g. apps and digital platforms). 11. Recognise and deal appropriately with red flags.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10, 1.11 2.2, 2.8

[3] HM Government (2005) *Mental Capacity Act.* https://www.legislation.gov.uk/ukpga/2005/9/contents

12. Educate people, carers and families and other healthcare professionals in the principles of holistic rehabilitation. 13. Critically evaluate the effectiveness of rehabilitation interventions, applying a high degree of skill across more than one setting within primary care. 14. Apply the principles of quality and service improvement within rehabilitation services and utilise asset-based community approaches in the context of changing roles, models of care and integrated care pathways. 15. Influence policy across local health and social care services and apply an understanding of the wider determinants of health to shape the design of multi-disciplinary pathways to support patient choice, improve quality of life, and promote self-management of injury and disease. 16. Critically apply health and social care legislation, national policy drivers and local systems, recognising how each impacts on the delivery of community rehabilitation service provision across the local health and social care economy. 17. Recognise and apply the local systems available for social prescribing to facilitate effective community rehabilitation service provision	
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 and signpost additional resources).[4] 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.	

[4] 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[5] and the Fraser Guidelines[6]).	
GC 1.3 Working with colleagues and in teams 1. Advocate and utilise the expertise and contribution of other allied 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

[5] HM Government (2005) *Mental Capacity Act.* https://www.legislation.gov.uk/ukpga/2005/9/contents
[6] 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, 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. Health Conditions

Area-specific capabilities (ASC)	MPF (2017)
ASC 2.1. Management of the acutely deteriorating person 1. Identify when to initiate medical intervention or emergency care. 2. Undertake prompt assessment of individuals who are acutely deteriorating, including who are shocked or unconscious. 3. Select, manage, and interpret appropriate investigations in a timely manner. 4. Utilise evidence-based interventions in relation to managing individuals who are acutely deteriorating. 5. Initiate interventions to form a collaborative, person-centred management plan, liaising with other team members as appropriate. 6. Communicate clinical-reasoning and decision-making to individuals and those important to them. 7. Demonstrate appropriate re-assessment and on-going management of individuals who are acutely unwell. 8. Recall and act in accordance with professional, ethical, and legal guidance in relation to cardiopulmonary resuscitation (CPR). 9. Demonstrate competence in carrying out resuscitation.	1.4, 1.5, 1.6, 1.7. 1.8, 1.11
ASC 2.2. Frailty 1. Recognise the definition of frailty as a long-term condition and how the implications of frailty impact on the provision of rehabilitation and moving into palliation. 2. Utilise the principles and apply the components of Comprehensive Geriatric Assessments[7] and national guidelines related to frailty, including identifying and recognising frailty. 3. Anticipate the likely potential physical, psychological, and social problems caused either by the condition or by treatment for individuals living with frailty. 4. Evaluate and assess the impact of polypharmacy on people living with frailty and key medications that may contribute to frailty syndromes.	1.4, 1.5, 1.6, 1.7, 1.8

[7] British Geriatric Society (2019) *Comprehensive Geriatric Assessment.* (https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-03-12/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners_0.pdf

5. Critically evaluate new and emerging interventions and synthesise new ideas and information to enhance the well-being of people living with frailty. 6. Assess the suitability of utilising different evidence-based exercise programmes to reduce the effects of frailty on individuals' independence and mobility. 7. Assess individuals' nutritional status to identify malnutrition or sarcopenia and where optimising nutrition and hydration may be needed. 8. Assess the suitability of validated methods when assessing for sarcopenia.	
ASC 2.3. Respiratory conditions 1. Assess individuals' respiratory function. 2. Undertake a chest examination and correlate findings to presentation. 3. Assess and evaluate the impact of the results of chest x-rays on assessment and treatment. 4. Utilise appropriate questions and outcome measure to assess individuals who are breathless, when at rest and during functional activities. 5. Assess the management of individuals who are breathless with pulmonary rehabilitation, including the use of exercise and self-management strategies. 6. Critically evaluate, assess and implement strategies (including exercise) in relation to the management of respiratory conditions. 7. Apply an understanding of a broad range of respiratory conditions (e.g. COPD, asthma, emphysema and post-COVID-19). **8.** Recognise and manage anxiety and depression associated with a range of respiratory conditions.	1.4, 1.5, 1.6, 1.7, 1.8
ASC 2.4. Cardiovascular conditions 1. Undertake a cardiovascular assessment that includes, but not limited to, assessing blood pressure, heart sounds, jugular venous pressure and oedema.	1.4, 1.5, 1.6, 1.7, 1.8

2. Utilise appropriate questions and outcome measures to assess individuals who are breathless at rest and during functional activities. 3. Interpret the features of a normal and abnormal ECG rhythm and correlate findings to presentation to formulate an appropriate management plan, escalating concerns if individuals fail to respond. 4. Apply understanding of a broad range of cardiovascular conditions (e.g. heart failure, arrhythmia). 5. Formulate lifestyle advice to facilitate individuals' self-management of their condition. 6. Critically evaluate, assess, and implement strategies (including exercise) to manage individuals' cardiovascular conditions. 7. Assess, implement, and evaluate cardiac rehabilitation. 8. Recognise and manage anxiety and depression associated with a range of cardiovascular conditions. **9.** Recognise and apply the local systems available for individuals' onward referral to community-based exercise opportunities beyond rehabilitation.	
ASC 2.5. Diabetes 1. Assess and evaluate the presenting features of diabetes to adopt a tailored, individualised approach. 2. Apply advanced clinical-reasoning skills to recognise changes in individuals' blood sugar levels and HbA1c and respond appropriately. 3. Assess and evaluate the risk of complications and their management (e.g. renal function, retinopathy, neuropathy). 4. Assess the diabetic foot and refer where appropriate. 5. Critically evaluate, assess, and implement new and emerging evidence in the management of diabetes. 6. Apply the principles of intensification of drug treatments. 7. Apply the evidence for promoting physical activity and nutrition in diabetes management. **8.** Liaise with and refer to specialist diabetes services as appropriate.	1.4, 1.5, 1.6, 1.7, 1.8
ASC 2.6. Neurological conditions 1. Assess common neurological presentations and evaluate medications and treatments.	1.4, 1.5, 1.6, 1.7, 1.8

2. Analyse the presenting neurological condition(s) and the implications of these for individuals' life-long rehabilitation. 3. Evaluate and apply best practice for the management of a range of neurological conditions and their presenting features (e.g. Parkinson's disease, multiple sclerosis and stroke). **4.** Liaise with and refer to specialist neurological services as appropriate.	
ASC 2.7. Musculoskeletal conditions 1. Select and conduct an appropriate initial MSK screening assessment. 2. Undertake observational and functional assessments of individuals relevant to their presenting condition to identify and characterise any abnormality. 3. Advise on the effects of injuries on MSK health and conditions. 4. Recognise how MSK conditions can impact on individuals' mental health and identify when this is relevant to individuals' care. 5. Recognise how MSK problems may be a manifestation of injury not only from trauma but also abuse, recognising particular at-risk groups (such as older people with frailty and those with cognitive impairment) and take appropriate action when there are grounds for concern. 6. Liaise with and refer to specialist MSK services as appropriate. **7.** Appraise the impact that a range of social, economic, and environmental factors can have on outcomes for individuals with MSK conditions, their carers and their circles of support.	1.4, 1.5, 1.6, 1.7, 1.8
ASC 2.8. Mental health 1. Apply a systems approach to mental health (e.g. evaluating wider determinants of health and integrated care pathways). 2. Recognise frequent presentations of mental ill-health (e.g. depression, dementia and anxiety) and offer appropriate interventions. 3. Risk-assess for self-harm and offer appropriate interventions. 4. Undertake appropriate cognitive assessments and plan interventions accordingly, including best interest and best capacity decisions. 5. Apply a conceptual understanding of mental health ill-health through the lens of biopsychological models of health. 6. Recognise that responses, interventions and treatments affect change in one or more components of the models that underpin conceptualisations of mental health.	1.4, 1.5, 1.6, 1.7, 1.8

7. Apply a conceptual understanding of a rising prevalence of comorbidities in communities that call for a population health management approach.	
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 to elicit and assess 'red flags' (including physical and psychosocial history). 4. Synthesise information, taking account of factors (that include the presenting complaint, condition or circumstance; existing factors, past medical history, genetic predisposition, medications, allergies, risk factors; and other determinants of health) to establish differential diagnoses. 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. 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.	1.4, 1.5

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[8]), 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, likely 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. 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 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 their respective effectiveness, validity, reliability, specificity and sensitivity and the implications of these limitations.	1.1, 1.2, 1.3, 1.6, 1.8

[8] 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

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 3.1. Falls 1. Critically evaluate and apply current thinking and research to assess individuals' falls risk and proactively mitigate their risk of falls. 2. Assess the suitability of utilising structured exercise programmes to reduce the incidence of falls in older people at risk. 3. Assess for risk of and recognise osteoporosis, orthopaedic conditions, types of fractures and promote the benefits of bone protection. 4. Be cognisant of the considerations needed when assessing a fall with suspected head injury or an unwitnessed fall. 5. Evaluate and mitigate the psychological impact of falls and seek specialist advice as appropriate. 6. Critically apply knowledge of the vestibular system and disorders. 7. Assess and evaluate foot health in relation to falls prevention and mitigation and the prescription of exercise. 8. Utilise technology and the adaptation of the environment, including how use of the environment affects individuals' risk of falling. 9. Explore any nutrition- and hydration-influencing factors that could be addressed.	1.4, 1.6, 1.7, 1.8
ASC 3.2. Skin integrity 1. Critically evaluate, assess and implement strategies for maintaining skin integrity. 2. Identify and categorise pressure ulcers and assess and utilise application of the international pressure ulcer classification system. 3. Evaluate a risk assessment and implement a systematic care-based plan. 4. Prescribe pressure redistribution equipment. 5. Assess the impact of optimised nutrition on pressure ulcers and implement strategies to enhance healing. 6. Assess and evaluate the options for treatment or the need for debridement. **7.** Initiate further relevant investigation and onward referral to specialist services.	1.4, 1.6, 1.7, 1.8

ASC 3.3. Nutrition 1. Critically evaluate, assess and implement new and emerging evidence regarding developments in nutrition. 2. Recognise the role nutrition that plays in the management of long-term conditions, how this can interact with individuals' physical and mental health and identify when this is relevant. 3. Select and conduct appropriate initial screening related to nutrition assessment (e.g. nutritional screening tools such as the Malnutrition Universal Screening Tool [9], The Patients Association nutrition checklist[10], the Subjective Global Assessment[11], and other relevant assessments such as QRISK3[12]). 4. Undertake appropriate clinical observational assessments of individuals relevant to their presenting condition to identify and characterise any abnormality that may have a nutritional cause or consequence (e.g. anthropometry, biochemistry, clinical history and physical examination, dietary intake, environmental, behavioural and social considerations, and functional capacity). 5. Monitor and review a nutritional care plan, taking account of individuals' complex health and wellbeing needs and identify when onward referral is indicated. **6.** Maintain a balanced opinion on nutrition for health and disease that is rooted in the evidence base when advising service users and colleagues.	1.4, 1.6, 1.7, 1.8
ASC 3.4. Swallow and communication 1. Assess, monitor and review individuals' health and wellbeing needs, physiological and psychological functioning when there are complex and/or undifferentiated abnormalities, diseases and disorders and develop interventions related to communication and/or swallowing difficulties.	1.4, 1.6, 1.7, 1.8

[9] British Association of Parenteral and Enteral Nutrition Malnutrition (undated) *Universal Screening Tool.* https://www.bapen.org.uk/screening-and-must/must-calculator

[10] Patients Association (2018) *Nutrition Checklist.* https://www.eatwellagewell.org.uk/checklist

[11] Journal of Parenteral & Enteral Nutrition (1987) *What is subjective global assessment of nutritional status?* https://www.providencehealthcare.org/general_surgery/surgical-trainees/documents/TPN_Dietician_LK.pdf

[12] *QRISK3 risk calculator*; accessed via https://qrisk.org/three/index.php

2. Diagnose and manage dyspepsia and gastroesophageal reflux disease (GORD). 3. Diagnose and manage issues around saliva (xerostomia and hypersalivation). 4. Provide advice on feeding and swallowing in end-of-life care to avoid unnecessary hospital admissions and provide advice on feeding at risk. 5. Utilise a range of augmentative and alternative communication (AAC) methods to meet individuals' needs. 6. Recognise the side effects of medication on swallow and communication. **7.** Apply understanding of the suitable food and fluid consistencies to comply with IDDSI-modified consistency[12], in line with advice, as required, from a speech and language therapist.[13]	
ASC 3.5. Pain 1. Critically appraise and apply new and emerging strategies for pain management. 2. Assess and identify chronic, persistent, long-term, ongoing, lasting, primary pain. 3. Evaluate and assess the impact of pharmacological interventions on daily function. 4. Communicate effectively and sensitively with individuals on issues relating to pain and pain management. 5. Evaluate the impact of pain on function, including psychological and social impacts. 6. Appraise appropriate interventions (e.g. exercise, psychological and physical therapy). **7.** Liaise with and refer on to specialist pain services as appropriate.	1.4, 1.6, 1.7, 1.8
ASC 3.6. Continence 1. Critically evaluate, assess and implement new and emerging evidence for the management of incontinence. 2. Evaluate and apply current best practice in continence management and deliver interventions (e.g. pelvic floor muscle training).	1.4, 1.6, 1.7, 1.8

[12] International Dysphagia Diet Standardisation Initiative (2019) *Complete IDDSI Framework.* https://iddsi.org/IDDSI/media/images/Complete_IDDSI_Framework_Final_31July2019.pdf

[13] NOTE: Practitioners to whom the capability applies may be speech and language therapists themselves.

3. Recognise a change in individuals' pattern of continence and offer appropriate diagnostic and treatment interventions. 4. Apply the principles of aetiology of change in continence. 5. Critically appraise the psychological impact that incontinence can have on individuals, their family and carers. **6.** Liaise with and refer individuals to specialist continence services as appropriate.	
ASC 3.7. Fatigue 1. Critically appraise and apply new and emerging strategies for fatigue management (e.g. strategies for managing fatigue resulting from longCOVID-19). 2. Assess individuals' improvement or deterioration in fatigue resulting from of a range of conditions (e.g. heart failure and frailty). 3. Assess any adverse, unexpected or unwanted effects of individuals' rehabilitation and tailor interventions appropriately. 4. Evaluate techniques and strategies for the management of fatigue (e.g. relaxation, diet, equipment, adaptations and graded exercise therapy). **5.** Recognise when individuals' onward referral to specialist services is appropriate and act accordingly.	1.4, 1.6, 1.7, 1.8
ASC 3.8. Palliative/end of life care 1. Identify people who may be approaching end of life. 2. Sensitively carry out a holistic needs assessment in line with the Care Act[14]. 3. Review current treatment to reduce individuals' treatment burden. 4. Formulate advanced care plans and discuss and complete 'do not attempt cardio-pulmonary rehabilitation' (DNA CPR) and recommended summary plans for emergency care and treatment (RESPECT[16]) forms.	1.4, 1.6, 1.7, 1.8

[14] HM Government (2014) *Care Act.* https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[16] Resuscitation Council UK (undated) *RESPECT for Healthcare Professionals;* accessed via https://www.resus.org.uk/respect/respect-healthcare-professionals

5. Apply a critical understanding of the Gold Standard Framework[15] and NICE guidelines on end-of life care[16]. 6. Share decision-making through sensitive communication with individuals and those important to them on a range of complex matters relating to end of life care in a non-judgemental, empathetic, genuine, collaborative and supportive manner that is appropriate to them and the situation. 7. Offer appropriate support for carers of adults approaching end of life. **8.** Facilitate the transfer of end-of life care between care settings and refer appropriately to palliative care services.	
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.	1.5, 1.7 4.2

[15] Gold Standards Framework (2011) *Gold Standards Framework in End-of-Life Care.* https://goldstandardsframework.org.uk/

[16] National Institute for Health & Care Excellence (2019) *End of life care for adults: service delivery.* https://www.nice.org.uk/guidance/ng142

6. Evidence and evaluate individuals' outcomes of care against existing standards and manage and adjust plans appropriately in line with best available evidence. 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 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 individuals' 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 individuals' 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[17] 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.

[17] 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 specification 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)[18]. 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.
- 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 community rehabilitation for healthy ageing is the formal assessment of their fulfilment of the outcomes and capabilities set out in this document. The purpose of the assessment strategy outlined

[18] 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)

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.[19]

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.

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.

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

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.

Appendix 1: References and bibliography of resources that have informed the production of this credential specification

British Association of Parenteral and Enteral Nutrition, *Malnutrition Universal Screening Tool*; accessed via: https://www.bapen.org.uk/screening-and-must/must-calculator

British Geriatric Society (2019) C*omprehensive Geriatric Assessment Toolkit for Primary Care Practitioners:* https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-0312/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners_0.pdf

British Geriatric Society (2018) *Fit for Frailty:* https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-14/fff2_short.pdf

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Chartered Society of Physiotherapy (2012) *Physiotherapy works: Rehabilitation:* https://www.csp.org.uk/publications/physiotherapy-works-rehabilitation

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

Gold Standards Framework (2011) *Gold Standards Framework in End-of-Life Care:* https://goldstandardsframework.org.uk/

Health Education England (2017) *Multi-professional framework for advanced clinical practice in England:* Multi-professional framework for advanced practice in England (2017) - Advanced Practice (hee.nhs.uk)

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

Health Education England (2022) *Making every contact count:* http://www.makingeverycontactcount.co.uk/

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/ACPinLD&A

HM Government (2014) *Care Act*: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

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

Journal of Parenteral & Enteral Nutrition (1987) *What is subjective global assessment of nutritional status?* Accessed via: https://www.providencehealthcare.org/general_surgery/surgicaltrainees/documents/TPN_Dietician_LK.pdf

National Institute for Health and Care Excellence (NICE) (2018) *Chronic heart failure in adults: diagnosis and management:* https://www.nice.org.uk/guidance/ng106

NICE (2007) *Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalomyelitis): diagnosis and management:* https://www.nice.org.uk/guidance/cg53

NICE (2019) *Chronic obstructive pulmonary disease in over 16s: diagnosis and management.* https://www.nice.org.uk/guidance/ng115

NICE (2020) *Chronic pain in over 16s: assessment and management:* https://www.nice.org.uk/guidance/gid-ng10069/documents/draft-guideline

NICE (2019) *End of life care for adults: service delivery:* https://www.nice.org.uk/guidance/ng142

NICE (2017) *Falls in older people*: https://www.nice.org.uk/guidance/qs86

NICE (2014) *Pressure ulcers: prevention and management:* https://www.nice.org.uk/guidance/cg179

NICE (2020) *Type 2 diabetes in adults: management:* https://www.nice.org.uk/guidance/ng28

Patients Association (2018) *Nutrition Checklist* accessed via: https://www.eatwellagewell.org.uk/checklist

Personalised Care Institute (2020) *Personalised Care Institute Curriculum:* https://www.personalisedcareinstitute.org.uk/pluginfile.php/133/mod_page/content/28/PCICurriculum.pdf

Resuscitation Council UK *ReSPECT for Healthcare Professionals*; accessed via: https://www.resus.org.uk/respect/respect-healthcare-professionals

Skills for Health, Skills for Care and Health Education England (2017) *End of Life Care Core Skills Education and Training Framework:* https://www.skillsforhealth.org.uk/images/services/cstf/EoLC - Core Skills Training Framework.pdf?s=form

Skills for Health, NHS England and Health Education England (2018) *Frailty: A Framework of Core Capabilities:* http://www.skillsforhealth.org.uk/images/projects/frailty/Frailty framework.pdf

Skills for Health, Health Education England and NHS England (2018) *Musculoskeletal Core Capabilities Framework for First Contact Practitioners:* http://www.skillsforhealth.org.uk/images/projects/msk/Musculoskeletal framework.pdf

World Health Organisation (2020) *Rehabilitation:* https://www.who.int/news-room/factsheets/detail/rehabilitation

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 the Centre for Advancing Practice.

Subsequently, a full draft of the area specific capability framework was made available for wider consultation. The draft and a link to an online survey was 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 the Centre for Advancing Practice for independent review and endorsement as a 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	28 July, 24 September, 26 November 2020 and 18 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 feedback	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 area specific capability framework was commissioned by NHS England.

The project steering group was chaired by Esther Clift, consultant practitioner in frailty, Southern Health NHS Foundation Trust. Project management was provided by Rosemarie Simpson, and Colin Wright, senior consultants for Skills for Health.

Membership of the project steering group is listed below.

Name	Title / Organisation
Esther Clift **(chair)**	Consultant practitioner in frailty, Southern Health NHS Foundation Trust
Ben Allen	Chief executive officer, Oomph
Kate Bennett	Clinical lead physiotherapist, King's fellow, Solent NHS Trust
Charmaine Chandler	Lecturer in occupational therapy, University of East Anglia
Dr Richard Collier	Lead for HEE Centre for Advancing Practice
Nicky Ellis	Specialist physiotherapist/director, Hobbs Rehabilitation
Beverley Harden	National AHP lead, HEE
Helen Hobbs	Co-founder Hobbs Rehabilitation, Hobbs Rehabilitation
Kate Jackson	Professional advisor (allied health professional) Community Services & Ageing Well Programme, NHSE/I
Dr Clare Killingback	Physiotherapy programme lead, University of Hull
Dr Neil Langridge	Consultant physiotherapist, musculoskeletal services, Southern Health NHS Foundation Trust
Suhailah Mohamed	Inpatient occupational therapy team leader, East London NHS Foundation Trust
Rosemarie Simpson	Senior consultant, Skills for Health
Marie Stern	Service user representative
Ciara Tilley	Therapy lead for dietetics and speech and language therapy, Ashford and St Peter's Hospitals NHS Foundation Trust
Bex Townley	LLT director, exercise specialist, Later Life Training
Jonathan Williams	Specialist manager – peripatetic team; continuing healthcare advisor, specialist services, Dorset Council
Colin Wright	Senior consultant (frameworks), Skills for Health
Jan Zietara	National programme lead (Advanced clinical practice, allied health professions, dementia and end of life care), HEE

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[20].
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.
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.

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

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[21].
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[22].
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

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

[22] 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