



The UK Hospital at Home Society

# **A UK guide for the implementation of Hospital at Home training placements for Resident Doctors**

**Identifying Training Opportunities and Mapping Competencies from Postgraduate Medical Training Curricula to Hospital at Home services**

**Endorsed by:**



**British Geriatrics Society**  
Improving healthcare  
for older people

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NHS England initially led this guidance. The Hospital at Home society has led the guidance since Winter 2025 to apply it to four nations setting. The guidance written by Dr Jack Haywood (Principal Clinical Teaching Fellow, Imperial College London, and previous National Medical Director's Clinical Fellow at NHS England) for both organisations. Contributors to the guidance over its lifespan are acknowledged at the end of the guidance.

# Introduction

Hospital at home allows patients to receive acute care in the place they call home, which includes care homes. It is an acute clinical service with the staff, equipment, technologies, medication, and skills usually provided in hospitals and is therefore able to substitute for acute clinical care. The NHS's definition of these services is aligned with the [World Hospital at Home Congress consensus definition \(2023\)](#). The phrase 'Hospital at Home' is used in this document to describe services that replace acute hospital admission, in keeping with the [UK Hospital at Home position](#). This guidance does not include other forms of acute care provision in the community, such as urgent community response services, outpatient or ambulatory care delivered at home, virtual wards, or services primarily intended to prevent deterioration or manage long-term conditions where the patient would not otherwise require acute hospital admission – however, many of the principles may be helpful.

Hospital at home services are fully responsible for the patient, providing medical, nursing and allied healthcare support through a multidisciplinary team (MDT). The acuity of the patients differentiates hospital at home from other community services and hospital at home services are therefore required to have clear lines of clinical responsibility that would usually entail consultant level physician oversight for all patients (to provide equivalent care at home to that provided in an acute hospital setting).

All members of staff require training to work in hospital at home services, which are often unpredictable and require a higher level of risk and acuity to be managed in the community and shared with the patient and those close to them. Frameworks exist for many healthcare professionals in some contexts, such as the [Hospital at Home Knowledge and Skills Development Framework](#) for healthcare support workers, nurses, and allied health professionals in Scotland. Yet very little exists for the medical profession – particularly those who are in training.

The [NHS England Future Doctor report](#) outlines the skills that doctors will need in the future NHS. This includes three key themes which are directly relevant to hospital at home:

1. Patient-doctor relationship – the hospital at home setting changes the dynamic of the patient-doctor relationship with the doctor being a “guest” in the patient’s place of residence.
2. The transformed multi-professional team – the hospital at home team is multi-professional, incorporating leadership and expertise from a range of healthcare professionals, including medical leadership.

3. Adoption of technology – hospital at home services utilise many technologies to allow for accurate diagnosis (e.g. point of care diagnostic technology) or remote communication/monitoring.

In most postgraduate curricula for Resident Doctors, there are no competencies or capabilities to be specifically achieved in hospital at home or community settings. The UK Hospital at Home Society are working on providing a framework for capabilities coupled with a credentialling mechanism.

Many of the competencies or capabilities in existing postgraduate medical curricula at all levels *could* be achieved in hospital at home settings. With the number of patients receiving care through hospital at home continuing to grow, this will become increasingly important. Therefore, training in hospital at home settings should be integrated into postgraduate medical training at the earliest opportunity.

This document was originally developed after extensive consultation with clinicians, current hospital at home providers and the national NHS England hospital at home team to bring together the established hospital at home capability frameworks and postgraduate medical training curricula to provide guidance for both trainees and trainers about the role of Resident Doctors in these settings. It therefore does not intend to create new curricula, capabilities, or competencies, but rather highlight and map the relevant sections of already established guidelines.

It will also provide guidance for Training Programme Director's (TPDs), Heads of School (HoS), and Clinical/Educational Supervisors (CS/ES) on how to ensure Resident Doctors are safely and effectively provided with hospital at home training opportunities.

## Who is this guidance for?

This guidance will be of interest to those designing Resident Doctors placements, those running hospital at home services, senior educational leaders, and to Resident Doctors placed in hospital at home settings.

### **Resident Doctors**

The guidance sets out the expectations of the Resident Doctor when in a hospital at home environment. It outlines what they should expect from a hospital at home experience, the supervision they should receive, and make clear the curriculum capabilities they could achieve in hospital at home settings.

It can be used as the basis for formal or informal discussions in Clinical and Educational Supervisor meetings. It can be used to inform their Personal Development Plan (PDP) for the placement.

It can be used by the Resident Doctor to structure how they will evidence the capabilities gained in their own ePortfolios.

### **Hospital at Home, Educational, and Clinical Supervisors**

Ideally, the Resident Doctor's named Clinical Supervisor will be a Hospital at Home physician, working in the service the doctor is placed in. However, this may not be possible. Therefore, the Resident Doctor may have a suitably qualified practitioner as a supervisor in the hospital at home (named 'Hospital at Home Supervisor' in this guidance). Where the Resident Doctor's CS does work in the Hospital at Home service, there will not be an additional supervision required. This guidance is still helpful for the Resident Doctor's named Clinical and Educational Supervisors to understand the expectations of the Resident Doctor and hospital at home training provider.

It can also be used by the supervisor as part of the appraisal process with the Resident Doctor.

More details on this can be found in the [Supervision](#) section.

### **Hospital at Home Leaders**

The guidance will be valuable to the leadership/management of hospital at home teams who have Resident Doctors placed with them. It will outline the expectations of both the hospital at home team in providing the training opportunity as well as the expectations of the

Resident Doctor by outlining core capabilities. It also outlines the supervision capacity required to keep the Resident Doctor and patients safe.

### **Training Programme Directors and Heads of Schools**

The guidance can be used by educational leaders to understand the expectations of the hospital at home training provider and of the Resident Doctor in achieving core hospital at home capabilities. It can help them plan the hospital at home training opportunities which are relevant and feasible in the local context, including the consideration of supervision and service capacity.

The mapping of postgraduate medical curricula with established hospital at home capability frameworks can also outline how Resident Doctors can achieve key areas of their own postgraduate medical curriculum in the hospital at home setting.

### **Patients, People who use services, and the Public**

The guidance should allow patients, people who use services, carers, and the wider public to understand how Resident Doctors are trained in hospital at home environments, allowing the Resident Doctor to be an active participant in a wider multi-professional team and be prepared to lead a hospital at home in the future.

# Resident Doctor Hospital at Home Training Opportunities

Hospital at home services are delivered differently across systems, depending on patient need, resources available, and the staff available to work in them. There are core requirements for hospital at home services as set out across the UK. Hospital at Home services must offer the same level of physician oversight as an acute hospital admission, which may include consultant physicians, SAS physicians or GPs, who also currently provide hospital level care (e.g. in rural and remote settings).

Whilst the specific role and purpose of the medical professional will be different depending on the hospital at home service, Resident Doctors will need to acquire a consistent set of skills that prepare them to work in any hospital at home context, either as a trainee or later in their career as a Consultant. Furthermore, even if the Resident Doctor does not work in a hospital at home setting in the future, it is important that they understand the role these services play in healthcare, their interaction with primary, community and secondary care, and the patient journey.

The purpose of this document is to provide the necessary guidance to provide Resident Doctors with an opportunity to train in a hospital at home setting. Doctors of all levels will benefit from an experience in hospital at home settings. These should be meaningful experiences, where doctors can importantly receive training and contribute to the service, but also feel part of the team, to increase confidence doing home and community visits, to get familiar with hospital at home processes, to use the necessary equipment, to care for patients through their admission, and more.

It is recommended that all **Foundation Year 2 (FY2)** doctors, **Internal Medical Trainees (IMT)**, **General Practice Specialty Registrars**, and **Specialty Registrars (StRs)** in Acute Medicine, Geriatric Medicine, Paediatrics doctors are offered hospital at home placements. The Hospital at Home Society recommends these placements are continuous, rather than ad-hoc or isolated days in the service. This is so the Resident Doctor can deliver the continuity of care critical in hospital at home settings, be immersed into the MDT, receive meaningful training, and contribute to the service. What each of these placements should offer will depend on the competency of the doctor, with the appropriate induction (covered later).

In some systems across the country, Resident Doctors are already receiving placements of 4-12 months in hospital at home settings. This will be more possible in some specialties over

others, particularly in General Practice and Geriatric Medicine. For example, Geriatric Medicine Trainees are required to select a Geriatric Medicine Specialty option, where they should spend three months focusing on one of five options.

The outcomes of a placement for Resident Doctors will depend on their stage of training and competency. The induction and level of supervision will also vary. For example, StRs will be more focused on more independent, senior decision making, progressing towards Consultant level practice. However, the suggested objectives of a placement in a hospital at home are the same for all Resident doctors, with their curriculum guiding the level of competency needed for each:

1. To understand how a hospital at home service is run, including the admission process, board rounds, the technologies used to monitor patients remotely, diagnostics, and discharge processes,
2. To understand the role of hospital at home in the local primary, secondary, and community healthcare context and how they interact,
3. To take part in the assessment and safe management of patients in hospital at home settings who would traditionally have been managed in the hospital, including during home visits, board rounds, and on call,
4. To assess a patient for admission to the hospital at home, to discharge them home, and/or to escalate to an acute in-patient bed (if needed),
5. To understand the clinical conditions that may be cared for in the hospital at home setting and undertake training experiences around these,
6. To take part in conversations with the patient and the MDT about future care planning, incorporating patient wishes and needs.
7. To understand and use the technologies used to deliver acute care in the community and point of care diagnostics such as point of care ultrasound (POCUS) and testing (PoCT), recognising the applications and limitations of these tools,
8. To understand the role of the doctor in hospital at home settings, both in leading a hospital at home and being a member of the multi-professional team, and
9. To understand and acquire confidence in the level of risk management required to care for patients in hospital at home settings, including remotely and in the home environment, particularly around the requirement to transfer a patient to an acute setting or to discharge a patient from the hospital at home.

Resident Doctors encouraged to complete workplace-based assessments (WPBAs) required in their curriculum to demonstrate these objectives have been met, including case-based discussions, supervised learning events, and reflections, as per their curriculum.

# Trainee Supervision

As part of Resident Doctor training, they will have an Educational and Clinical Supervisor.

*The Gold Guide* defines these roles as the following:

1. Educational Supervisor (ES) – a named trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements.<sup>1</sup>
2. Clinical Supervisor (CS) - a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and for providing constructive feedback during a training placement.<sup>4</sup>

It is important that the Resident Doctor is adequately supervised in the hospital at home setting, irrespective of whether their ES and/or CS also works in the service. Therefore, it will be important the Resident Doctor also has a named Hospital at Home Supervisor – **this is only necessary if their ES/CS does not work in the service.**<sup>2</sup>

The CS or Hospital at Home Supervisor will fulfil the following functions:

1. Welcome the Resident Doctor to the hospital at home and provide an induction (further details below),
2. Ensure the Resident Doctor meets the objectives outlined in the [Training Opportunities](#) section,
3. Ensure the Resident Doctor can develop the capabilities to be safe and competent to run a hospital at home consultation both face-to-face and virtually,
4. Provide sign-off for workplace-based assessments (WPBA) in the hospital at home,
5. Provide a short report to the Resident Doctor clinical or educational supervisor, if requested.

This Hospital at Home Supervisor should be a clinician working within the hospital at home multi-disciplinary team. They should be suitably qualified to supervise and have a clear line of communication with the Resident Doctor's Educational/Clinical Supervisor(s).

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<sup>1</sup> [Gold-Guide-9th-Edition-August-2022.pdf \(copmed.org.uk\)](#)

<sup>2</sup> The Gold Guide also states: *"In addition to having educational and clinical supervisors, some specialties may include additional defined formal supervision arrangements for specific stages of training or modules in their curriculum."* This facilitates the use of a separate Hospital at Home supervisor

The induction process will be very important for the Resident Doctor in the hospital at home as this type of work and training may be unfamiliar. The induction should be adapted according to the specific service and the level of training, but should cover the following:

1. The admission and discharge processes,
2. Escalation processes (i.e., shared decision-making and admissions to an acute hospital),
3. The conditions that can be managed in the hospital at home setting,
4. The practicalities of managing patients in their own homes,
5. Risk management in the home setting including lone working,
6. The technology used in the hospital setting, including PoCT, virtual calls, and remote monitoring,
7. The on-call process, and
8. Trainee wellbeing

# Core Capabilities

Resident Doctors have a curriculum that they must follow in their training programme, and this provides core capabilities to be achieved to complete Foundation or Internal Medical Training or gain a Certificate of Completion of Training (CCT) in that specialty.

It should be possible, and encouraged, for a Resident Doctor in a hospital at home setting to meet some of their curriculum core capabilities during that time. The purpose of this section is to map the [Skills for Health Virtual Ward and Urgent Community Response Capabilities Framework](#) to specialty curriculum capabilities. This framework was developed in collaboration with NHS England, however the principles and practice of Hospital at Home are broadly analogous across all four nations. Therefore, this section may be instructive for all regions in detailing how clinical capabilities can be met in a Hospital at Home setting.

This guidance also prioritises key skills that have been identified as being vital for Resident Doctors to learn in a hospital at home setting, as well as the clinical conditions expected to be cared for in these settings to prepare the Resident Doctor to have a senior role in them in the future.

## Key Skills

After consultation with hospital at home partners, key skills that are particularly unique to the hospital at home setting were identified. It was felt that the following key skills are critical for the Resident Doctor to gain during their hospital at home experience:

1. MDT working in a community setting, where the role of the clinician may be significantly different to that in the in-patient acute setting,
2. Risk management in the hospital at home setting, where the risk threshold may be significantly different to the in-patient setting with more clinical uncertainty,
3. Caring for a patient in a non-healthcare environment, including their own home or a place they call home (e.g. care home) and remotely, with an understanding of the technologies available in hospital at home/ community settings,
4. The ability to deliver individualised care plans for patients in the community, incorporating future care planning and shared decision making, and
5. Being aware of the services available in the community to care for patients.

## Curriculum Mapping

The relevant postgraduate specialty capabilities are mapped against the Skills for Health Framework. The numbering within the tables below correspond to the sections of the respective curriculum documents. Using these tables, WPBA can be completed by identifying the Skills for Health Framework capabilities, which staff in hospital at home

settings may be more familiar with, and then mapped to the Resident Doctors curriculum capabilities.

It should also be noted that a Senior Clinician or Consultant, which the Resident Doctor is training to become, are given as Tier 3 indicative roles in the Skills for Health framework. This is defined as *“most relevant to those staff with clinical and professional accountability and responsibility for the whole care of the patient, including escalations within the system”*. They are therefore expected to meet **all** the core capabilities to work as senior clinicians in the Hospital at Home setting.

To ensure adequate mapping to postgraduate medical curricula, the Core Capabilities outlined in this section will focus on those capabilities that will contribute directly to a Resident Doctors training needs, as per their specialty curriculum. This means there will be some Skills for Health Framework Tier 3 capabilities that are not included below (as they do not directly map to postgraduate medical curricula) – however, the capabilities not featured in this guidance will still be critical when a doctor has a senior role in the Hospital at Home.

### **Foundation Resident Doctors**

Foundation Doctors must meet 3 Higher Level Outcomes (HLOs) which are based on the nine General Medical Council General Professional Capabilities (GPCs) framework. These nine GPCs need to be met by all specialty trainees, and so also feature in the medical and paediatric curricula – however, they are presented differently in each curriculum.

The 3 HLOs are split into 13 Foundation Professional Capabilities (FPCs). The FPCs are mapped below.

### **Medical Specialty Resident Doctors**

Medical postgraduate doctor in training curricula for both Internal Medical Training and Higher Specialty Training are split into:

1. Generic capabilities in practice – composed of six generic capabilities in practice which are based on the nine General Medical Council GPCs.
2. Clinical capabilities in practice – there are eight internal medicine clinical capabilities in practice which are required by all medical postgraduate curricula.
3. Higher specialty capabilities in practice – these describe the clinical tasks or activities which are essential to the practice of the specific higher specialty (such as Geriatric Medicine or Respiratory Medicine, as examples).<sup>3</sup> *To keep this guidance as generic as possible, these capabilities will not be mapped. **However, this is not to say that***

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<sup>3</sup> [Internal Medicine \(Stage 2\) 2022 curriculum FINAL 200522\\_0.pdf \(jrcptb.org.uk\)](#)

***they cannot be achieved during a hospital at home placement and the UK Hospital at Home Society is currently working on a clinical capabilities framework to facilitate this mapping.***

### **Paediatric Specialty Resident Doctors**

The paediatric postgraduate doctor in training curriculum is split into 11 curriculum domains based on the GMC GPCs. If a doctor sub-specialises in a paediatric discipline, they will need to meet “Level 3” capabilities<sup>4</sup> – *to keep this guidance as generic as possible, these capabilities will not be mapped. However, this is not to say that they cannot be achieved during a hospital at home placement and the UK Hospital at Home Society is currently working on a clinical capabilities framework to facilitate this mapping.*

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<sup>4</sup> [rcpch-progress-main-curriculum-report-2018--final- pdf-73260745.pdf \(gmc-uk.org\)](https://www.gmc-uk.org/curriculum/progress-main-curriculum-report-2018--final-pdf-73260745.pdf)

Table 1 maps the Foundation Curriculum FPCs with the Skills for Health framework capabilities that can be used to contribute to these FPCs.

Table 2 maps the GPCs as described in the medical and paediatric curricula with the Skills for Health framework capabilities that can be used to contribute to these GPCs.

Table 3 maps the medical clinical capabilities in practice with the Skills for Health framework capabilities that can be used to contribute to these.

**This mapping is not exhaustive – there may be other Skills for Health framework capabilities that map to postgraduate curricula capabilities. This mapping focuses on the capabilities that are most directly relevant to be captured by WPBA, as required by the postgraduate curricula.**

*Table 1: Foundation Professional Capabilities (FPCs) mapped with the Skills for Health Framework*

| Foundation Curriculum |                                                                                                                       | Skills for Health Framework |                                                                                                                                                                                                                                                                                              |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FPC1                  | Clinical assessment: assess patient needs in a variety of clinical settings including acute, non-acute and community. | 2m                          | Evaluate the implications of lack of capacity, and apply in practice, the relevant legislation for informed consent and shared decision-making (e.g., mental capacity legislation)                                                                                                           |
|                       |                                                                                                                       | 5a                          | Record all pertinent information gathered concisely and accurately for clinical management, and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance.                                                      |
|                       |                                                                                                                       | 5b                          | Undertake appropriate assessment and formulate an appropriate plan of care jointly with individuals, including psychosocial history to provide some context for patients' issues.                                                                                                            |
|                       |                                                                                                                       | 5d                          | Understand and apply a range of consultation models appropriate to the clinical situation and appropriately across physical, mental, social and psychological presentations                                                                                                                  |
|                       |                                                                                                                       | 5f                          | Incorporate information on the nature of the patient's needs, preferences, and priorities from various other appropriate sources, e.g., third parties, previous histories, and investigation.                                                                                                |
|                       |                                                                                                                       | 5g                          | Undertake systematic clinical examination of complex, incomplete, ambiguous, and conflicting information gathered from history-taking and/or examination, distilling and synthesising key factors from the appraisal, and identifying those elements that may need to be pursued further.    |
|                       |                                                                                                                       | 5h                          | Deliver diagnosis and test/investigation results (including sad and difficult news) sensitively and appropriately in line with local or national guidance, using a range of media such as spoken word and diagrams to ensure the patient has understanding about what has been communicated. |

|  |  |      |                                                                                                                                                                                                                                                                                                                                                                                 |
|--|--|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  |  | 6c   | Apply a range of physical assessment and cognitive clinical examination skills appropriately, systematically, and effectively, including for delirium and dementia, and escalate or refer as appropriate.                                                                                                                                                                       |
|  |  | 6d   | Undertake appropriate monitoring for the individual and clinical situation, recognising the deterioration of an individual's physical and mental health, and intervene, escalate, or refer as appropriate.                                                                                                                                                                      |
|  |  | 7a   | Make a differential diagnosis in a structured way using a problem-solving methodology informed by an understanding of probability based on prevalence, incidence, and natural history of illness to aid decision-making.                                                                                                                                                        |
|  |  | 7b   | Synthesise the expertise of multi-professional teams across organisations and professional boundaries to aid in diagnosis where needed.                                                                                                                                                                                                                                         |
|  |  | 7c   | Interpret findings and results using advanced diagnostics skills and undertake appropriate interventions, including urgent referral/escalation as in life threatening situations, or further investigation, treatment, or referral, considering clinician limitations and patients' wishes                                                                                      |
|  |  | 7f   | Arrange appropriate follow up that is safe and timely to monitor changes in the patient's condition in response to treatment and advice, recognising the indications for a changing clinical picture and the need for escalation or alternative treatment as appropriate                                                                                                        |
|  |  | 7h   | Vary the management options responsively according to the circumstances, priorities, needs, preferences, and benefits for those involved, with an understanding of local service availability and relevant guidelines and resources, ensuring that risks are understood and the rationale for decisions clearly documented.                                                     |
|  |  | 7k   | Simultaneously manage acute and chronic problems, including for patients with multiple morbidities, and those who are living with frailty, 5 adopting an anticipatory care approach to both identify and manage current and future issues, including physical, emotional, mental, and psychosocial.                                                                             |
|  |  | VW2d | Develop a personalised management plan (including documented and agreed criteria for discharge) in partnership with the patient, their family and/or carer(s), to ensure full understanding of the requirements of being cared for in a virtual ward, and to enable the patient, their family and/or carer to make an informed decision about their ongoing care and treatment. |
|  |  | VW3c | Ensure the patient is aware of monitoring parameters and when to seek help, as per SOPs, understands how, and, is able to self-monitor their condition using the device(s) provided in line with the agreed monitoring plan, with appropriate support if required.                                                                                                              |
|  |  | VW3f | Enable effective communication approaches in non face-to-face situations e.g., remote consultation, either via phone or video conferencing.                                                                                                                                                                                                                                     |
|  |  | VW3g | Utilise video conferencing, as and when deemed a safe and appropriate method of assessment, to conduct a visual assessment of the patient and their general condition.                                                                                                                                                                                                          |

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|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|      |                                                                                                                                                                                             | VW3h | Undertake a 'virtual visit,' utilising telephone monitoring to gain current health status of the patient, arrange a home visit if required, ensuring the appropriately skilled practitioner attends to carry out required interventions.                                                                                                                                                                                                |
| FPC2 | Clinical prioritisation: recognise and, where appropriate, initiate urgent treatment of deterioration in physical and mental health.                                                        | VW1e | Conduct a holistic assessment, utilising clinical judgement and diagnostic reasoning, within scope of professional practice, to determine that the patient meets the admission criteria for the virtual ward.                                                                                                                                                                                                                           |
|      |                                                                                                                                                                                             | VW1b | Recognise the risk and acuity involved with each referral and manage appropriately                                                                                                                                                                                                                                                                                                                                                      |
|      |                                                                                                                                                                                             | VW1e | Conduct a holistic assessment, utilising clinical judgement and diagnostic reasoning, within scope of professional practice, to determine that the patient meets the admission criteria for the virtual ward.                                                                                                                                                                                                                           |
|      |                                                                                                                                                                                             | VW3i | Identify and evaluate any deterioration in a patient's condition and take appropriate action, or escalate to others where appropriate, adhering to established escalation pathway                                                                                                                                                                                                                                                       |
| FPC3 | Holistic planning: diagnose and formulate treatment plans (with appropriate supervision) that include ethical consideration of the physical, psychological and social needs of the patient. | 2b   | Work collaboratively with the wider multi-disciplinary team to promote physical and mental wellbeing for all individuals as appropriate.                                                                                                                                                                                                                                                                                                |
|      |                                                                                                                                                                                             | 2d   | Understand and be able to describe the factors affecting the health and wellbeing of a community (e.g., equity, income, education, environment).                                                                                                                                                                                                                                                                                        |
|      |                                                                                                                                                                                             | 2e   | Recognise and foster the importance of social networks and communities for the patient and where applicable their carers/families in managing long-term health conditions, such as working appropriately with social prescribers, link workers, health coaches, statutory and voluntary organisations, and support groups. Signpost to voluntary, community and social enterprise organisations and community resources as appropriate. |
|      |                                                                                                                                                                                             | 2f   | Respond appropriately to the impact of psychosocial factors on the presenting problems or general health such as housing issues, work issues, family/carers issues, lack of support, social isolation and loneliness, and consider in the context of local social prescribing services.                                                                                                                                                 |
| FPC4 | Communication and care: provide clear explanations to patients/carers, agree a plan and deliver healthcare advice and treatment where appropriate.                                          | 1a   | Communicate clearly and coherently, taking into account the needs of the patient.                                                                                                                                                                                                                                                                                                                                                       |
|      |                                                                                                                                                                                             | 1b   | Acknowledge and respond to communication promptly, actively listening to the personal views, beliefs and spiritual views of patients, their informed choices, and their individual goals.                                                                                                                                                                                                                                               |
|      |                                                                                                                                                                                             | 1c   | Adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to the patient's communication and language needs, preferences, and abilities (including levels of spoken English and health literacy) and use accessible information                                                                                                                                                                       |
|      |                                                                                                                                                                                             | 1e   | Ensure that the environment is as conducive as possible to effective communication, evaluating and remedying situations, circumstances or places (during home visits, care home visits or in emergency situations) which make it difficult to communicate and have strategies in place to overcome these barriers.                                                                                                                      |

|      |                                                                                                                                                                                                 |    |                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|      |                                                                                                                                                                                                 | 1j | Reflect on communication strategies and skilfully adapt these to ensure they foster an environment of patient empowerment, including taking steps to ensure patients, families and carers are enabled to use technology.                                                                                                                                                                                                     |
|      |                                                                                                                                                                                                 | 1k | Convey information and address issues in ways that avoid jargon and assumptions; respond appropriately to questions and concerns to promote understanding with verbal, written and digital information that is realistic, balanced and honest, and provide advice which can empower better informed choices and foster higher quality shared decision-making with patients, their families and carers, rather than for them. |
|      |                                                                                                                                                                                                 | 3a | Work with families and carers to ensure that patients receive the necessary care, keeping them updated, and consider how local professionals can work together to support this process.                                                                                                                                                                                                                                      |
|      |                                                                                                                                                                                                 | 3b | Understand what support, services and resources are available for families and carers, including practical and emotional support services, and support them to access them.                                                                                                                                                                                                                                                  |
|      |                                                                                                                                                                                                 | 3c | Support families/carers to make well-timed decisions, which are in the best interests of their relative where appropriate, such as those who have impaired capacity or where a lasting power of attorney is in place.                                                                                                                                                                                                        |
|      |                                                                                                                                                                                                 | 3d | Recognise the impact of the presenting problem on family and carers as well as on the patient, including any resulting stress, and the potential impact on carers of providing care at home.                                                                                                                                                                                                                                 |
| FPC5 | Continuity of care: contribute to safe ongoing care both in and out of hours.                                                                                                                   | 7l | Manage interface with care provision which may be needed out of hours                                                                                                                                                                                                                                                                                                                                                        |
| FPC6 | Sharing the vision: work confidently within and, where appropriate, guide the multiprofessional team to deliver a consistently high standard of patient care based on sound ethical principles. | 4a | Work effectively and respectfully within and across multi-disciplinary health and social care teams and across organisations. Maintain a knowledge and understanding of the wider primary, community and secondary care, voluntary sector services and teams, and refer independently using professional judgement.                                                                                                          |
|      |                                                                                                                                                                                                 | 4b | Advocate and utilise the expertise and contribution to patients' care of all allied health and social care professionals and work collaboratively within the multi-professional team to optimise assessment, diagnosis and integrated management and care for people.                                                                                                                                                        |
|      |                                                                                                                                                                                                 | 4c | Work within and across a complex systems environment of multi-specialty teams and different pathways, managing the complexity of transition from one team to another or membership of multiple teams and cross organisational and professional boundaries                                                                                                                                                                    |

*Table 2: Generic Professional Capabilities (GPCs) in the medical and paediatric curricula mapped with the Skills for Health Framework*

| Medical Curriculum |                                                                                                                                                                       | Paediatric Curriculum                                                                                                                                  | Skills for Health Framework |                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1                  | Able to function successfully within NHS organisational and management systems                                                                                        | Domain 1: Professional values and behaviours and professional knowledge                                                                                | 2d                          | Understand and be able to describe the factors affecting the health and wellbeing of a community (e.g., equity, income, education, environment).                                                                                                                                                                                                                                                                             |
|                    |                                                                                                                                                                       |                                                                                                                                                        | 4a                          | Work effectively and respectfully within and across multi-disciplinary health and social care teams and across organisations. Maintain a knowledge and understanding of the wider primary, community and secondary care, voluntary sector services and teams, and refer independently using professional judgement.                                                                                                          |
| 2                  | Able to deal with ethical and legal issues related to clinical practice                                                                                               | Domain 1: Professional values and behaviours and professional knowledge<br>Domain 5: Health promotion and illness prevention<br>Domain 9: Safeguarding | 9h                          | Demonstrate receptiveness to challenge and preparedness to constructively challenge others across organisational and professional boundaries, escalating concerns that affect patients, families, carers, communities and colleagues' safety and wellbeing when necessary.                                                                                                                                                   |
| 3                  | Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement | Domain 2: Professional skills: communication<br>Domain 4: Professional skills: patient management<br>Domain 6: Leadership and team working             | 1b                          | Acknowledge and respond to communication promptly, actively listening to the personal views, beliefs and spiritual views of patients, their informed choices, and their individual goals.                                                                                                                                                                                                                                    |
|                    |                                                                                                                                                                       |                                                                                                                                                        | 1c                          | Adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to the patient's communication and language needs, preferences, and abilities (including levels of spoken English and health literacy) and use accessible information                                                                                                                                                            |
|                    |                                                                                                                                                                       |                                                                                                                                                        | 1e                          | Ensure that the environment is as conducive as possible to effective communication, evaluating and remedying situations, circumstances or places (during home visits, care home visits or in emergency situations) which make it difficult to communicate and have strategies in place to overcome these barriers.                                                                                                           |
|                    |                                                                                                                                                                       |                                                                                                                                                        | 1j                          | Reflect on communication strategies and skilfully adapt these to ensure they foster an environment of patient empowerment, including taking steps to ensure patients, families and carers are enabled to use technology.                                                                                                                                                                                                     |
|                    |                                                                                                                                                                       |                                                                                                                                                        | 1k                          | Convey information and address issues in ways that avoid jargon and assumptions; respond appropriately to questions and concerns to promote understanding with verbal, written and digital information that is realistic, balanced and honest, and provide advice which can empower better informed choices and foster higher quality shared decision-making with patients, their families and carers, rather than for them. |

|  |  |  |    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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|  |  |  | 2b | Work collaboratively with the wider multi-disciplinary team to promote physical and mental wellbeing for all individuals as appropriate.                                                                                                                                                                                                                                                                                                |
|  |  |  | 2e | Recognise and foster the importance of social networks and communities for the patient and where applicable their carers/families in managing long-term health conditions, such as working appropriately with social prescribers, link workers, health coaches, statutory and voluntary organisations, and support groups. Signpost to voluntary, community and social enterprise organisations and community resources as appropriate. |
|  |  |  | 2g | Support patient self-care and self-management and work in such a way that is non-judgmental and respects the rights, privacy, and dignity of individuals, promoting choice and independence as applicable.                                                                                                                                                                                                                              |
|  |  |  | 2h | Enable and support individuals to assert their views, control their own lives and make informed choices about the services and care they receive. Awareness of and support to individuals in the management of Personal Health Budgets (PHB) and related supply of care and services.                                                                                                                                                   |
|  |  |  | 2j | Develop and promote shared decision-making and shared management/personalised care/support plans with people, individualised to meet their needs and personal goals in partnership, where appropriate, with other health and social care providers and with family, carers, and voluntary organisations where applicable.                                                                                                               |
|  |  |  | 3a | Work with families and carers to ensure that patients receive the necessary care, keeping them updated, and consider how local professionals can work together to support this process.                                                                                                                                                                                                                                                 |
|  |  |  | 3b | Understand what support, services and resources are available for families and carers, including practical and emotional support services, and support them to access them.                                                                                                                                                                                                                                                             |
|  |  |  | 3c | Support families/carers to make well-timed decisions, which are in the best interests of their relative where appropriate, such as those who have impaired capacity or where a lasting power of attorney is in place.                                                                                                                                                                                                                   |
|  |  |  | 3d | Recognise the impact of the presenting problem on family and carers as well as on the patient, including any resulting stress, and the potential impact on carers of providing care at home.                                                                                                                                                                                                                                            |
|  |  |  | 4a | Work effectively and respectfully within and across multi-disciplinary health and social care teams and across organisations. Maintain a knowledge and                                                                                                                                                                                                                                                                                  |

|   |                                                                                          |                                                                                                                                                                                                                                                                                                                                   |      |                                                                                                                                                                                                                                                                                                                                                                                 |
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|   |                                                                                          |                                                                                                                                                                                                                                                                                                                                   |      | understanding of the wider primary, community and secondary care, voluntary sector services and teams, and refer independently using professional judgement.                                                                                                                                                                                                                    |
|   |                                                                                          |                                                                                                                                                                                                                                                                                                                                   | 4b   | Advocate and utilise the expertise and contribution to patients' care of all allied health and social care professionals and work collaboratively within the multi-professional team to optimise assessment, diagnosis and integrated management and care for people.                                                                                                           |
|   |                                                                                          |                                                                                                                                                                                                                                                                                                                                   | 4c   | Work within and across a complex systems environment of multi-specialty teams and different pathways, managing the complexity of transition from one team to another or membership of multiple teams and cross organisational and professional boundaries                                                                                                                       |
|   |                                                                                          |                                                                                                                                                                                                                                                                                                                                   | 9c   | Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit).                                                                                                                                                                                                                                                                      |
|   |                                                                                          |                                                                                                                                                                                                                                                                                                                                   | 9d   | Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working.                                                                                                                                                                                                                                             |
|   |                                                                                          |                                                                                                                                                                                                                                                                                                                                   | VW2d | Develop a personalised management plan (including documented and agreed criteria for discharge) in partnership with the patient, their family and/or carer(s), to ensure full understanding of the requirements of being cared for in a virtual ward, and to enable the patient, their family and/or carer to make an informed decision about their ongoing care and treatment. |
|   |                                                                                          |                                                                                                                                                                                                                                                                                                                                   | VW4c | Work with the differing skills within multi-disciplinary teams and empower members of the team to make independent decisions in accordance with their scope of practice, knowledge, skills, and expertise.                                                                                                                                                                      |
| 4 | Is focussed on patient safety and delivers effective quality improvement in patient care | Domain 1: Professional values and behaviours and professional knowledge<br>Domain 2: Professional skills: communication<br>Domain 4: Professional skills: patient management<br>Domain 5: Health promotion and illness prevention<br>Domain 6: Leadership and team working<br>Domain 7: Patient safety including safe prescribing | 9g   | Demonstrate receptiveness to challenge and preparedness to constructively challenge others across organisational and professional boundaries, escalating concerns that affect patients, families, carers, communities and colleagues' safety and wellbeing when necessary.                                                                                                      |

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| 5 | Carrying out research and managing data appropriately | Domain 1: Professional values and behaviours and professional knowledge<br>Domain 9: Safeguarding<br>Domain 11: Research | 5a   | Record all pertinent information gathered concisely and accurately for clinical management, and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance      |
|   |                                                       |                                                                                                                          | 11c  | Critically engage in research/quality improvement activity, adhering to good, ethical research practice guidance, so that evidence-based strategies are developed and applied to enhance quality, safety, productivity and value for money. |
|   |                                                       |                                                                                                                          | 11h  | Lead on quality improvement initiatives/projects – sharing outcomes and leading change                                                                                                                                                      |
|   |                                                       |                                                                                                                          | VW4e | Understand information governance and legal safeguards for sharing patient data together with their proportionate application.                                                                                                              |

*Table 3: Medical clinical capabilities in practice mapped with Hospital at Home (Virtual ward and Urgent Community Response Capabilities Framework) capabilities*

| Medical Curriculum |                                                                                                                           | Skills for Health Framework |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2                  | Managing the acute care of patients within a medical specialty service                                                    | VW1a                        | Know and understand the admission (inclusion and exclusion) criteria and main referral routes into the virtual ward to adhere to the referral pathway, in accordance with the standard operating procedure (SOP) for the service.                                                                                                                                                                                                       |
|                    |                                                                                                                           | VW1b                        | Recognise the risk and acuity involved with each referral and manage appropriately                                                                                                                                                                                                                                                                                                                                                      |
|                    |                                                                                                                           | VW1e                        | Conduct a holistic assessment, utilising clinical judgement and diagnostic reasoning, within scope of professional practice, to determine that the patient meets the admission criteria for the virtual ward.                                                                                                                                                                                                                           |
|                    |                                                                                                                           | VW1f                        | Manage patient/family/carer expectations with respect to patients not being medically fit and back to baseline when referred/discharged to a virtual ward.                                                                                                                                                                                                                                                                              |
| 4                  | Managing patients in an outpatient clinic, ambulatory or community setting (including management of long-term conditions) | 2e                          | Recognise and foster the importance of social networks and communities for the patient and where applicable their carers/families in managing long-term health conditions, such as working appropriately with social prescribers, link workers, health coaches, statutory and voluntary organisations, and support groups. Signpost to voluntary, community and social enterprise organisations and community resources as appropriate. |
|                    |                                                                                                                           | 2g                          | Support patient self-care and self-management and work in such a way that is non-judgmental and respects the rights, privacy, and dignity of individuals, promoting choice and independence as applicable                                                                                                                                                                                                                               |
|                    |                                                                                                                           | 2h                          | Enable and support individuals to assert their views, control their own lives and make informed choices about the services and care they receive. Awareness of and support to individuals in the management of Personal Health Budgets (PHB) and related supply of care and services.                                                                                                                                                   |
|                    |                                                                                                                           | 2j                          | Develop and promote shared decision-making and shared management/personalised care/support plans with people, individualised to meet their needs and personal goals in partnership, where appropriate, with other health and social care providers and with family, carers, and voluntary organisations where applicable.                                                                                                               |
|                    |                                                                                                                           | 3b                          | Understand what support, services and resources are available for families and carers, including practical and emotional support services, and support them to access them.                                                                                                                                                                                                                                                             |
|                    |                                                                                                                           | 3c                          | Support families/carers to make well-timed decisions, which are in the best interests of their relative where appropriate, such as those who have impaired capacity or where a lasting power of attorney is in place.                                                                                                                                                                                                                   |

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|  | 3d | Recognise the impact of the presenting problem on family and carers as well as on the patient, including any resulting stress, and the potential impact on carers of providing care at home.                                                                                                 |
|  | 5d | Understand and apply a range of consultation models appropriate to the clinical situation and appropriately across physical, mental, social and psychological presentations                                                                                                                  |
|  | 5f | Incorporate information on the nature of the patient's needs, preferences, and priorities from various other appropriate sources, e.g., third parties, previous histories, and investigation.                                                                                                |
|  | 5g | Undertake systematic clinical examination of complex, incomplete, ambiguous, and conflicting information gathered from history-taking and/or examination, distilling and synthesising key factors from the appraisal, and identifying those elements that may need to be pursued further.    |
|  | 5h | Deliver diagnosis and test/investigation results (including sad and difficult news) sensitively and appropriately in line with local or national guidance, using a range of media such as spoken word and diagrams to ensure the patient has understanding about what has been communicated. |
|  | 6c | Apply a range of physical assessment and cognitive clinical examination skills appropriately, systematically, and effectively, including for delirium and dementia, and escalate or refer as appropriate.                                                                                    |
|  | 6d | Undertake appropriate monitoring for the individual and clinical situation, recognising the deterioration of an individual's physical and mental health, and intervene, escalate, or refer as appropriate.                                                                                   |
|  | 7a | Make a differential diagnosis in a structured way using a problem-solving methodology informed by an understanding of probability based on prevalence, incidence, and natural history of illness to aid decision-making.                                                                     |
|  | 7b | Synthesise the expertise of multi-professional teams across organisations and professional boundaries to aid in diagnosis where needed.                                                                                                                                                      |
|  | 7c | Interpret findings and results using advanced diagnostics skills and undertake appropriate interventions, including urgent referral/escalation as in life threatening situations, or further investigation, treatment, or referral, considering clinician limitations and patients' wishes   |
|  | 7d | Monitor and review hypotheses in light of additional information and think flexibly around problems, generating functional problem lists and safe treatment plans, acknowledging patient autonomy.                                                                                           |
|  | 7e | Recognise limitations in evidence, data, and situation, and when taking mitigating actions to manage risk appropriately. Recognise and acknowledge the concept of prognostic                                                                                                                 |

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|  |  |      | uncertainty and, where that exists, consider this in discussions with patients, their families and/or carers when exploring options, and discuss treatment expectations and scenarios for preferred anticipatory management.                                                                                                                                                   |
|  |  | 7f   | Arrange appropriate follow up that is safe and timely to monitor changes in the patient's condition in response to treatment and advice, recognising the indications for a changing clinical picture and the need for escalation or alternative treatment as appropriate                                                                                                       |
|  |  | 7h   | Vary the management options responsively according to the circumstances, priorities, needs, preferences, and benefits for those involved, with an understanding of local service availability and relevant guidelines and resources, ensuring that risks are understood and the rationale for decisions clearly documented.                                                    |
|  |  | 7i   | Safely prioritise problems in situations using shared agenda setting where the patient presents with multiple issues.                                                                                                                                                                                                                                                          |
|  |  | 7j   | Undertake a comprehensive geriatric assessment (CGA) for people living with moderate or severe frailty.                                                                                                                                                                                                                                                                        |
|  |  | 7k   | Simultaneously manage acute and chronic problems, including for patients with multiple morbidities, and those who are living with frailty, 5 adopting an anticipatory care approach to both identify and manage current and future issues, including physical, emotional, mental, and psychosocial.                                                                            |
|  |  | 7l   | Manage interface with care provision which may be needed out of hours                                                                                                                                                                                                                                                                                                          |
|  |  | VW2a | Conduct remote triage of patients and undertake, in accordance with the SOP for the service, an initial screening to assess patient suitability for the virtual ward environment, including home access issues, KeySafe location, safety of home environment, impact on family and/or carer(s), cultural and/or language sensitivities.                                        |
|  |  | VW2b | Undertake clinical risk assessment in the absence of face-to-face review.                                                                                                                                                                                                                                                                                                      |
|  |  | VW2c | Explain the processes and procedures, including use of digital devices, to patients deemed suitable for admission to a virtual ward, and gain their consent for monitoring and/or treatment.                                                                                                                                                                                   |
|  |  | VW2d | Develop a personalised management plan (including documented and agreed criteria for discharge) in partnership with the patient, their family and/or carer(s), to ensure full understanding of the requirements of being cared for in a virtual ward, and to enable the patient, their family and/or carer to make an informed decision about their ongoing care and treatment |
|  |  | VW2g | Establish the patient's competence and willingness in engaging with remote monitoring. Give information and set expectations as to what is required by the patient or their carer.                                                                                                                                                                                             |

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|   |                                                                              | VW3b | Discuss and agree monitoring arrangements with the patient, including ensuring timely delivery of appropriate monitoring equipment. The importance of timely submission of data for those patients that are not being continuously monitored should be discussed and agreed.                                        |
|   |                                                                              | VW3c | Ensure the patient is aware of monitoring parameters and when to seek help, as per SOPs, understands how, and, is able to self-monitor their condition using the device(s) provided in line with the agreed monitoring plan, with appropriate support if required.                                                  |
|   |                                                                              | VW3f | Enable effective communication approaches in non face-to-face situations e.g., remote consultation, either via phone or video conferencing.                                                                                                                                                                         |
|   |                                                                              | VW3g | Utilise video conferencing, as and when deemed a safe and appropriate method of assessment, to conduct a visual assessment of the patient and their general condition.                                                                                                                                              |
|   |                                                                              | VW3h | Undertake a 'virtual visit,' utilising telephone monitoring to gain current health status of the patient, arrange a home visit if required, ensuring the appropriately skilled practitioner attends to carry out required interventions.                                                                            |
|   |                                                                              | VW3i | Identify and evaluate any deterioration in a patient's condition and take appropriate action, or escalate to others where appropriate, adhering to established escalation pathway                                                                                                                                   |
| 5 | Managing medical problems in patients in other specialties and special cases | 4c   | Work within and across a complex systems environment of multi-specialty teams and different pathways, managing the complexity of transition from one team to another or membership of multiple teams and cross organisational and professional boundaries.                                                          |
|   |                                                                              | 6d   | Undertake appropriate monitoring for the individual and clinical situation, recognising the deterioration of an individual's physical and mental health, and intervene, escalate, or refer as appropriate.                                                                                                          |
|   |                                                                              | 7c   | Interpret findings and results using advanced diagnostics skills and undertake appropriate interventions, including urgent referral/escalation as in life threatening situations, or further investigation, treatment, or referral, considering clinician limitations and patients' wishes                          |
|   |                                                                              | VW3i | Identify and evaluate any deterioration in a patient's condition and take appropriate action, or escalate to others where appropriate, adhering to established escalation pathway                                                                                                                                   |
| 6 | Managing a multi-disciplinary team including effective discharge planning    | 4a   | Work effectively and respectfully within and across multi-disciplinary health and social care teams and across organisations. Maintain a knowledge and understanding of the wider primary, community and secondary care, voluntary sector services and teams, and refer independently using professional judgement. |
|   |                                                                              | 4b   | Advocate and utilise the expertise and contribution to patients' care of all allied health and social care professionals and work collaboratively within the multi-professional team to optimise assessment, diagnosis and integrated management and care for people                                                |

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|  | 4c   | Work within and across a complex systems environment of multi-specialty teams and different pathways, managing the complexity of transition from one team to another or membership of multiple teams and cross organisational and professional boundaries.                                                                                                           |
|  | 4d   | Be able to bring out the best in multi-professional teams with different skills, empowering the team to make decisions in accordance with their expertise.                                                                                                                                                                                                           |
|  | 4e   | Initiate effective multi-disciplinary team activity as a lead member and understand the importance of effective team and/or organisation dynamics. (This may include, but is not limited to, evidence based practice with monitoring processes such as audit/quality improvement, significant event review, shared learning and continuous professional development) |
|  | 9c   | Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit).                                                                                                                                                                                                                                                           |
|  | 9d   | Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working.                                                                                                                                                                                                                                  |
|  | 9e   | Actively seek and be positively responsive to feedback and involvement from patients, families, carers, communities, multi-disciplinary colleagues and across organisational and professional boundaries in the co-production of service improvements.                                                                                                               |
|  | 9l   | Demonstrate leadership, resilience, and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others.                                                                                                                                                                                                  |
|  | VW4b | Establish and maintain a safe remote team environment in which team members can access opportunities to discuss concerns about patients and are encouraged to support and challenge                                                                                                                                                                                  |
|  | VW4c | Work with the differing skills within multi-disciplinary teams and empower members of the team to make independent decisions in accordance with their scope of practice, knowledge, skills, and expertise.                                                                                                                                                           |

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