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# CEDAR

Centre for Healthcare Evaluation,  
Device Assessment and Research

## All Wales Urgent Primary Care Practitioner Competency Framework Evaluation Final Report

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## Abbreviations

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Abbreviation	Definition
ABUHB	Aneurin Bevan University Health Board
AMaT	Audit Management and Tracking
ACP	Advanced Care Practitioner
CBD	Case Based Discussions
CEX	Consultation Assessment Proforma
CPD	Continuing Professional Development
CAVUHB	Cardiff and Vale University Health Board
DOPS	Direct Observations of Procedures
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
MSF	Multisource Feedback
NMC	Nursing and Midwifery Council
OOH	Out of Hours
PGD	Patient Group Directions
SDEC	Same Day Emergency Care
SPA	Supported Professional Activities
UHB	University Health Board
UCP	Urgent Care Practitioner
UPC	Urgent Primary Care

## About CEDAR

CEDAR is an NHS-academic research and evaluation centre which is part of Cardiff and Vale University Local Health Board and Cardiff University. CEDAR

focuses on research and evaluation

involving medical devices and diagnostics. We work with the NHS, academic institutions, commercial sector, publicly funded organisations, and charities. Our areas of expertise include systematic reviewing, health economics, clinical trial facilitation, qualitative research, analysis of routinely-collected and linked health data, and medical device regulations.



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- Alice Groves, National Clinical Lead for Urgent Primary Care, Aneurin Bevan University Health Board (ABUHB)

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- Amelia Perry, Administrator, CEDAR

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Health Education and Improvement Wales provided the funding for the project through the Urgent Primary Care Practitioner Competency framework. There are no conflicts of interest the authors need to declare.

## Copyright

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## Approval

This evaluation was registered as a service evaluation project on the Audit Management and Tracking system at Cardiff and Vale UHB.

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Audit code:	EU/SE/2024-25/08
Audit registration date:	07/03/2025

## Executive Summary

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### Background and Aims

To help manage pressures on emergency departments and general practice, the All Wales Urgent Care Practitioner (UCP) Competency framework was developed to support a growing, multi-professional urgent care workforce. Health Education and Improvement Wales ([HEIW](#)) commissioned [CEDAR](#) to evaluate the 12-month pilot phase of this framework. A total of 17 practitioners and 7 assessors were enrolled on the pilot. The evaluation aimed to assess the framework's effectiveness in enhancing clinical skills, identify real-world barriers to completion, and provide practical recommendations ahead of a potential All Wales rollout.

### Methods

A mixed-methods approach was used to capture feedback on the pilot from the perspective of both practitioners and their clinical assessors. Data was collected at baseline (upon enrolment) and at a 12-month follow-up, consisting of online surveys and 20 in-depth, semi-structured online interviews. Survey response rates for practitioners were 59% (n=10) at baseline and 76% (n=13) at follow-up, while assessor rates were 86% (n=6) and 57% (n=4) respectively.

### Key Findings

The evaluation identified that while the framework is considered to have real clinical value, the operational realities of urgent care make it incredibly difficult to complete.

- **An increase in practitioner confidence and competence:** Despite low module completion rates, the framework was successful in acting as a robust 'map and gap' tool, encouraging practitioners to confront knowledge gaps and target their learning. Between baseline and follow-up, reports of low clinical confidence dropped from 40% at baseline, to 0% at follow-up, while the proportion of practitioners feeling highly confident and competent more than doubled (increasing from 30% at baseline to over 70% at follow-up).
- **Time is the biggest barrier:** Initial engagement with the training was high, but progress stalled over time. By the 12-month mark, only 15% of practitioners had completed a module, with the primary barrier reported as being available training time. Practitioners emphasised that the framework cannot be squeezed into 10-minute 'quiet spells' on shift; it requires deep focus. Even when protected learning time, or supported professional

activities (SPA) time was allocated, it was frequently interrupted by service demands, reducing the time available for study.

- **Implementation and clarity:** While an induction was provided at the start of the pilot, both assessors and practitioners reported a need for a more robust, mandatory onboarding alongside continuous support. Without ongoing guidance, participants experienced confusion regarding expectations, timeframes, and the level of detail required for evidence. Furthermore, assessors struggled to balance their assessor duties with their clinical caseloads, and noted a need for clearer, standardised criteria for formally signing off competencies.
- **Usability:** Relying on a paper document in a folder frustrated staff. For clinicians constantly on the move, especially those working out in the community, a bulky physical folder was said to be impractical, and many suggested they would prefer the option of a digitally accessible framework.

## Discussion

Ultimately, feedback from the pilot suggests that the clinical content of the UCP framework is highly relevant to the role of an urgent care practitioner, and is respected by the staff using it. Practitioners value it for robust clinical governance and heavily support the idea of it being a recognised 'Clinical Passport' they can take to future employers across Wales. The challenge for HEIW is not redesigning the clinical core of the framework, but rather supporting its delivery. To succeed, the framework needs protected time that staff can reliably use despite service pressures, along with clearer instructions, and a modern digital format that fits seamlessly into a fast-paced workflow.

## Priority recommendations

To bridge the gap between the framework's high clinical value and the demanding operational reality of urgent care, the following key actions are recommended before a wider All Wales rollout:

1. **Mandate and protect SPA time:** Formally ring-fence SPA time for both practitioners and assessors. Ideally, this should be undertaken away from clinical environments to reduce interruptions and competing demands.
2. **Introduce joint assessment shifts:** Rather than relying on practitioners and their assessors to schedule a meeting together, where feasible, roster assessors and practitioners together on specific clinical shifts. This allows them to see patients, discuss cases, and document competencies in real-time.

3. **Provide a mock portfolio and formal induction:** Remove the reliance on practitioners to onboard themselves ad-hoc, and introduce a formal HEIW induction event, either in person or hybrid. Also supply a high-quality, completed mock portfolio upon enrolment, so staff can clearly see the required level of detail, removing the anxiety of self-grading and standardising expectations across all sites.
4. **Offer a digital/app-based format:** Transition the framework from a paper folder to a digital app. This is a functional necessity, allowing community-based staff to complete the framework.
5. **Rebalance the clinical focus:** Ensure the content reflects the reality of the daily caseload by placing a heavier emphasis on minor injuries and minor illnesses, rather than general medicine and major presentations.

# Urgent Primary Care Practitioner Competency framework Evaluation

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## Background

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### The Urgent Primary Care Service

The latest data available show that in 2024-2025, there were almost 1.1 million attendances at emergency departments across Wales, the highest level on record (Welsh Government, 2025). Similar pressures exist for the Urgent Primary Care and Out of Hours Services (OOH), which manage approximately 0.5 million patients annually in Wales. Historically, these services have faced significant workforce challenges, often relying on a small pool of GPs, and facing frequent rota gaps (Wales Audit Office, 2018). As a result, all Welsh health boards are exploring alternative staffing models.

To address these issues and alleviate pressures on emergency departments, the 'Urgent Primary Care (UPC) Centre Pathfinder' programme was launched. The aim of these multi-professional hubs is to provide a primary care service for patients with urgent, but not life-threatening conditions, thereby managing demand more effectively to take patients away from emergency departments and GP practices.

### The Urgent Care Practitioner (UCP) role

Central to this new model of care is the 'Urgent Care Practitioner' (UCP). This is a relatively new clinical role which has expanded in recent years to include nurses, paramedics, pharmacists, physician associates and allied health professionals. These practitioners work across nurse-led Urgent Primary Care Centres in Hywel Dda University Health Board (HDUHB), as well as traditional OOH Services in Cardiff and Vale University Health Board (CAVUHB).

### The UCP Competency Framework

To support the development of this multi-professional workforce, the [All Wales Urgent Primary Care Practitioner Competency Framework](#) was recently developed in alignment with the [Strategic Workforce Plan for Primary Care \(2025-2030\)](#).

The framework is not intended to be an in-depth curriculum, but instead a tool to guide, measure and track development of UCPs. It provides a structure for individuals to gather work-based evidence, enabling them to demonstrate their level of practice and progress through defined career pathways, from a UCP at

level 1, through to an Expert Generalist. Specifically, it enables clinicians to describe their knowledge and skill development in both non-patient facing and patient-facing roles.

Practitioners can enter and progress through five levels of competency:

- Urgent Care Practitioner Level 1
- Urgent Care Practitioner Level 2
- Urgent Care Practitioner Level 3
- Senior Urgent Care Practitioner
- Expert Generalist

Practitioners on the framework are assessed using several assessment tools including a mini-Consultation Assessment Proforma (CEX), Case Base Discussions (CBD), Direct Observations of Procedures (DOPS), Multisource Feedback (MSF) and reflective review.

The framework comprises 16 non-clinical, 16 clinical, and 2 triage competency modules. While practitioners at UCP Level 3 and above must complete the entire suite of modules, those at Levels 1 and 2 are exempt from certain modules, such as research, audit, teaching and training, both women's and men's health, and sexual health.

Competency sign-off is completed by a practitioner who is experienced in that competency, typically a lead UCP or another senior clinician. The full framework and assessment portfolio can be found on Health Education and Improvement Wales Website: <https://heiw.nhs.wales/files/all-wales-urgent-primary-care-practitioner-competency-framework/>.

The first pilot cohort of practitioners commenced the programme in early 2025, funded by HEIW.

## Purpose of the Evaluation

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### Aim

CEDAR has been commissioned to undertake an evaluation to assess the effectiveness of the Urgent Primary Care Practitioner (UCP) Competency framework pilot in Wales. This aims to identify areas for improvement and the wider impact on urgent care services and workforce development to inform potential future roll-out.

### Objectives

The objectives of the evaluation are to:

- Explore the perspectives, expectations, and experiences of practitioners, and assessors involved in the Urgent Care Practitioner framework course.
- Assess the effectiveness of the framework in enhancing the skills, confidence, and professional development of UCP clinicians.
- Recognise potential barriers to implementation or completion of the course, to help facilitate widespread adoption.
- Identify any additional, unintended benefits or drawbacks that may further impact the Urgent Primary Care workforce and services.
- Suggest recommendations for improvements to the framework to support an All Wales rollout.

## Methods

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### Study Design

The project was registered with, and approved by, the Cardiff and Vale University Health Board (CAVUHB) Audit Management and Tracking (AMaT) team as a service evaluation. As a large proportion of the assessors and practitioners contacted during the evaluation are based in Hywel Dda University Health Board (H DUHB), the application was also shared with the H DUHB AMaT team, with confirmation that it was not necessary for it to be registered in both health boards.

A project group, consisting of three researchers from CEDAR (MB, EM, KW), with input from a project manager (LB) within HEIW and a lead clinician (AG) from Aneurin Bevan University Health Board (ABUHB) provided input on the design, and guidance throughout the evaluation. Their input ensured that the evaluation was designed to align with the objectives of the framework, and that all relevant training aspects were evaluated. This included supporting the design of a survey at the start of the framework, and follow-up surveys a year later, and also the topic guides for online interviews. However, all data collection, analysis and reporting was conducted independently by CEDAR.

### Data Collection

A mixed-methods approach to data collection was adopted, including a survey with quantitative and qualitative questions which were explored in more depth during semi-structured interviews. The key data collection methods were:

- Practitioner Surveys: Administered online via Microsoft Forms at two time points - Baseline at the start of the framework ([Appendix 1](#)), and follow-up at 1 year after enrolment ([Appendix 5](#))

- Assessor Surveys: Administered online via Microsoft Forms at two time points - Baseline at the start of the framework ([Appendix 2](#)), and follow-up at 1 year after enrolment ([Appendix 6](#))
- Semi structured online interviews (Practitioners): - Conducted online via Microsoft Teams at baseline upon enrolment, and follow-up approximately 1 year after enrolment onto the framework.
- Semi structured online interviews (Assessors) - Conducted online via Microsoft Teams at baseline upon enrolment, and follow-up approximately 1 year after enrolment onto the framework.

## Surveys

Two online surveys were developed by CEDAR - one for practitioners on the framework, and another for their assessors. These were distributed via email to all practitioners (n=17) and assessors (n=7), by CEDAR, HEIW, and local clinical leads, with several reminders sent by email and messages on Microsoft Teams.

The baseline survey was sent in April 2025 following enrolment onto the framework, and remained open for a total of 95 days to July 2025. The follow-up survey was sent 11 months later in March 2026, with the aim that practitioners would have had enough time to progress with the framework during this time. The follow-up survey remained open for a total of 60 days to May 2026. Both surveys collected data on demographics, current confidence levels, perceptions of the framework's utility, and the practitioners perceived impact on their clinical practice, confidence, competence, and the urgent care service.

## Semi-Structured Interviews

Initially, the baseline survey asked respondents if they were willing to participate in an informal online interview. Through this method, of those who had completed the survey, only 3 out of 10 practitioners and 4 out of 6 assessors initially agreed to participate. Due to this slow uptake and low engagement, the recruitment strategy was broadened. Between August and October 2025, direct email invitations were issued to the entire cohort of practitioners (n=17) and assessors (n=7). This approach was more successful, resulting in 13 practitioners and 4 assessors being interviewed between August and October 2025 during the baseline phase.

During the follow-up phase in May 2026, all practitioners and assessors were emailed to complete the follow-up survey. This communication (by email and Microsoft Teams message) included a secondary request for interviews; however, follow-up invitations were specifically targeted at those who had completed the survey and has actively progressed or withdrawn from the framework. This approach was taken because the barriers for those not starting or progressing had

already been captured in detail during the baseline phase. Based on follow-up survey responses, 5 practitioners and 1 assessor were invited to interview, resulting in a final follow-up total of 3 interviews (2 practitioners and 1 assessor).

In total, 20 in-depth interviews were conducted via Microsoft Teams. A topic guide was used for both groups (see Practitioner topic guide in [Appendix 3](#) and Assessor topic guide in [Appendix 4](#)). Each topic guide aimed to explore themes raised in the initial survey in greater depth, such as specific barriers to progression and the quality of supervision.

A study flowchart outlining the steps in the study is available in Figure 1 below.

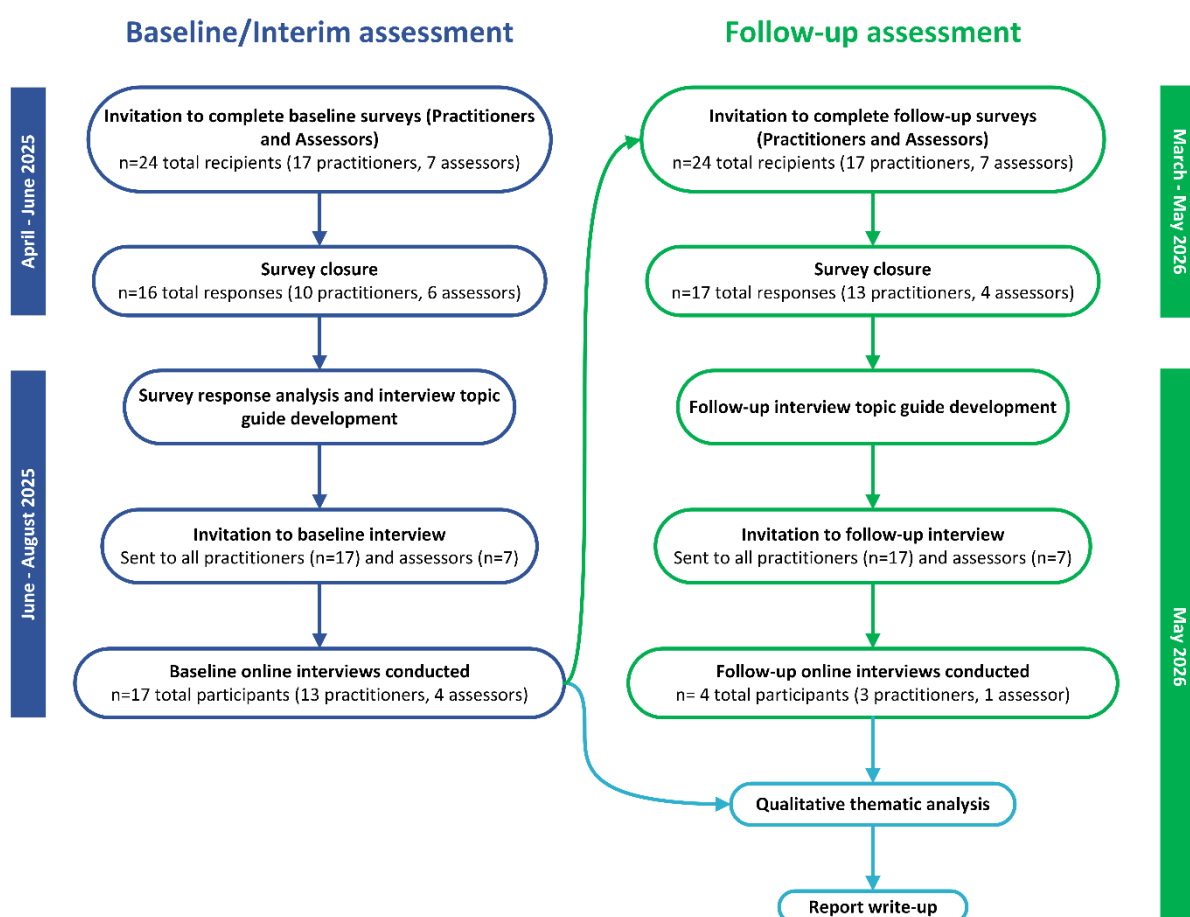


Figure 1 Study flowchart

## Data Analysis

Survey data were exported to Microsoft Excel for analysis. Descriptive statistics (frequencies and percentages) were used to characterise both cohorts and identify changes in aspects such as confidence, competence and engagement with the framework.

Interviews were recorded and transcribed using Microsoft Teams automatic transcription function. CEDAR researchers then listened back to the recordings and corrected the transcription where necessary. The transcripts were manually coded and analysed thematically to identify recurring patterns, barriers, and facilitators regarding the framework's implementation.

### Ethical considerations

Participation in the evaluation was voluntary. For the surveys, consent was implied by completion. For the interviews, verbal consent was obtained prior to recording. To ensure confidentiality, each practitioner and assessor was assigned unique alphanumeric codes (e.g., P1, A1) which were used within interview transcripts to maintain anonymity. Data storage complied with CAVUHB information governance policies.

## Results

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### Practitioner Survey

The survey was distributed to all 17 practitioners enrolled on the framework at both the baseline and follow-up stages. In total, 10 practitioners (59%) completed the baseline survey, while 13 practitioners (76%) completed the follow-up survey. It is important to note that these two groups do not form a matched paired cohort, as the specific individual participants varied between the two stages. Throughout the following results section, percentages represent the proportion of respondents who answered the survey at that time point, rather than the entire 17-person cohort.

#### Demographics and professional background

The demographic and professional profile of the respondents remained consistent across both the baseline and follow-up surveys. Across both time points, the majority of practitioners were based in HDUHB and employed full-time. The cohort was highly experienced; at follow-up, 7 (54%) practitioners possessed over 10 years of experience in urgent or primary care, having worked across various settings including Emergency Departments, Minor Injuries Units, and Community Services.

#### Framework progress

While initial engagement with the framework was high (80% had commenced the framework at baseline), progress stalled for many people over the 12-month pilot period. By the follow-up survey, only 31% of practitioner responders reported actively progressing on the framework. The remaining practitioner responders had

either paused their progress (n=6, 46%), not yet started (n=2, 15%), or withdrawn entirely (n=1, 8%). Consequently, only 2 (15%) practitioners had successfully completed one or more of the 34 modules by the 12-month mark.

At baseline, 4 (40%) practitioners cited a lack of time due to work commitments as a barrier. By follow-up, this figure surged to 12 (92%), with 9 (69%) citing work absence related factors (such as sickness or annual leave) as a limiting factor.

The difficulty of balancing the framework with clinical workloads also intensified over the evaluation period. At baseline, 4 (40%) responders found this balance 'difficult'; and by follow-up, 10 (77%) reported it as 'difficult' or 'very difficult.' This challenge is directly linked to a lack of designated study capacity: 11 (85%) of respondents at follow-up reported having to complete the framework during regular clinical duties or in their personal time. Furthermore, supervisory engagement was limited, with just over half (n=7, 54%) of the practitioners meeting their assessor only once every few months, and 3 (23%) reporting they meet rarely or had not managed to meet at all.

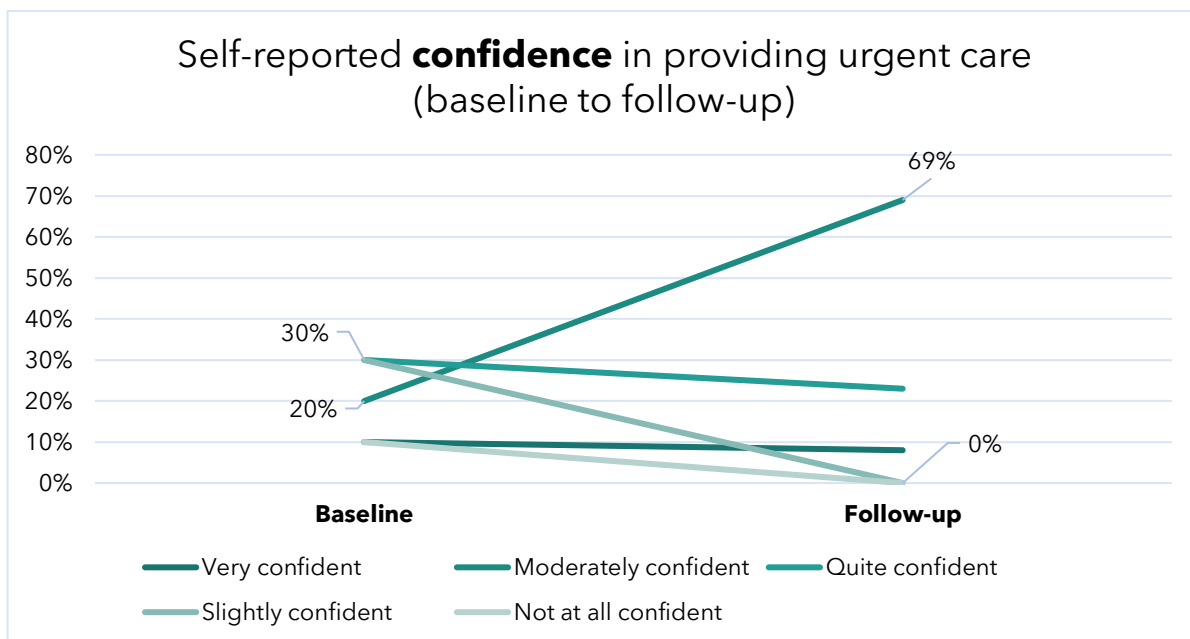
#### Motivations and expected outcomes

At baseline, practitioner responders were asked what their motivations were for enrolling on the framework. The most frequently cited motivations were to enhance skills (n=8, 80%), meet job role requirements (n=8, 80%), and improve patient care (n=8, 80%). Regarding expected outcomes, all respondents (n=10, 100%) hoped to develop new clinical skills and competencies. Additionally, practitioners hoped the framework would improve patient care and outcomes (n=9, 90%), improve their confidence in clinical decision-making (n=8, 80%), and help meet professional development requirements (n=8, 80%).

#### Clinical confidence

At baseline, there was a notable gap in practitioner assurance in providing urgent care: 4 (40%) of the cohort reported low confidence (rating themselves as 'Slightly' or 'Not at all' confident), while only 3 (30%) felt highly confident (rating themselves as 'Very' or 'Quite confident'). By the follow-up stage, this had reversed; reports of low confidence dropped to zero (0%), while high confidence more than doubled to 10 (76%) (see Figure 2 - Data labels are provided for those with the biggest change from baseline to follow-up - 'Moderately confident' and 'Slightly confident').

Figure 2 - Practitioner confidence in providing urgent care at baseline and follow-up



As detailed in table 5 ([Appendix 7](#)), trends in confidence across specific domains from baseline (n=10) to follow-up (n=13) included:

**Clinical decision making:** Four (40%) practitioners reported low confidence at baseline, and by follow-up, confidence had increased, with 11 (85%) of the cohort reporting to be 'moderately confident', 'quite confident' or 'very confident'.

**Patient assessment:** The number of practitioners reporting feeling 'very confident' in patient assessment increased from 1 (10%) at baseline to 3 (23%) at follow-up.

**Prescribing and medicine management:** Initial confidence in prescribing and medicine management was notably low at baseline (50% felt only 'slightly confident'). By follow-up, this number had dropped slightly to 4 (31%), with a further 4 (31%) now feeling 'quite' or 'very' confident.

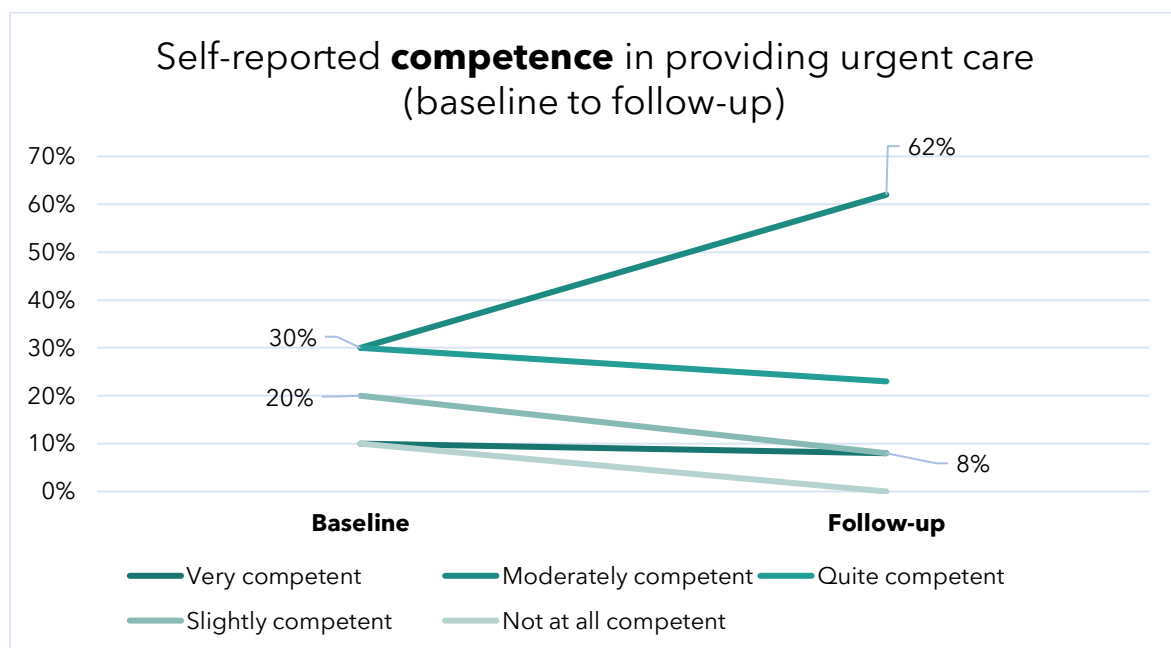
**Communication:** Confidence in communication skills did not change much from baseline, from 3 (30%) feeling very confident at baseline, to 5 (38%) at follow-up.

**Leadership & managing complex cases:** Both domains remained much the same from baseline to follow-up, with the exception of those feeling 'Moderately confident' - from 4 (40%) at baseline to 7 (54%) at follow-up.

### Clinical competence

Changes in self-reported clinical competence followed a similarly positive trend. At baseline, 3 (30%) of the cohort reported low confidence (rating themselves as 'Slightly' or 'Not at all' confident), while only 4 (40%) felt highly confident (rating themselves as 'Very' or 'Moderately confident'). By the follow-up stage, reports of low confidence dropped to 1 (8%), while high confidence increased to 9 (70%) (see Figure 3 - Data labels are provided for those with the biggest change from baseline to follow-up - 'Moderately confident' and 'Slightly confident').

Figure 3 - Practitioner competence in providing urgent care at baseline and follow-up



As detailed in table 6 ([Appendix 7](#)), trends in competence across specific domains from baseline (n=10) to follow-up (n=13) included:

**Clinical decision making:** The number of practitioners reporting 'moderately' competent or higher increased from 7 (70%) at baseline, to 11 (85%) at follow-up. Notably, the 'not at all' competent category was completely eliminated over the evaluation period (dropping from 1 to 0).

**Patient assessment:** Practitioners feeling highly competent ('quite' or 'very') increased from 4 (40%) at baseline to 6 (46%) at follow-up. The vast majority of the cohort - 12 out of the 13 (92%) reported feeling moderately competent or higher at follow-up.

**Prescribing and medicine management:** Initial reports of low competence ('not at all' or 'slightly') dropped from 7 (70%) at baseline to 4 (31%) at

follow-up. Furthermore, the number of practitioners feeling highly competent doubled from 2 (20%) to 4 (31%).

**Communication:** The 'not at all competent' rating was eliminated (dropping from 1 to 0). The number of practitioners reporting high competence ('quite' or 'very') increased from 5 (50%) at baseline to 8 (62%) at follow-up.

**Leadership:** The 'not at all competent' rating was eliminated (dropping from 1 to 0), and high competence ratings remained much the same as 3 (30%) at baseline to 4 (31%) at follow-up. The bulk of the cohort at baseline (n=6, 60%) and follow-up (n=6, 46%) were in the moderately competent.

**Managing complex cases:** High competence ratings ('quite' or 'very') increased slightly from 2 (20%) at baseline to 3 (23%) at follow-up. Although this domain continued to be the most challenging for the cohort, with 4 (31%) practitioners continuing to report low competence ('not at all' or 'slightly') at follow-up, and 2 (20%) at baseline.

### Perceived impact and support needs

Practitioners consistently recognised the framework's clinical value, with 8 (80%) rating the content as 'very relevant' or 'highly relevant' to their day-to-day role at baseline and 10 (77%) at follow-up.

Regarding the impact on patient care and service delivery, initial optimism changed over time. At baseline, 9 (90%) of practitioners anticipated the framework would impact patient care. By follow-up, this had dropped to 6 (46%) reporting a realised impact, while 6 (46%) remained unsure. All close-ended questions and responses are detailed in Table 2.

When assessing the framework's perceived impact on clinical practice, positive sentiment grew as practitioners spent more time on the framework. At baseline, only 3 (30%) felt the learning had impacted their practice, with 6 (60%) unsure. By follow-up, half the cohort (n=7, 54%) reported a positive impact, and no respondents stated it had no impact.

At the follow-up stage, practitioners were asked to what extent the framework had helped them achieve specific professional goals. Table 1 lists responses to each clinical domain in descending order of agreement.

Table 1 - Survey responses on the impact of the framework at follow-up

		Not at all	Somewhat	Fully
<b>To what extent has the framework helped you achieve the following? (follow-up only)</b>	Improve multidisciplinary teamwork and collaboration	1 (8%)	10 (77%)	2 (15%)
	Develop new clinical skills and competencies	1 (8%)	11 (85%)	1 (8%)
	Improve patient care and outcomes	1 (8%)	11 (84%)	1 (8%)
	Expand knowledge of urgent primary care settings	2 (15%)	8 (61%)	3 (23%)
	Increase ability to work autonomously in urgent care	2 (15%)	9 (69%)	2 (15%)
	Improve confidence in urgent care decision-making	3 (23%)	10 (76%)	0 (0%)
	Enhance career progression opportunities	6 (46%)	6 (46%)	1 (8%)
	To gain a formal qualification or accreditation	7 (53%)	6 (46%)	0 (0%)

The feedback at follow up was largely positive regarding clinical knowledge, collaboration and confidence:

**Clinical knowledge and skills:** Eight (61%) practitioners felt that the framework had ‘somewhat’ helped them expand their knowledge of urgent primary care and develop new competencies, with an additional 3 (23%) who felt this was ‘fully’ achieved.

**Care and collaboration:** Ten (76%) practitioners felt the framework ‘somewhat’ improved multidisciplinary teamwork, and 11 (84%) practitioners felt it ‘somewhat’ improved patient care and outcomes.

**Autonomy and confidence:** The majority of the cohort (n=9, 69%) felt their ability to work autonomously had somewhat improved, with 2 (15%) stating it was fully achieved. Similarly, 10 (76%) practitioners felt that the framework had ‘somewhat’ helped improve their confidence in urgent care decision-making.

The framework was least effective in impacting career-related goals at this pilot stage. Nearly half of the cohort (n=6, 46%) reported that the framework had ‘not at all’ helped them enhance career progression opportunities, and 7 (53%) felt it had not at all helped them gain a formal qualification or accreditation.

Table 2 Practitioner Survey Responses

Question	Category	Baseline responses (n=10)	% of overall responses	Follow-up responses (n=13)	% of overall responses
Health board	Hywel Dda UHB	8	80%	12	92%
	Cardiff and Vale UHB	2	20%	1	8%
Current professional role	Urgent Care Practitioner	1	10%	5	38%
	Nurse Practitioner	7	70%	5	38%
	Paediatric Minor Illness Practitioner	1	10%	0	0%
	Advanced clinical/nurse practitioner	1	10%	3	24%
Current work status	Full time	9	90%	11	85%
	Part time	1	10%	2	15%
Urgent care settings worked in previously*	Community Services	4	40%	5	38%
	UPC (out of hours)	2	20%	1	8%
	Minor Injuries Unit	4	40%	5	38%
	Emergency Department (ED)	5	50%	5	38%
	Intensive Care Unit	1	10%	1	8%
	SDEC	0	0%	2	15%
Years of experience in urgent or primary care	0-2 years	1	10%	1	8%
	2-5 years	2	20%	3	23%
	5-10 years	2	20%	2	15%
	>10 years	5	50%	7	54%
Engagement status on the framework	Yes - I am actively progressing	8	80%	4	31%
	Yes - but my progress is currently paused	0	0%	6	46%
	No - I have not started on the framework	2	20%	2	15%

Question	Category	Baseline responses (n=10)	% of overall responses	Follow-up responses (n=13)	% of overall responses
	No - I have withdrawn from the framework	0	0%	1	8%
Time elapsed since framework enrolment (months)	0-3 months	7	70%	2	15%
	4-6 months	1	10%	3	23%
	7-9 months	NA		1	8%
	10-12 months	NA		4	31%
	Not answered	2	20%	3	23%
Level of framework enrolled on	Urgent Care Practitioner Level 1	3	30%	2	15%
	Urgent Care Practitioner Level 2	2	20%	1	8%
	Urgent Care Practitioner Level 3	3	30%	2	15%
	Senior Urgent Care Practitioner	2	20%	5	38%
	Expert generalist	0	0%	1	8%
	Unsure	0	0%	2	15%
Modules completed	I have started one or more modules but have not completed any	6	60%	8	62%
	I have completed one or more modules	0	0%	2	15%
	I have not started any modules yet	4	40%	3	23%
Motivations for framework enrolment* (baseline only)	To enhance my skills in urgent care	8	80%	NA	
	To improve my confidence in managing urgent care cases	7	70%	NA	
	To meet job role requirements	8	80%	NA	
	To improve patient care	8	80%	NA	
	To gain formal recognition for my skills	5	50%	NA	
	Pilot that the team agreed to	1	10%	NA	

Question	Category	Baseline responses (n=10)	% of overall responses	Follow-up responses (n=13)	% of overall responses
	To improve career progression opportunities	4	40%		NA
	To help manage the demand for urgent and emergency care	6	60%		NA
Expected outcomes of framework completion* (baseline only)	Develop new clinical skills and competencies	10	100%		NA
	To improve confidence in urgent care decision-making	8	80%		NA
	To gain a formal qualification or accreditation	7	70%		NA
	Improve patient care and outcomes	9	90%		NA
	Expand knowledge of urgent primary care settings	8	80%		NA
	Increase ability to work autonomously in urgent care	6	60%		NA
	Improve multidisciplinary teamwork and collaboration	7	70%		NA
	Meet professional development or CPD requirements	8	80%		NA
	Enhance career progression opportunities	7	70%		NA
Self-reported <b>confidence</b> in providing urgent care	Very confident	1	10%	1	8%
	Quite confident	3	30%	3	23%
	Moderately confident	2	20%	9	69%
	Slightly confident	3	30%	0	0%
	Not at all confident	1	10%	0	0%
Self-reported <b>competence</b> in providing urgent care	Very competent	1	10%	1	8%
	Quite competent	3	30%	3	23%

Question	Category	Baseline responses (n=10)	% of overall responses	Follow-up responses (n=13)	% of overall responses
	Moderately competent	3	30%	8	62%
	Slightly competent	2	20%	1	8%
	Not at all competent	1	10%	0	0%
Types of support that would help practitioners successfully complete the framework* (baseline only)	More structured guidance from supervisor/assessor	6	60%		NA
	Peer learning or study groups	7	60%		NA
	More time allocated within my job role	9	70%		NA
	Appropriate CPD/courses	6	50%		NA
	Additional resources or materials	6	50%		NA
	Other	0	0%		NA
Experience of engaging with the self-paced learning format of the framework	Very easy	0	0%	0	0%
	Easy	2	20%	3	23%
	Neutral	3	30%	9	69%
	Difficult	1	10%	1	8%
	Very difficult	0	0%	0	0%
Experience balancing the framework with clinical workload	Very easy	0	0%	0	0%
	Easy	0	0%	0	0%
	Neutral	2	20%	3	23%
	Difficult	4	40%	8	62%
	Very difficult	0	0%	2	15%
Provided with protected, rostered study time within work hours to complete the framework (follow-up only)	Yes - sufficient protected time		NA	1	8%
	Yes - but not enough time		NA	1	8%
	No - I have had to do it during regular clinical duties or in my personal time		NA	11	85%
	Weekly		NA	0	0%

Question	Category	Baseline responses (n=10)	% of overall responses	Follow-up responses (n=13)	% of overall responses
How often practitioners are able to meet with their supervisor/assessor for the framework (follow-up only)	Monthly	NA		3	23%
	Once every few months	NA		7	54%
	Rarely / We have not managed to meet yet	NA		3	23%
Issues that have prevented practitioners from starting the modules	I haven't had the time due to work commitments	4	40%	12	92%
	I haven't had the time due to personal commitments (e.g. annual leave, sickness, holidays, family responsibilities etc.)	3	30%	9	69%
	The assessor hasn't engaged with me yet	0	0%	0	0%
	There have been delays in my enrolment onto the framework that are outside of my control	1	10%	0	0%
	I am unsure of how to get started or what is required of me	0	0%	2	15%
	I am waiting for access to the framework materials or resources	0	0%	0	0%
	Technical issues have prevented me from accessing the framework	0	0%	0	0%
	Other	1	10%	4	31%
	Relevance of the framework to day-to-day role	Highly relevant	1	10%	0
Very relevant		7	70%	10	77%
Moderately relevant		2	20%	3	23%
Slightly relevant		0	0%	0	0%
Not relevant		0	0%	0	0%
	Yes	3	30%	7	54%

Question	Category	Baseline responses (n=10)	% of overall responses	Follow-up responses (n=13)	% of overall responses
Impact of the framework on clinical practice	No	1	10%	0	0%
	Unsure	6	60%	6	46%
Impact of the framework on patient care or service delivery	Yes	9	90%	6	46%
	No	0	0%	1	8%
	Unsure	1	10%	6	46%
Improvements needed to the framework	Yes	2	20%	3	23%
	No	8	80%	10	77%
Requirements or modules within the framework that are outside the scope of capabilities of the urgent care setting or practice	Yes	NA		2	15%
	No	NA		2	15%
	Unsure	NA		9	69%

ICU: Intensive Care Unit; NA: Not Applicable / Not Answered; SDEC: Same Day Emergency Care; UCP: Urgent Care Practitioner; UHB: University Health Board. \*Multiple responses allowed

## Assessor Survey

Of the 7 assessors who were sent the survey at both the baseline and a year later at follow-up, 6 (86%) responses were received at baseline, and 4 (57%) at follow-up. Three assessors completed the survey at both time points. The assessor survey findings at baseline and follow-up are described below, with all closed-ended results detailed in Table 3.

### Demographics

The assessor cohort was predominantly based in Hywel Dda UHB (67% at baseline, 75% at follow-up), with the remainder based in Cardiff and Vale UHB. The respondents included Advanced Nurse Practitioners, GPs, and Nurse Practitioners, and most acted in dual capacities as both mentors/supervisors and educational/clinical assessors. The cohort brought significant supervisory experience to the pilot, with 50% of respondents at both time points possessing over 10 years of individual personal experience in assessing healthcare professionals. At baseline, 5 (83%) had previously assessed or supervised practitioners specifically within urgent or primary care training programmes.

### Assessor engagement and workload balance

The responses reveal a decrease in active assessment over the 12-month pilot. At baseline, 5 (83%) of respondents reported they had started assessing or supervising practitioners on the framework. By the follow-up stage, only 1 (25%) was actively assessing, with 3 (75%) stating they were not currently assessing anyone.

At the follow-up stage, 4 (100%) of respondents reported receiving no protected, funded time to complete their assessor duties, forcing them to complete the work during standard clinical hours or their own personal time. Consequently, the experience of balancing assessor responsibilities with clinical workloads worsened during the pilot period. At baseline, the split was equal between those finding it 'difficult' (n=3, 50%) and 'neutral' (n=3, 50%) with none finding it 'very difficult'. At follow-up, half the cohort (n=2, 50%) rated it as 'very difficult,' while the remaining half stated the question was no longer relevant as they were not actively assessing any practitioners.

### Framework support and expectations

As the pilot progressed and assessors attempted to use the framework, perceptions regarding the level of support and role expectations shifted negatively. At baseline, all respondents (n=6, 100%) felt the expected level of

supervision and assessment was reasonable. At follow-up, (n=3, 75%) felt the expectations were no longer reasonable.

Similarly, at baseline, 4 (67%) assessors felt they had adequate support and resources to effectively assess practitioners. At follow-up, this reversed, with 3 (75%) stating they did not have adequate support. Clarity regarding their role also declined slightly; while 5 (83%) felt 'clear' or 'neutral' about expectations at baseline, at follow-up, most (n=3, 75%) felt 'neutral', with 1 (25%) respondent reporting that expectations were 'not clear at all.' When rating communication, guidance, and administrative support at follow-up, all 4 (100%) of the follow-up cohort provided a 'neutral' rating.

### Framework effectiveness

Despite the operational challenges, the assessors who responded remained largely positive about the clinical validity of the framework itself. Across both time points, the majority of assessors felt the framework 'fully' or 'quite' aligned with the real-world requirements of urgent care (100% at baseline, 75% at follow-up). No assessors at either baseline or follow-up felt that the framework was 'not very aligned' or 'not aligned at all'. Similarly, confidence that the training adequately prepares practitioners for clinical decision-making remained high (100% at baseline, 75% at follow-up). However, there was a significant drop in the proportion of assessors who felt practitioners were provided with enough hands-on clinical experience to complement their theoretical training. While 100% agreed this was sufficient at baseline, this dropped to 50% at the 12-month follow-up. Assessors also observed practitioners were struggling with the framework's self-paced format; while no assessors felt the self-paced learning was difficult for practitioners at baseline, 2 (50%) rated it as 'difficult' or 'very difficult' for practitioners at follow-up. Consequently, while 6 (100%) assessors felt no areas of the training needed improvement at baseline, 3 (75%) stated that improvements or expansions were necessary by the follow-up stage.

### Overall impact

The logistical barriers to progressing with the framework ultimately diluted the perceived impact of the framework on the assessors themselves and the wider service. At baseline, 6 (100%) of respondents reported that being an assessor was having a positive impact on their own clinical practice or supervision approach. By follow-up, this figure dropped to 1 (25%), with 3 (75%) stating it had no impact. Furthermore, initial confidence (n=6, 100% at baseline) that the training would improve patient care and service delivery dropped to 50% (n=2) at follow-up, reflecting the stalled progress of the cohort.

Table 3 Assessor Survey Responses

Question	Category	Baseline responses (n=6)	% of overall responses	Follow-up responses (n=4)	% of overall responses
Health board	Cardiff and Vale UHB	2	33%	1	25%
	Hywel Dda	4	67%	3	75%
Current professional role	GP	2	33%	1	25%
	Advanced Nurse Practitioner	3	50%	3	75%
	Nurse Practitioner	1	17%	0	0%
Role(s) within the Urgent Care Practitioner framework?*	Mentor	3	50%	0	0%
	Clinical Assessor	1	17%	1	25%
	Mentor & Supervisor	0	0%	1	25%
	Mentor, Clinical Assessor, Educational Assessor, Supervisor	2	33%	2	50%
Years of experience in supervising/assessing healthcare professionals	0-2	2	33%	1	25%
	2-5	1	17%	1	25%
	>10	3	50%	2	50%
Previously assessed/supervised practitioners in urgent or primary care training programmes	Yes	5	17%	NA	
	No	1	83%	NA	
Currently assessing or supervising any practitioners on the framework	Yes	5	83%	1	25%
	No	1	17%	3	75%
Rating of the communication, guidance and administrative support received for the framework (follow-up only)	Excellent	NA		0	0%
	Good	NA		0	0%
	Neutral	NA		4	100%
	Poor	NA		0	0%
	Very poor	NA		0	0%
	Very clear	0	0%	0	0%

Question	Category	Baseline responses (n=6)	% of overall responses	Follow-up responses (n=4)	% of overall responses
Clarity of the expectations as an assessor of the framework	Clear	2	33%	0	0%
	Neutral	3	50%	3	75%
	Not very clear	0	0%	0	0%
	Not clear at all	0	0%	1	25%
	N/A	1	17%	0	0%
Level of supervision and assessment expected is reasonable	Yes	6	100%	1	25%
	No	0	0%	3	75%
Adequate support and resources provided to effectively assess practitioners	Yes	4	67%	1	25%
	No	2	33%	3	75%
Provided with protected, funded time to complete assessor duties	Yes - sufficient protected time	NA		0	0%
	Yes - but not enough time	NA		0	0%
	No - I am completing these duties during my standard clinical time or my own personal time	NA		4	100%
How well the framework aligns with what is required in real-world urgent care	Fully aligned	1	17%	1	25%
	Quite aligned	5	83%	2	50%
	Neutral	0	0%	1	25%
	Not very aligned	0	0%	0	0%
	Not at all aligned	0	0%	0	0%
Training adequately prepares practitioners for clinical decision-making in urgent care	Yes	6	100%	3	75%
	No	0	0%	1	25%
Practitioners on the framework are receiving enough opportunities for hands-on clinical experience alongside the theoretical training	Yes	6	100%	2	50%
	No	0	0%	2	50%

Question	Category	Baseline responses (n=6)	% of overall responses	Follow-up responses (n=4)	% of overall responses
Areas of the training that you feel should be improved or expanded to better support practitioners	Yes	0	0%	3	75%
	No	6	100%	1	25%
Practitioners experience of engaging with the self-paced learning format from assessor's perspective	Very easy	0	0%	0	0%
	Easy	1	17%	0	0%
	Neutral	5	83%	0	0%
	Difficult	0	0%	1	25%
	Very difficult	0	0%	1	25%
	Unsure	0	0%	2	50%
Experience balancing being an assessor with clinical/existing workload	Very easy	0	0%	0	0%
	Easy	0	0%	0	0%
	Neutral	3	50%	0	0%
	Difficult	3	50%	0	0%
	Very difficult	0	0%	2	50%
	Not relevant (I haven't started assessing yet)	0	0%	2	50%
Impact (positive or negative) of being an assessor on own clinical practice or supervision approach	Yes (positive impact)	6	100%	1	25%
	Yes (negative impact)	0	0%	0	0%
	No	0	0%	3	75%
Impact of the framework on patient care or service delivery	Yes	6	100%	2	50%
	No	0	0%	2	50%

GP: General Practitioner; NA: Not Applicable / Not Answered; UHB: University Health Board. \*Multiple responses allowed

## Interviews

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A total of 20 interviews were conducted throughout the evaluation. Seventeen of these took place at baseline (at enrolment onto the framework); 13 of which were with practitioners, and 4 with assessors which were conducted between 21/08/2025-24/10/2025.

A further 3 interviews were conducted at follow-up between the dates 08/05/2025-13/05/2026. Two of which were with practitioners, and one with an assessor. Two practitioners were interviewed at both baseline and follow-up.

The average duration of interviews was 46 minutes (range: 35-73) and 35 minutes (range: 32-37) for follow-up interviews.

## Themes

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To provide deeper context to the quantitative survey data, free-text survey responses were triangulated with insights gathered from interviews with practitioners and clinical assessors. By merging these perspectives, several prominent themes emerged regarding the framework's usability, clinical impact, and recommendations for change.

### **Theme 1: Time and operational pressures**

Across both surveys and interviews, severe time constraints were universally cited as the primary barrier to framework progression for both practitioners and assessors. One assessor commented:

*"Honestly, I don't feel that this has even been started as we don't have time. I find that when you come to work, the focus is on getting through the shift and seeing the patients. I don't have the time or energy to run after other clinicians to ensure they are making efforts to complete their portfolio and remind them of things they need to do. I can barely remember to do it myself"*

During interviews, practitioners emphasised that the framework cannot be completed in 10-minute 'quiet spells' on shift; it requires deep focus. Even when SPA time (protected learning time) is allocated, this time is frequently interrupted by acute service pressures or last-minute staffing requirements.

To prevent these interruptions, practitioners suggested that framework time should be completed strictly out of uniform or off-site. Many spoke about the guilt they felt focusing on the framework or training, while patients are kept waiting and

colleagues are overwhelmed, which often results in them abandoning their study time to be pulled back onto the clinical floor.

*“The only way I feel is going to work is if you're given like 4/5 hours, or a study day when you're not in the workplace, because I've been here twice in the workplace in my uniform, and I get pulled [into clinic]. So, you either come in not in uniform, or you do it from home without distractions.”*

Assessors validated this pressure, noting that even when time is carved out, the nature of shift patterns and community outreach often prevents the assessor and practitioner from being in the same room. A key repeated suggestion from assessors was the move away from traditional meetings toward ‘Joint assessment shifts.’ This involves rostering assessors and practitioners together clinically to see patients and document competencies in real-time. Furthermore, both groups highlighted the difficulty of juggling the framework alongside other academic commitments, such as the Advanced Clinical Practice (ACP) Master's degree, which a large number of practitioners were completing concurrently with the framework, which took priority.

## **Theme 2: Implementation and clarity of expectations**

A prominent theme was a feeling of being overwhelmed regarding the framework's rollout. Practitioners described the implementation as relying on word of mouth, with the framework simply handed to them and being told to complete it, without much guidance on how to do this.

*“we've just been given it and told get on with it and don't really know what we're doing, and I think that's been the massive barrier. I don't think that it was rolled out properly to begin with”*

The lack of central communication caused confusion at both pilot sites, with a couple of assessors unaware that they were an assessor, and who they were supposed to be assessing:

*“To be honest I am not sure what the expectations [of being an assessor] are at all. I don't have time to even complete my own work”*

Both groups also noted the frustration of duplicated work, urging HEIW to ensure the framework integrates with existing portfolios:

*“This is a huge project and for a lot of us it is confusing, duplicated....and attempting to intermingle more than one framework is overwhelming ”*

One assessor stepped back from the role initially, feeling they needed to figure out the ‘wordy’ document themselves before guiding others.

There was overwhelming consensus that HEIW must provide a formal introductory ‘Development Day’ with webinars and resources throughout to outline expectations, timeframes, and assessment criteria:

*“I think if we had development days in the early stages provided by HEIW, it would have propelled us forward but as a low cost no cost project it has been difficult for the team.”*

Assessors also specifically advocated for better guidance and an instruction manual for supervisors to standardise the mapping and gapping process, and their expectations as assessors in terms of meeting frequency, assessment style etc.

### **Theme 3: Assessor ambiguity**

The lack of clarity on the assessor’s role heavily impacted the assessment process. Practitioners expressed anxiety over self-grading, feeling too modest to tick ‘expert’ even when functioning as one. The framework’s grading structure was noted by many as being overly rigid. Practitioners highlighted that the current model prevents them from claiming proficiency in a broad domain if they have not encountered a single, niche, or infrequent clinical presentation that is unlikely to occur in their specific practice. To address this, practitioners recommended introducing greater flexibility within modules, for example, by allowing them to demonstrate competence in four out of five key areas rather than requiring completion of every listed competency.

Assessors also noted a potential legal and data-governance barrier: the ambiguity of whether an assessor is permitted to access the clinical records of a patient they did not personally treat to verify a practitioner’s write-up. To solve the ambiguity around evidence requirements, both groups strongly advocated for a ‘Mock Portfolio’, similar to the gold-standard examples provided for the Nursing and Midwifery Council (NMC) revalidation.

*“A pretend one [portfolio] that we can look at would be helpful... that that might start us getting a bit more interested, but looking at a wad of paper that you don't really understand, it's not going to happen, is it?”*

Seeing completed examples would remove the anxiety of self-grading, clarify the level of detail required, and ensure consistent standards across different teams.

*"If they'd done a mock portfolio and went, this is basically what we want, but you do it in your own way in your own words. I would have just cracked on by myself by now."*

#### **Theme 4: Framework format**

Opinions on the physical format of the framework were divided. While many staff preferred the paper folder, community-based and outreach staff strongly advocated for digitising the framework, or giving practitioners the option of both. For these practitioners, a digital format is a necessity to enable them to record reflections while in transit or between home visits:

*"Online is much better, and you know, if I was waiting in the doctor's surgery or if I was waiting outside a patient's house or something, I could do it then"*

Practitioners also noted that digital formats would also allow for accessibility tools (text-to-speech, font scaling), which is vital for neurodivergent staff who find big blocks of text visually daunting.

Additionally, both groups suggested a dedicated MS Teams channel or online directory/forum purely for those on the framework. This would serve as a centralised hub to upload anonymised, high-quality case studies (e.g., Discharge Advice Letters) to foster peer-to-peer shared learning. The preference for this was to have this within their own team rather than accessible to all framework practitioners across Wales.

#### **Theme 5: Clinical impact and the practitioner passport**

Despite operational hurdles, the perceived clinical value of the framework remains high. Staff praised the 'map and gap' exercise for forcing them to recognise gaps in their knowledge, such as minor injuries, paediatrics, or sexual health.

*"I've already identified a need in minors though, and I'm working on exposing myself a lot more to minor injuries so that I get that experience....so in a personal way, yeah, already I'm seeing there's a bit of a change."*

*"I think the main thing is that it just enables people to think, actually, do you know what? I really don't know enough about that,*

*but I need to. That's where I need to improve my competence.  
So yeah, it's been, it's been thought provoking."*

Both practitioners and assessors viewed the framework not as a 12-month course to be 'completed,' but instead viewing it as a continuous, lifelong portfolio for practitioners use throughout their career in their current role and any future roles.

*"it does evidence what you're doing and what you have achieved. So if circumstances were to change and I needed to apply for another job then you have got that formal backup."*

The framework was recognised as providing vital clinical governance. For nurse-led units making autonomous decisions, it provides proof of safety and competence. Looking to the future, both the practitioner and assessor groups supported an All Wales rollout. Practitioners conceptualised the framework as a transferable 'Passport' for future career progression.

*"it is your passport, if you like, to take with you to wherever you go."*

Both groups felt as though this framework, with some improvements, has the potential to become the trusted, gold-standard passport for Urgent Primary Care across Wales.

## Discussion

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The evaluation of the pilot Urgent Primary Care Practitioner Competency framework highlights a very clear contrast between its clinical value and practical feasibility: practitioners and assessors see the clinical value in it, but in busy, often overstretched clinical departments, finding the protected time and supervisory support to actually engage with it is a real struggle.

Even though progress has been slow, with only 15% of practitioners finishing a module by the 12-month mark, the framework does seem to be starting to achieve what it set out to do. The survey data shows an increase in confidence and competence across the board from baseline at enrolment and a year later at follow-up. However, it is difficult to know whether this change is attributed to the framework, or other courses running alongside the framework such as the advanced clinical practitioner course. It is proving to be a useful tool to help staff identify gaps in their knowledge, and gives nurse-led teams the clinical backing they need to make safe, autonomous decisions. Practitioners on the ground really like the idea of having a recognised role and 'Clinical Passport' they can take with them to future roles anywhere in Wales.

However, the pilot also clearly shows that the day-to-day reality of working in urgent care makes it incredibly hard to complete the framework. Time was undoubtedly the biggest hurdle for both practitioners and assessors. Without guaranteed, protected SPA time, staff are trying to juggle the framework alongside busy clinics, staff shortages, and other courses which often take priority. Groups felt that expecting people to pick up the framework and write up cases during a 'quiet shift' was not realistic.

On top of the time constraints, the way the framework was initially rolled out left a lot of people feeling overwhelmed and unsure where to start. Without a proper induction day, clear guidelines, or examples of what a good portfolio looks like, both practitioners and assessors were essentially left guessing what was expected of them. Furthermore, some staff found relying on a sizeable paper folder frustrating. For clinicians working unsocial shifts or those working out in the community, completing a framework during a night shift or carrying a bulky folder around was not practical. They noted the need for a modern, digital solution that fits into their workflow, like an app they can dictate notes into between visits or can complete while at home without the need to take a folder with them.

Ultimately, this evaluation of the pilot suggests that the clinical content of the UCP framework is useful, relevant, and respected by the staff using it. The main challenge for HEIW ahead of an All Wales rollout is not changing the content, but rather facilitating how it is delivered and supported. Table 4 below consolidates the key recommendations to aid HEIW in developing the framework for current and future cohorts. Categorized by theme, these findings are drawn from a triangulation of data across 33 survey responses and 20 interviews, capturing the perspectives of both practitioners and assessors at the baseline and follow-up stages.

## Recommendations for Improvement

Table 4 Summary of recommendations from Practitioners and Assessors

Area of recommendation	Recommendation / suggestion
<b>Timelines and progression</b>	<p><b>Clarify competency longevity:</b> Provide explicit guidance on whether module sign-off grants permanent, transferable competency across health boards, or if reassessments are required when clinical pathways or practice changes.</p>
	<p><b>Establish clear progression targets:</b> Set formal, expected timeframes for progressing between levels (e.g. UCP 1 to 2) at the point of enrolment, and during appraisals. This can be on a case-by-case basis.</p>
	<p><b>Set personal deadlines:</b> To prevent the framework from being deprioritised against other courses, assessors should agree on soft or personal deadlines for specific modules with practitioners.</p>
<b>Protected time and induction</b>	<p><b>Mandate protected study time:</b> Allocate specific, uninterrupted (off site) SPA time (e.g. half a day a month) within standard working hours to prevent reliance on practitioners' personal time.</p>
	<p><b>Host a formal HEIW induction:</b> Replace ad-hoc onboarding with a mandatory hybrid induction event or videos/webinars explaining the purpose, evidence types (DOPS/Mini-CEX), and timeframes.</p>
	<p><b>Introduce joint assessment shifts:</b> Roster assessors and practitioners together for specific clinical sessions to see patients and document competencies in real-time, removing the need for scheduling separate meetings.</p>

<b>Assessor guidance and standardisation</b>	<p><b>Establish catch-up frequency:</b> Provide a minimum contact guide or target (e.g., monthly check-ins) for assessors to meet with practitioners, to ensure momentum isn't lost.</p>
	<p><b>Clarify assessor seniority/experience:</b> Explicitly state the minimum framework level or clinical seniority required to act as a designated assessor for each UCP level.</p>
	<p><b>Introduce external verification:</b> Consider adopting an All Wales external verifier, or cross-site assessors, to ensure competency standards remain consistent across different departments and health boards.</p>
<b>Structure and content</b>	<p><b>Refine and categorise conditions:</b> Categorise clinical presentations within the framework by relevance (e.g. mandatory core competencies vs. desirable supplementary skills) depending on the specific clinical setting.</p>
	<p><b>Rebalance clinical focus:</b> Increase the emphasis and detail on minor injuries and minor illnesses to better reflect the daily caseload of most participating centres and practitioners, rather than focusing heavily on general medicine/majors.</p>
	<p><b>Allow modular flexibility:</b> Allow practitioners to achieve 'expert' status by completing a threshold (e.g., 5 out of 7 criteria) rather than requiring 100% completion of every niche case.</p>
	<p><b>Categorise conditions by relevance:</b> Clearly label conditions as 'core/common' (need to know) versus 'desirable/rare' (nice to know) to prevent staff from being overwhelmed by rare presentations they may never see.</p>

	<p><b>Reduce repetition:</b> Create a core skills section for universal tasks (e.g., observations, basic bloods) so they do not need to be re-evidenced across every clinical module.</p> <p><b>Integrate a gap analysis:</b> Include a formal gap analysis section for each descriptor to help practitioners identify strengths and development areas at enrolment and throughout the framework.</p> <p><b>Develop a 'Prescribing passport':</b> Incorporate the <a href="#">All Wales Patient Group Directions (PGD) training</a> into the portfolio. Collaborate with relevant bodies to integrate independent prescribing (Level 7) to create a combined competency record and reduce duplication of effort.</p>
<p><b>Evidencing and resources</b></p>	<p><b>Provide a mock portfolio:</b> Supply a high-quality, completed example portfolio (similar to NMC revalidation guides) to demonstrate the type of content, required level of detail and writing style.</p> <p><b>Create a centralised digital resource:</b> Establish a shared directory or forum (e.g., an MS Teams channel or Intranet page) for practitioners and assessors to easily access resources, anonymised case studies, best-practice examples, and to enable discussion between practitioners on the framework.</p> <p><b>Introduce a digital framework option:</b> While the paper format is popular, development of an online/app-based version would give practitioners the choice and to allow community-based practitioners to update their portfolios securely via mobile devices during downtime.</p>
<p><b>Career progression</b></p>	<p><b>Align with career progression:</b> Clarify if framework levels are tailored to job descriptions or vice versa, and whether the framework will be an essential or desirable criterion for future roles.</p>

	<p><b>Clinical Passport:</b> Position the framework as a respected, transferable document that demonstrates competence to future employers across all Welsh Health Boards.</p>
<p><b>Engagement and peer support</b></p>	<p><b>Establish a buddy system:</b> Pair practitioners (potentially across different sites) to collaborate on portfolios and share ideas.</p>
	<p><b>Facilitate regular peer meetings:</b> Host quarterly case discussion meetings where staff can share interesting presentations and evidence-gathering tips in a supportive environment.</p>
	<p><b>Secure management/department buy-in:</b> For future rollouts, ensure management teams are fully briefed on the purpose and are committed to protecting practitioner time within work hours.</p>

## Strengths and Limitations

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### Strengths

- Feedback was gathered from both practitioners and their clinical assessors, providing a comprehensive perspective of the pilots implementation, rather than a one-sided view.
- Tracking the pilot over 12 months highlighted how initial engagement decreased when staff encountered everyday workplace pressures. This provided a realistic projection of what to expect for future rollouts.
- Gathering feedback directly from frontline staff managing busy shifts ensures that the resulting recommendations are highly practical. They reflect the messy reality of urgent care, not just how things work on paper.

### Limitations

- The overall pilot cohort was small, and not every practitioner and assessor took part in either or both the survey and interviews. Survey responses received at baseline and follow-up were not from a matched paired sample, limiting the ability to draw definitive conclusions regarding changes in self-reported competencies and confidence.
- A significant challenge in this evaluation is that most practitioners were concurrently enrolled in other demanding university courses. It is therefore difficult to isolate how much of their reported increase in clinical confidence and skill is attributable solely to the framework versus their other studies.
- Due to initially slow survey response rates, some baseline data was collected iteratively a few weeks or months after practitioners had already commenced the framework, capturing early engagement rather than a pure pre-enrolment snapshot.
- Because progress stalled for the majority of the cohort due to time constraints, this evaluation primarily captures the onboarding and early phases of the framework. There is currently insufficient data to assess the impact of completing a significant proportion or the entirety of the framework.
- The pilot was restricted to two specific urgent care centres across two Welsh health boards, with distinct operational models. Therefore, the identified barriers and successes may not be entirely generalisable to other hospitals, urgent care centres, or minor injury units across Wales.

## Conclusion

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The 12-month pilot demonstrates that the All Wales UCP Competency Framework holds significant potential. For those who could engage, it successfully acted as a 'map and gap' tool, highlighting clinical areas of weakness and set practitioners out on a structured pathway of learning. There is a clear appetite for those involved for the framework to become a standardised 'clinical passport' for urgent care practitioners across NHS Wales.

However, the evaluation highlighted a disconnect between this potential value and the operational realities of urgent care. Low module completion rates were driven by a lack of time as practitioners simply could not complete a bulky paper portfolio during already overstretched clinical shifts.

Ultimately, the framework's clinical content is solid and respected by those taking part; the challenge for HEIW is refining the delivery. For a successful All Wales rollout, HEIW should focus on providing continuous enrolment and implementation support to practitioners and assessors, including making the framework digitally available, mock portfolios, and standardised assessor guidance. Concurrently, for health boards adopting the framework, success will depend on mandating protected study time to ensure the framework fulfils its potential.

## References

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