NHS
Health Education England

First Contact Practitioners and Advanced Practitioners in Primary Care: (Podiatry)

A Roadmap to Practice

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Acknowledgements

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Development of the Podiatry Roadmap to First Contact Practice and Advanced Practice in Primary Care was project-managed by Amanda Hensman-Crook (Health Education England). The development of the Podiatry Knowledge Skills and Attributes document was led by Helen Beaumont-Waters, advanced practitioner (paramedic/podiatrist, Kensington Partnership) and Dr Lindsey Cherry, senior clinical academic podiatrist (University of Southampton & Solent NHS Trust). Supervision content was led Julia Taylor (Lister House Surgery and Health Education England). The College of Podiatry, along with respective specialist interest groups and the Institute of Chiropodists and Podiatrists, provided expert support in the building of this roadmap. We are extremely grateful to the many stakeholders who have been instrumental in shaping this piece of work, in particular to our patient representatives who sit at the heart of the roadmap.

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Table of Contents

Glossary

Abbreviation	Full text
ABPI	Ankle Brachial Pressure Index
AfC	Agenda for Change
ALT	Alanine Aminotransferase Test
ANA	Anti-Nuclear Antibody
AP	Advanced Practice/Advanced Practitioner
AST	Aspartate Aminotransferase Test
CBD	Case-Based Discussion
CCG	Clinical Commissioning Group
CCP	Cyclic Citrullinated Peptise antibody test
CEPs	Clinical Examination Procedural skills
CHA2DS2	Clinical prediction of stroke algorithm
CoP	College of Podiatry
COT	Consultation Observation Tool
CPD	Clinical Professional Development
CRP	C-Reactive Protein
CS	Clinical Supervisor
CSP	Chartered Society of Physiotherapy
CT	Computerised Tomography
CTD	Connective Tissue Disease
DEXA	Dual Energy X-ray Absorptiometry
ECG	Electrocardiogram
eGFR	Estimate Glomerular Filtration Rate
ESR	Erythrocyte Sedimentation Rate
FBC	Full Blood Count
FCP	First Contact Practitioner
FRAT	Falls Risk Assessment Tool
FTE	Full Time Equivalent
GP	General Practice/General Practitioner
GOCOG	GP Assessment of Cognition
HAS BLED	Bleeding risk classification tool
HbA1c	Glycated haemoglobin test
HEE	Health Education England
HEI	Higher Education Institute
IA	Inflammatory Arthritis

Abbreviation	Full text
ICS	Integrated Care System
JIA	Juvenile Idiopathic Arthritis
KSA	Knowledge, Skill, Attribute
LFT	Liver Function Test
MDT	Multi-Disciplinary Team
MPACF-LLV	Multi-Professional Advanced Capabilities Framework for Lower Limb Viability
MPFACP	Multi-Professional Framework for Advanced Clinical Practice
MRI	Magnetic Resonance Imaging
MSF	Multi-Source Feedback
MSK	Musculoskeletal
NHSE	National Health Service England
OA	Osteoarthritis
PCN	Primary Care Network
PDP	Personal Development Plan
PHQ2	Patient Health Questionnaire-2
PSQ	Patient Satisfaction Questionnaire
QAA	Quality Assurance Agency
QI	Quality Improvement
QIP	Quality Improvement Plan
QRISK3	Heart Attack or Stroke risk classification tool
RCGP	Royal College of General Practitioners
SMART	Specific, Measurable, Attainable, Relevant, Timebound
TFT	Thyroid Function Test
U & E	Urea & Electrolytes test
UK	United Kingdom
US	Ultrasound
VTE	Venous Thromboembolism
WB	Weight-Bearing
WPBA	Workplace-Based Assessment
The Centre	HEE Centre for Advancing Practice
Band 7 Band 8a	AfC pay bands, e.g. 7= FCP 8a = AP
Level 7 Level 8	Academic level of practice, e.g. 7 = Master 8 = Doctorate

Introduction

i Purpose

This document provides a roadmap of education for practice when moving into First Contact Practitioner (FCP) roles, and onward to Advanced Practice (AP) roles in Primary Care. It sets out:

- The definition of First Contact roles, their respective training processes, and educational pathways
- The definition of Advanced Practice roles, their respective training processes, and educational pathways
- How to build a portfolio of evidence for both FCP and AP roles
- How to support training with relevant supervision and governance, and how to connect with Health Education England's Centre for Advancing Practice

This is the roadmap version of the educational pathway to FCP and AP for experienced Podiatrists recruited to work in Primary Care. The framework presented is applicable across adults and children dependent on the scope of practice, appropriate and applicable knowledge and skills, and the job description that the FCP is working under.

ii Historical background and context

FCP roles began with the development of the FCP Physiotherapist in 2014, in response to the shortage of General Practitioners (GPs) in Primary Care. FCP roles are designed to support GPs as part of an integrated care team and to optimise the patient care pathway by seeing the right person in the right place at the right time. Visit the Getting it Right First Time Website for more information.

As the FCP role evolved (see historial perspectIve), it created a template for other professions to use and develop FCP roles in Primary Care. This created an assurance that there was a standardisation of quality provided across multiple professions at this level of practice. This standardisation assures governance and ultimately patient safety, ensuring capability to see and manage undifferentiated and undiagnosed presentations within an agreed scope of practice.

To create sustainability for multi-professional FCP roles, there is a need to build a clear national Primary Care training pathway for clinicians moving into FCP roles, onto AP, which ultimately will provide a pipeline of professionals at the right level of practice, and help to recruit and retain them in Primary Care.

HEE Primary Care training typically begins at a minimum of five years' post- registration experience (see diagram below) in a clinician's professional role in the area where they will be practicing in Primary Care.

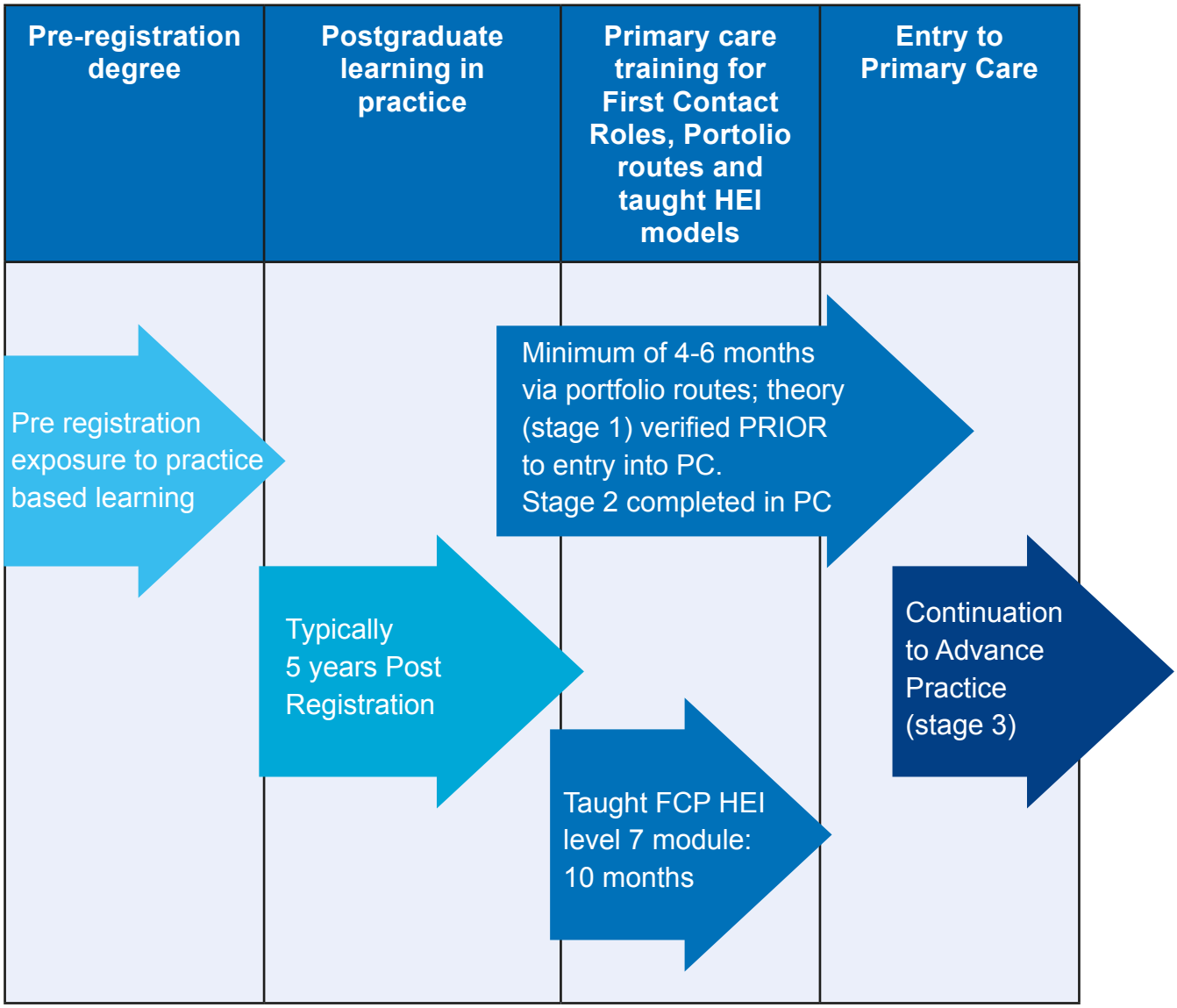


Figure 1: Illustration of career progression for Primary Care roles.

Clinicians will need to be supported by a verified FCP AP supervisor outside Primary Care to complete required Primary Care recognition prior to entry into an FCP role (see sections 8 and 9).

To provide further background to FCP roles in Primary Care, please refer to the following documents from The College of Podiatry (CoP), The Chartered Society of Physiotherapy (CSP), Health Education England (HEE), and NHS England (NHSE).

1. The College of Podiatry
2. A retrospective review of the influences, milestones, policies and practice developments in the first contact MSK model
3. NHS England - First contact physiotherapists

iii The Centre for Advancing Practice

The Health Education England Centre for Advancing Practice (The Centre) has been established, working extensively and collaboratively with professional bodies and other stakeholders, to support education and training for FCPs and APs in England. FCP roles will be supported by The Centre in the following ways:

- A retrospective route for existing FCPs will be available via the portfolio route to gain recognition.
- FCP recognition is not a 'short cut' to full AP status and not all FCPs will chose to progress to AP. However, any evidence collected in the FCP portfolio relevant to the AP portfolio can be used for further submission, in combination with the additional evidence required for AP status (see appendix 12.16).
- The Knowledge, Skills, and Attributes (KSA) document describes the prerequisite knowledge, skills, and attributes stipulated for clinical professionals moving into Podiatric FCP roles within Primary Care (appendix 12.15). Mapping against the KSA document with a portfolio of evidence is the recognition requirement for Stage 1 (see section 5), alongside completion of the Primary Care and personalised care e-learning modules (see section 5.1).
- FCP supervisors will be required to have completed an approved Primary Care two-day training programme, which will allow them to support clinicians in achieving both FCP and AP recognition (appendix 12.11).
- GP Trainers will be able to access a shortened version of the above course.

1.0 Declarations

1.1 What is a First Contact Practitioner?

✔ A First Contact Practitioner (FCP) is a diagnostic clinician working in Primary Care at the top of their clinical scope of practice at master's level, Agenda for Change Band 7 (see 1.3) or equivalent and above. This allows the FCP to be able to assess and manage undifferentiated and undiagnosed lower limb presentations.

✔ It is the minimum threshold for working as a first point of contact with undifferentiated undiagnosed conditions in Primary Care. With additional training, FCPs can build towards advanced practice (see figure two).

✔ The clinician must have a minimum of three years of postgraduate experience in their professional specialty area of practice before starting Primary Care training to become an FCP.

✔ To become an FCP, recognition is required through Health Education England, whereby a clinician must have completed a taught or portfolio route.

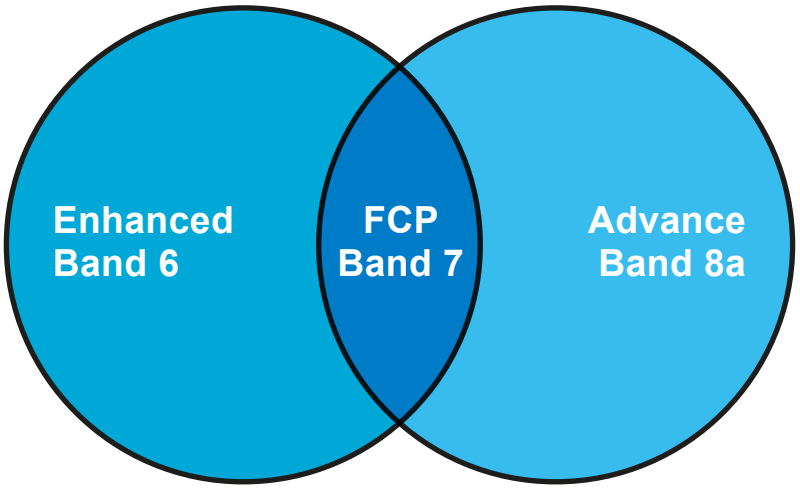


Figure 2: Illustration of AfC role progression within Primary Care.

✔ FCPs refer patients to GPs for the medical management of a patient with non-podiatric presentations or pharmacology outside of their agreed scope of practice.

✔ FCPs work at master's level in their clinical pillar of practice (QAA level 7, see 1.4), but have not yet reached an advanced level in all four pillars of practice to be verified as an AP.

1.2 What is an Advanced Practitioner?

- An AP is a clinician working at an advanced level across all four pillars of advanced practice at master's level (QAA level 7, see 1.4).
- The four pillars include research, leadership and management, education, and clinical practice (see figure three).
- AP works at Agenda for Change band 8a (see 1.3) or equivalent and above.
- An AP Podiatrist in Primary Care can develop from a range of specialties, if their evidence (either through an HEI or portfolio route) is mapped against the relevant capabilities/frameworks and level 7 educational standards (see appendix 12.16).

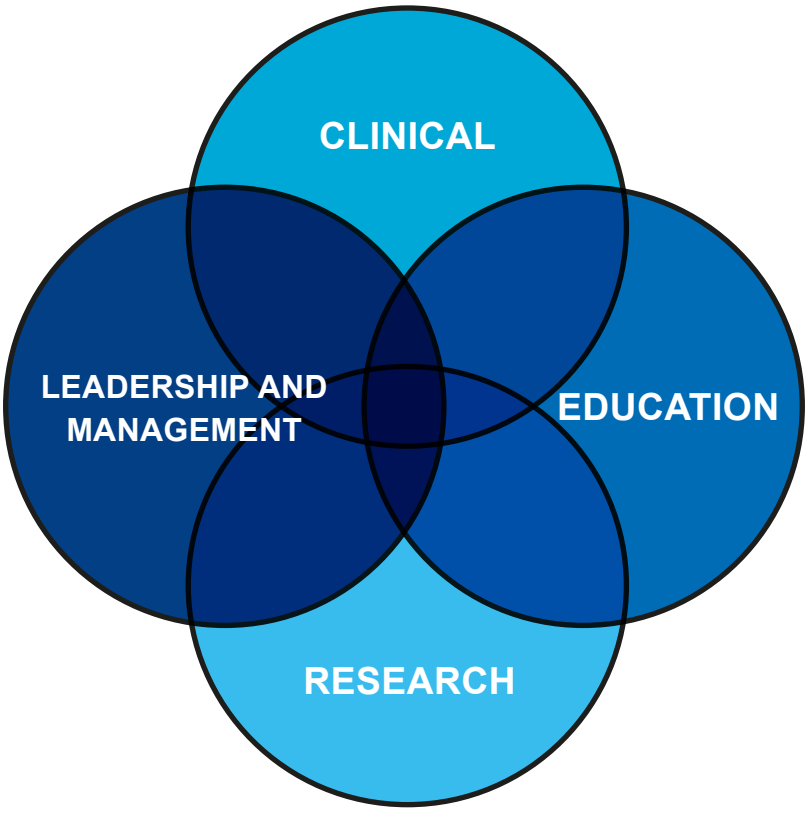


Figure 3: Illustration of inter-linkage of the four pillars of Advanced Practice.

1.3 How do we remunerate clinicians based on their evidence of capability?

- Remuneration should be based on a clinician's evidenced capability in practice.
- Primary Care does not traditionally use AfC pay bands to determine rate of pay but AfC is useful as a guide to a minimum rate of pay in relation to a clinician's level of practice.
- Agenda for Change 'Bands' are NHS pay bands that are applicable to all professionals with the exception of doctors, dentists and some very senior managers in the NHS.
- The table below shows the difference in capabilities between an FCP (master's level in the clinical pillar, pay band 7) and an AP (master's level across all four pillars, pay band 8a) and the added breadth of practice that an AP demonstrates.
- An AP demonstrates all the capabilities listed for FCP plus the additional capabilities listed for AP.

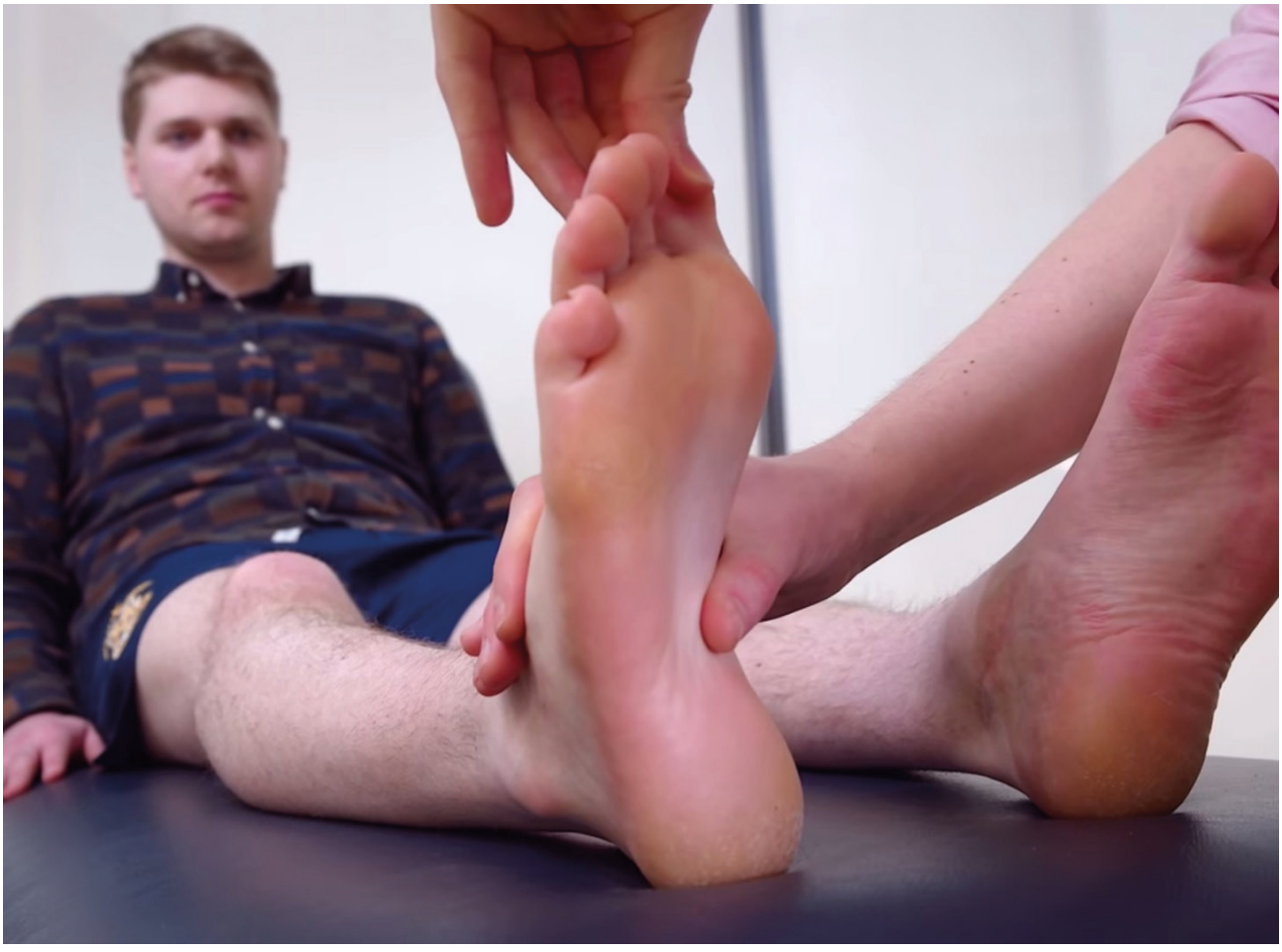


Table 1: Table to show capabilities across Band 7 and Band 8a (AfC) in Primary Care.

First Contact Practioner Band 7	Advanced Clinical Practioner Band 8a
• Manages undifferentiated, undiagnosed conditions. • Able to identify red flags and underlying serious pathology and take appropriate action. • Works within practices, across a PCN, in multi-organisational and multi-professional environments, and across care pathways and systems including health, social care, and the voluntary sectors. • Undertakes a high-level of complex decision-making to inform investigation, diagnosis, management, and onward referral within scope of practice. • Actively takes a personalised care approach to enable shared decision-making. • Contributes to audit and research projects. • Contributes to education and supervision within their scope of practice for the multi-professional team. • Facilitates inter-professional learning in area of expertise. • Promotes and develops area of expertise across care pathways. • Working at level 7 in clinical practice pillar and could work toward Advanced Practice (level 7 across all 4 pillars).	• Manages undifferentiated, undiagnosed conditions. • Able to identify red flags and underlying serious pathology and take appropriate action. • Works within practices, across a PCN, CCG and ICS, in multi-organisational and multi-professional environments, and across care pathways and systems including health, social care, and the voluntary sectors. • Undertakes a high-level of complex decision-making to inform investigation, diagnosis, complete management of episodes of care within a broad scope of practice, and onward referral within scope of practice. • Actively takes a personalised care approach to enable shared decision-making. • Flexible skill set to adapt to and meet needs of the PCN population and support public health. • Manages medical complexity. • Actively engages in care delivery from a population care viewpoint. • Leads audit and research projects. • Provides multi-professional clinical and CPD supervision across all four pillars with relevant training. • Leads education and supervision within their scope of practice and area of expertise for the multi-professional team. • Facilitates interprofessional learning in area of expertise. • Promotes, enables, facilitates, and develops change across care pathways and traditional boundaries in area of expertise. • Working at level 7 across all four pillars.

1.4 What is Quality Assurance Agency (QAA) Level 7?

- The Quality Assurance Agency (QAA) Level 7 is the UK academic master's (MSc) level.

- **FCPs work at master's level in their Clinical Practice pillar but have not yet reached that level in all four pillars of practice to be verified as an AP (research, leadership and management, education, and clinical practice) (see appendix 12.16).**

- Level 7 practice requires complex clinical reasoning skills and critical thinking.

- The QAA (2010) MSc level 7 descriptors are found below (table two) or via this link:

QAA (2010) MSc Level 7 descriptors
Graduates of specialised/advanced study master's degrees typically have: Subject-specific attributes: **An in-depth knowledge and understanding of the discipline, informed by current scholarship and research, including a critical awareness of current issues and developments in the subject.** **The ability to complete a research project in the subject, which may include a critical review of existing literature or other scholarly outputs.** **A range of generic attributes, abilities, and skills, (including skills relevant to an employment-setting), that include the ability to:** ✔ Use initiative and take responsibility, ✔ Solve problems in creative and innovative ways, ✔ Make decisions in challenging situations, ✔ Continue to learn independently and to develop professionally, ✔ Communicate effectively, with colleagues and a wider audience, in a variety of media.

2.0 Primary Care educational pathways

There are two main educational pathways to practice in Primary Care, illustrated in figure four:

- FCP portfolio or taught route plus portfolio of evidence within Primary Care,
- AP portfolio or taught routes plus portfolio with the addition of the required Primary Care KSA training.

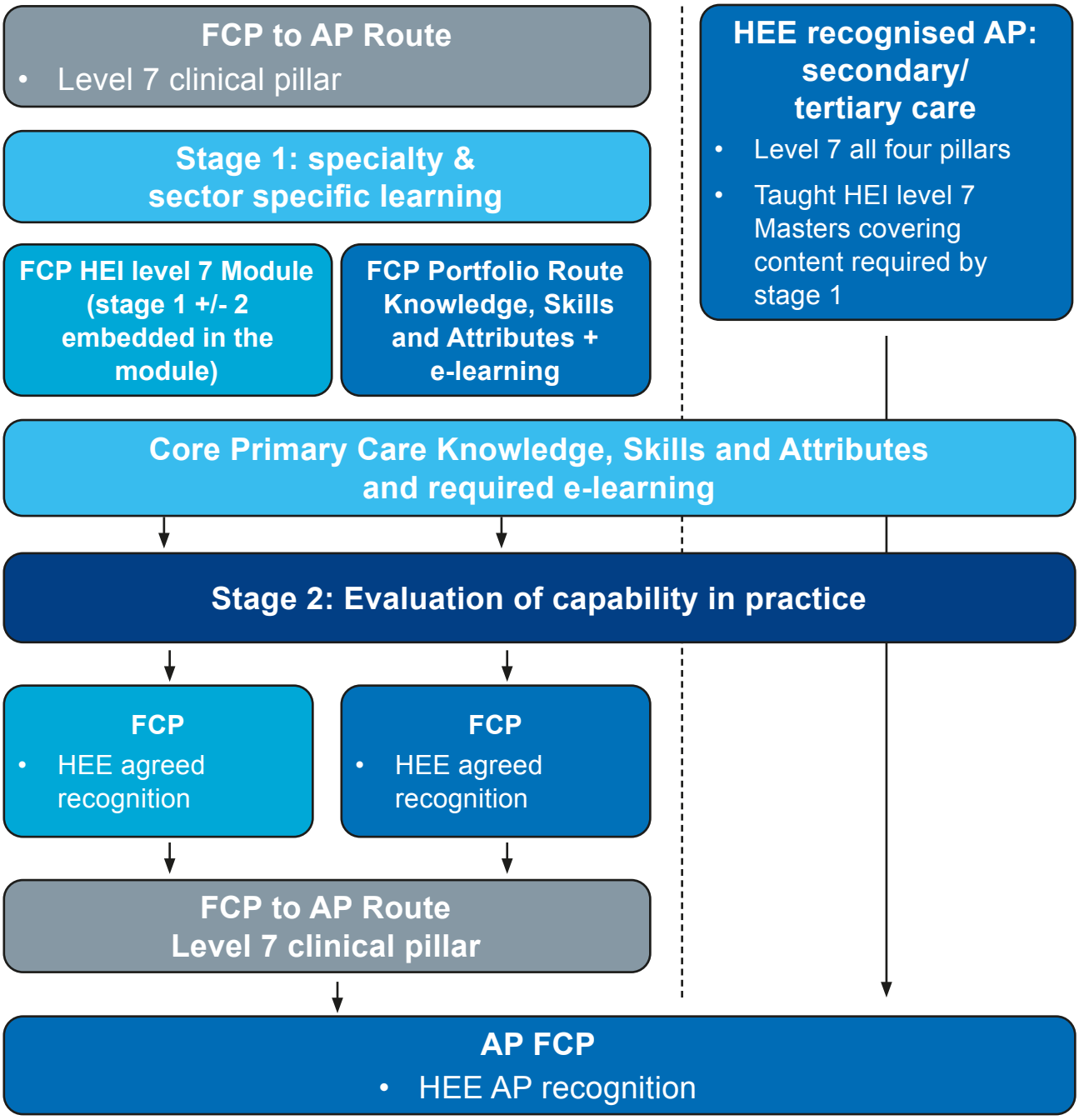


Figure 4: Illustration of pathways to FCP and AP in Primary Care

3.0 National standards and frameworks for Podiatrists

- There are a number of frameworks that underpin this roadmap.

- The capabilities as defined in the domains below have been developed to set the standard required for a Podiatrist working in a First Contact Practitioner role within Primary Care.

- The capabilities are cross-referenced with the Health Education England Multi-Professional Advanced Capabilities Framework for Lower Limb Viability (MPACF-LLV), College of Podiatry (CoP) Foot and Ankle Musculoskeletal (MSK) Competency Framework and outlined in accordance with QAA level 7 descriptors.

- It is important to note that Podiatry is a distinct profession, hence some framework capabilities have been changed, added, or removed to fit with the unique skills and attributes Podiatrists bring to the Primary Care setting. The recognition processes and capabilities within the presented documentation are designed to link the frameworks together, which will encourage effective use of evidence across FCP and AP and allow the clinician to see a pathway from FCP into AP as part of clinical professional development. This ensures evidence is used systematically, in a time-efficient way, and minimises duplication.

- The College of Podiatry is developing specialist practice frameworks, which are targeted at Podiatrists but could be used by other professions who treat lower limb pathology in Primary Care, such as Orthotists or Tissue Viability Nurses.

- FCP Podiatrists work within Primary Care to assess, diagnose, formulate, and implement management plans for conditions affecting the lower limb, specifically the foot and ankle. The care navigation included within each KSA sub-section outlines key clinical presentations that Podiatrist FCPs need to manage within Primary Care, according to the scope of their role. Each KSA sub-section details the corresponding knowledge and skill that the FCP Podiatrist must be able to appropriately apply within the context of the capabilities outlined and the context of their diverse PCN population.

The application of these clinical presentations will be determined by **the scope of the role of the FCP Podiatrist** and the context in which they operate, and would be **agreed between the FCP Podiatrist and their employer.**

It should be noted that some key clinical presentations can be related to more than one system and that systems interlink. Therefore, while it is important for the FCP Podiatrist to have the appropriate knowledge and skills of each system outlined below, they must also understand the complex inter- and co-dependencies of systems when providing care to people.

It will be for the FCP Podiatrist and their clinical supervisor to contextualise the knowledge statements appropriate to the clinical environment.

In addition to the generic capabilities outlined in the KSA framework (see appendix 12.15) the FCP Podiatrist will need to know and understand:

- *When a more focussed history is required relating to a specific presenting problem.*
- *That conditions can present differently in people, and that many presentations can be attributed to more than one system.*
- *How to assess and recognise `red flags' for the variety of presenting problems and an awareness of `masquerading red flags'.*
- *How individuals' current medication and existing conditions may affect their presenting symptoms.*
- *The anatomy and physiology of the human body as it applies to the clinical condition/ presentation to be assessed.*
- *The different stages of specific health conditions, including the short, medium, and long-term effects of specific health conditions on the individual's physiological, psychological, mental, and biological states and functions.*
- *Where further investigations can be carried out, who undertakes them, and the timescales involved.*
- *The importance of supporting people to develop their knowledge, confidence, and skills in managing their own health and improving their levels of empowerment.*

Importantly, where there is doubt or ambiguity the FCP Podiatrist is not expected to make a diagnosis but rather to keep an open mind and treat according to presentation, formulating an impression/differential diagnosis as to what might be the cause and what needs escalation to be ruled out. At all times, the FCP Podiatrist is required to put peoples' safety first and to manage risk(s) appropriately.

3.1 Core Capability Frameworks

Health Education England Multi-Professional Advanced Capabilities Framework for Lower Limb Viability (MPACF-LLV)

- This multi-professional framework was commissioned by Health Education England and developed in collaboration with the College of Podiatry and Skills for Health.

- The multi-professional framework is aimed at practitioners assessing, diagnosing, and treating conditions that impact lower limb viability, across the healthcare landscape.

- The framework sets out expected practitioner capabilities across the four pillars (clinical practice, leadership and management, education, and research). Within the clinical practice pillar, two domains are outlined against which the KSAs below are cross-referenced: Area A (A1-3), 'Specific capabilities for lower limb viability', and Area B (B1-3), 'Core capabilities in advanced clinical practice'.

College of Podiatry (CoP) Foot and Ankle Musculoskeletal Competency Framework (CoP MSKCF)

- This framework outlines Foot and Ankle MSK capability expected across levels of practice, ranging from pre-registration to Consultant and was produced by the College of Podiatry.

- The CoP framework is targeted at Podiatrists but may be considered of relevance to all health professionals assessing, diagnosing, or managing MSK conditions of the foot and ankle.

- The CoP framework outlines capabilities expected across four domains of clinical practice, totalling 14 capabilities, against which the KSAs below are cross-referenced: Domain A: person-centred care; Domain B: assessment, investigation, and diagnosis; Domain C: condition management, interventions, and prevention; and Domain D: service and professional development.

Multi-Professional Framework for Advanced Clinical Practice in England (MPFACP)

- The MPFACP (2017) was a vital publication as it standardised the domains of advanced practice, incorporating clinical skills, leadership and management, education, and research pillars. The roadmap aligns the development of the FCP, via the KSAs, towards AP so that the FCP can continue development without interruption or duplication of learning.

3.1.1 Linking the frameworks

- The cross-referenced frameworks align the clinician's evidence of accomplishment across most of the **clinical practice pillar** required for AP and partially across the other three pillars. This is an important differentiation between FCP and AP (see appendix 12.16).

- To help the clinician navigate this process, the clinician should utilise the **"Knowledge, Skills and Attributes"** (KSA) document that outlines the initial (Stage 1) FCP Podiatry recognition process (see appendix 12.15).

- This roadmap signposts the 'trainee' FCP to domains of practice that can be fulfilled through the education process, and enables the evidence produced to be cross-referenced against the relevant frameworks.

- Effectively the learner can build evidence within the KSA and use the same evidence (where indicated) as part of a process of evidence-building towards AP.

- The KSA outlines triangulated capabilities underpinned by the frameworks relevant to FCP Podiatrists. As the 'trainee' FCP achieves capability, the supporting roadmap documentation highlights to the trainee how their collated evidence can be cross-referenced to demonstrate accomplishment against multiple frameworks.

This takes the 'trainee' FCP, with their portfolio of evidence of accomplishment, through levels of practice that start in specialised podiatry practice, and progress to mastery of practice in Primary Care. This ultimately supports the final completion of an AP portfolio ready for submission and recognition by The Centre.

3.2 Building the evidence

The provision of high-quality supervision to individual clinicians is crucial and this will provide a structure for the evaluation of learning and future development (see 9.0).

Clinicians and supervisors should familiarise themselves with the national frameworks concerning FCP and AP (see 3.1), on which the structure of a portfolio of evidence can be based. The KSA can be evaluated to determine any immediate learning needs prior to an FCP role. The learning needs can be traced dependent upon whether the clinician is working towards FCP or AP. The KSA document aids the learner to build their evidence prior to embarking on their FCP accreditation process (Stage 1), working up to mastery of practice in Primary Care (Stage 2), and allows the trainee to build evidence toward AP (Stage 3), (see below for further details).

Essential requirements of the clinician in their journey are: ongoing reflective practice, peer review, patient feedback, and the monitoring of personal wellbeing to provide an enriched learning experience. The appendices of this roadmap document provide further information and resources to support this. Both clinician and supervisor will need to negotiate a supportive learning environment, allow space for reviewing the learning experience, and facilitate a route that is as seamless as possible through the process of recognition towards FCP or AP.

The ‘trainee’ FCP will be positioned ready for recognition once a portfolio of evidence has been developed alongside support from a supervisor.

As the Podiatrist begins to develop their portfolio of evidence with support from the supervisor, it is sensible to build training towards specific learning objectives that are mapped against the **appropriate frameworks**. This can be helpful in focussing on opportunities and when requests for support (money and/or time) are made. The Podiatrist can work within the aforementioned frameworks and use these as a reference for professional development at all stages of career development. **This can occur at any time in a career pathway and even prior to embarking on a formal training pathway.** The KSA, Health Education England MPACF-LLV, CoP MSK CF and MPFACP will inform the learner and supervisor of capabilities and standards that the learner can work towards prior to attaining a role as an FCP or AP within Primary Care.

4.0 The Roadmap to FCP

The process to train formally to be an FCP can begin at a minimum of three years of post-registration experience. Clinicians at every stage should be up to date with all required statutory and mandatory training in their area of practice.

- **Stage 1** must be completed with a portfolio of evidence and verified before employment in Primary Care. The KSA must be completed prior to employment as an FCP or AP in Primary Care to ensure patient safety. For podiatrists already working in Primary Care, this can be completed retrospectively.

- **Stage 2** is completed with a portfolio of evidence and verified in Primary Care. This is the recognition process of the application of the KSA in Stage 1 to clinical practice in Primary Care. Best practice is that this should be completed within six months for a full time member of staff, but this can be longer provided a completion date is agreed with the employer.

- Once **Stage 1** and **Stage 2** are verified, the practitioner can apply for inclusion on the directory at the Centre for Advancing Practice as an FCP and would be able to continue building evidence towards AP.

- **The clinical supervisor who recognises the above stages must be a verified FCP, an Advanced Practitioner, a Consultant Practitioner, or a GP who has completed the HEE two-day Primary Care supervisor training (see appendix 12.11).** This is a specific two-day supervision course to train as an AP roadmap supervisor to support FCP and AP practice in Primary Care, and to learn how to use the adapted RCGP toolkit for **Stage 2** recognition.

- **GP trainers will be able to access a shortened version of this course.**

There are currently two surveys that form an interim process to collect a list of practitioners who have completed FCP recognition to be credentialed, and who will be transferred to the Centre for Advancing Practice. Once the Centre for Advancing Practice is fully operational, the surveys will be transferred towards the directory.
Primary Care Clinical Level 7 - FCP Survey
Primary Care Clinical Level 7 - FCP Supervisor Survey

- **A taught level 7 HEI FCP module will have both stages within the course content and will be verified by the HEI.** The clinician completing the taught FCP course will need to complete both surveys until The Centre is operational.

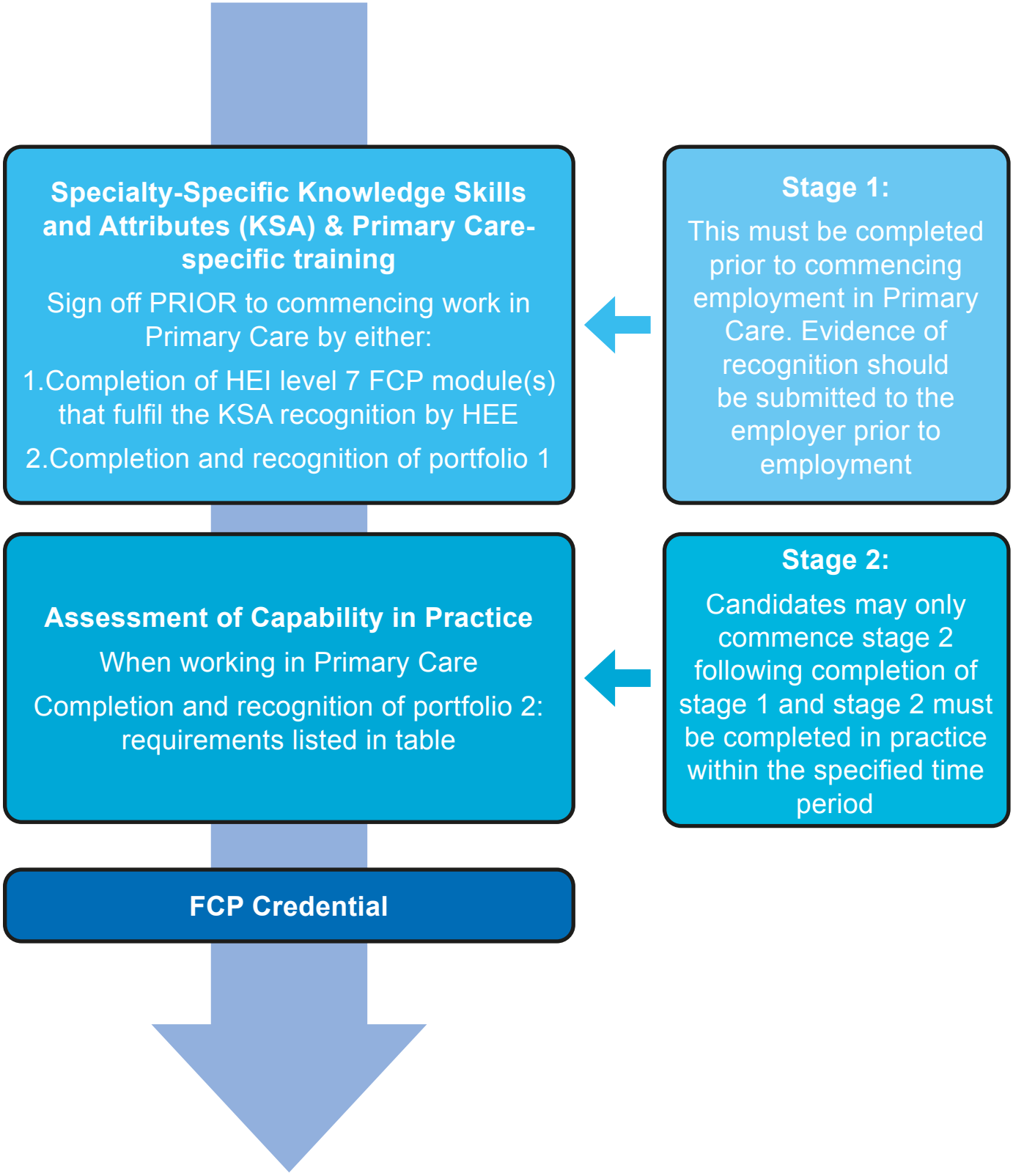


Figure 5: Illustration of the process of FCP recognition.

5.0 Stage 1: Knowledge, Skills & Attributes (KSA)

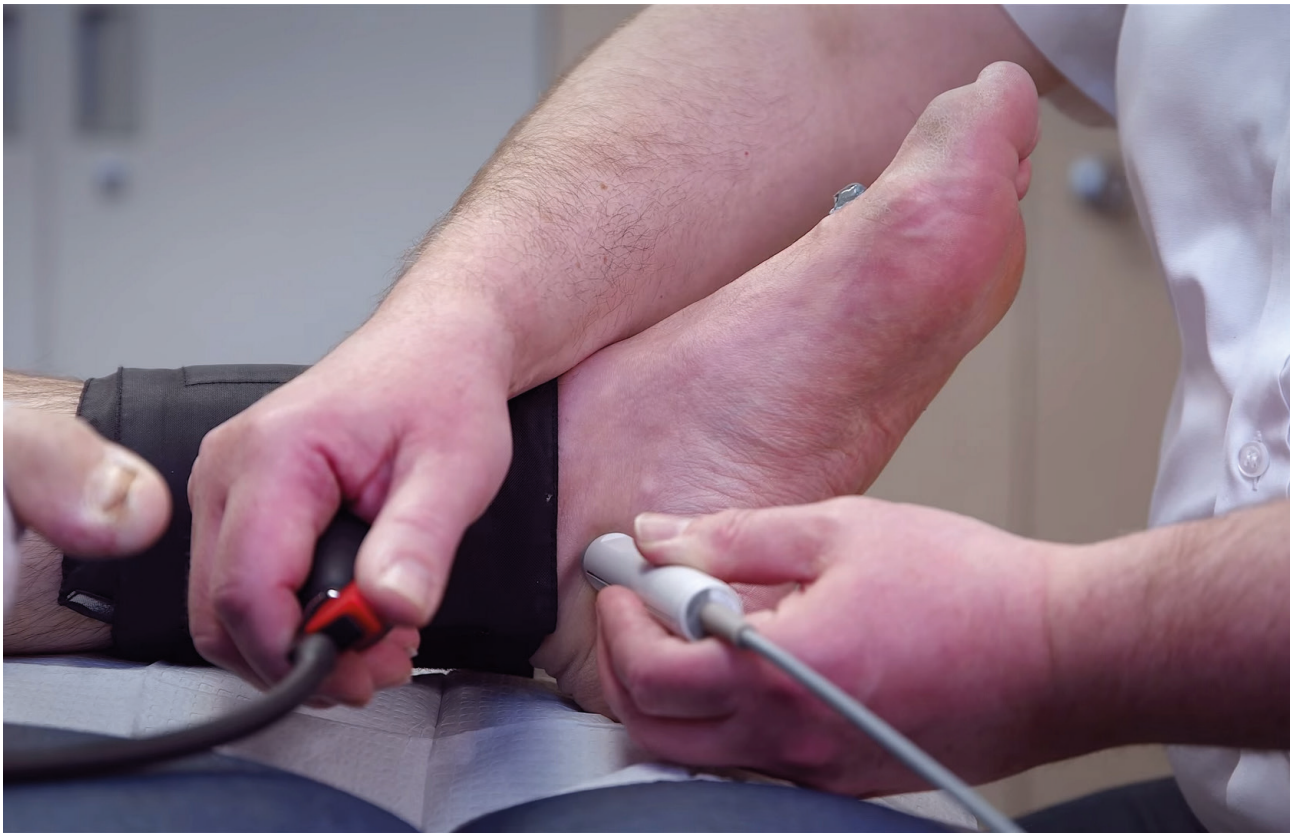
5.1 E-learning

- The early stages of creating a portfolio of evidence towards FCP start with the completion of several important e-modules. These are free to access for NHS staff and can be accessed by external partners for a small fee.

- The Primary Care modules cover areas such as managing complexity, mental and public health, illness identification, and red flags and are complemented by a series of e-modules covering personalised care. Podiatrists are required to complete all modules associated with both programmes.

- Once the e-learning modules have been completed, the ‘trainee’ FCP must access an appropriately trained AP supervisor (see section 9 for details).

- Once agreed, the supervisor will work with the ‘trainee’ FCP to review their current portfolio of knowledge and assess any learning needs required against the KSA document (appendix 12.15).



5.2 Next steps

- The supervisor and 'trainee' FCP will create a plan that will be based on their profession and/or speciality, and the FCP Podiatrist KSA and related frameworks.

- The 'trainee' FCP is advised to register with The Centre and utilise the online portal. This will allow the 'trainee' FCP to upload evidence of transferable capability against this training pathway, which can be applicable across all CPD settings including Primary Care.

- The 'trainee' FCP then begins the process of portfolio of evidence development against the KSA document prior to embarking into Primary Care. Some evidence can be cross-referenced against the relevant frameworks and will allow the 'trainee' FCP to build evidence towards competence within Primary Care (FCP) or AP. Evidence can be from practice, from higher educational institutions (HEIs), or from both as required. Once Stage 1 is complete, the individual can embark into Primary Care.

- If an individual does not wish to complete a portfolio route to FCP, they could access a HEI FCP level 7 module to evidence relevant study for their role.

- The 'trainee' FCP using a HEI route will still be expected to complete the e-learning modules and have their KSA verified, but their Primary Care recognition may occur within the module itself and may not require any further process.

- Throughout the clinical experiences, it is recommended that evidence is continually uploaded into the HEE Advanced Practice portal, enabling the 'trainee' FCP to continue logging their learning/career journey towards AP.

- In the other two frameworks this reads as: for the already verified advanced practitioner registered on the Centre for Advancing Practice Directory wishing to also work in Primary Care, the process still requires the e-learning to be completed and the KSA capabilities verified within Primary Care.

5.3 KSA document

The KSA document found in **appendix 12.15** is for use as part of the process of recognition of an FCP. Each capability is described. To the right of each capability there is indication of cross-referencing to the Health Education England Multi-Professional Advanced Capabilities Framework for Lower Limb Viability (MPACF-LLV) and College of Podiatry (CoP) Musculoskeletal (MSK) Competency Framework (CF).

6.0 Stage 2: Moving into Primary Care

On completion of the KSA recognition (Stage 1), the 'trainee' FCP can continue to build their Primary Care portfolio in practice (Stage 2) which should demonstrate competence across the Podiatry KSA (see Appendix 12.15). These tasks comprise the core Primary Care knowledge and skills required.

A range of portfolio materials have been derived from tools used by GP Specialty Trainees and adapted with kind permission from the Royal College of General Practitioners (RCGP) (see appendices). The portfolio and Workplace-Based Assessment (WPBA) materials have been developed to support FCPs, Clinical Supervisors, and other stakeholders to evidence capability. The portfolio tools offer the opportunity to collate a range of triangulated evidence.

This includes not only WPBA but also personal reflective log entries, work around audit/quality improvement, and feedback from patients and the clinical and non-clinical team members. It provides the opportunity and the means for supervisors to review and comment on progress and support learning.

These tools have been used by the RCGP as part of the GP training programme for many years and they provide robust evidence. Primary Care Schools, general practice, and GPs will be familiar with these WPBA tools helping implementation.

FCPs should maintain a portfolio of evidence to demonstrate capability and/or career progression. Each FCP and AP should keep a Learning Log that includes regular case-based or professional reflection. Detailed evidence of applied learning or action points arising from reflection should be noted.

While specific evidence may be suggested on the advice of the supervisor to support recognition, it is advised that the portfolio for recognition includes the following (see appendices for corresponding tools):

- Personal Development Plan (PDP) identifying SMART objectives (with formal six-month and yearly reviews)
- A record of e-modules successfully completed
- A record of HEI modules successfully completed
- A contemporary record of mandatory training, including Basic Life Support and Safeguarding
- Reflective learning logs

The portfolio should also include a record of Workplace-Based Assessments to include a minimum of:

- Consultation Observation Tool (COT) – one per month (Full Time Equivalent (FTE))
- Case-Based Discussion (CBD) – one per month (FTE)
- A range of Clinical Examination Procedural skills (CEPs)
- Quality Improvement Projects/complete audit cycles demonstrating ongoing engagement improvement methods and shows systematic change/leaves a legacy
- Patient compliments or complaints
- Significant Event Analysis
- Patient Satisfaction Questionnaires (PSQ) – at least one full round with 40 respondents
- Multi-Source Feedback (MSF) – at least one full round with 10 respondents, five clinical and five non-clinical

7.0 Building the portfolio

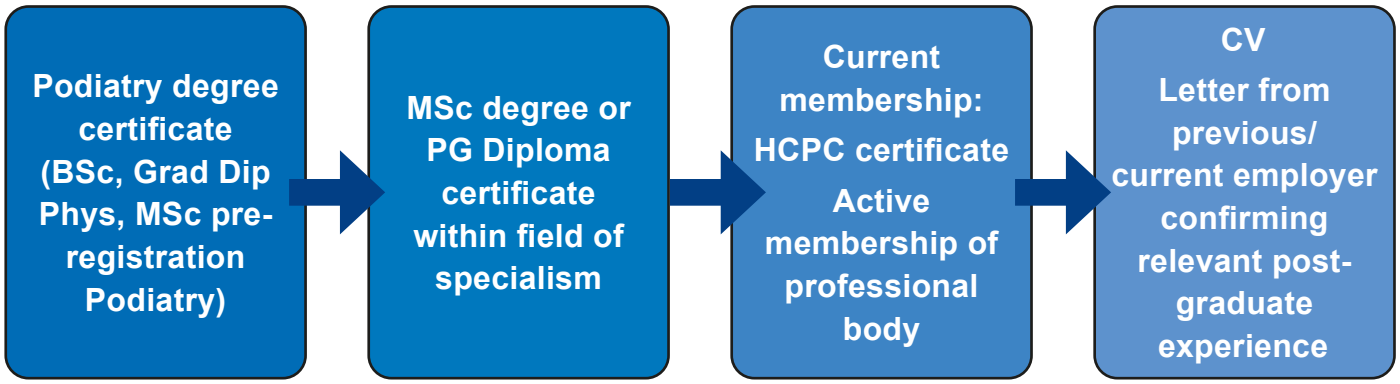
A portfolio is an individual's collection of evidence that illustrates development and learning to date and provides an overview of plans for future development. In addition, it facilitates analysis of current skills and knowledge through critical reflection and evaluation of learning and development. It is therefore more than a record of the CPD activity undertaken. Brown (1992) usefully defines a portfolio as:

'A private collection of evidence which demonstrates the continuing collection of skills, knowledge, attitudes, understanding and achievement. It is both retrospective and prospective, as well as reflecting the current stage of development of the individual.'

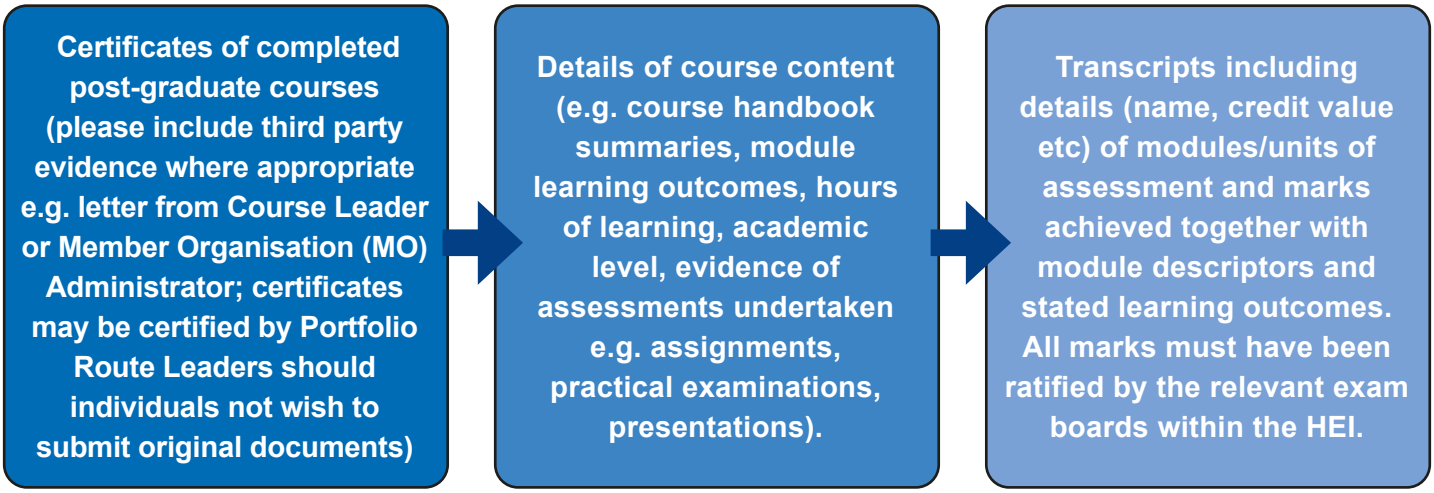
STEP 1: COLLATE KEY DOCUMENTS

As an example, submission and evaluation of a completed portfolio could take the following form:

(1) QUALIFICATIONS AND MEMBERSHIP AND (2) CLINICAL EXPERIENCE

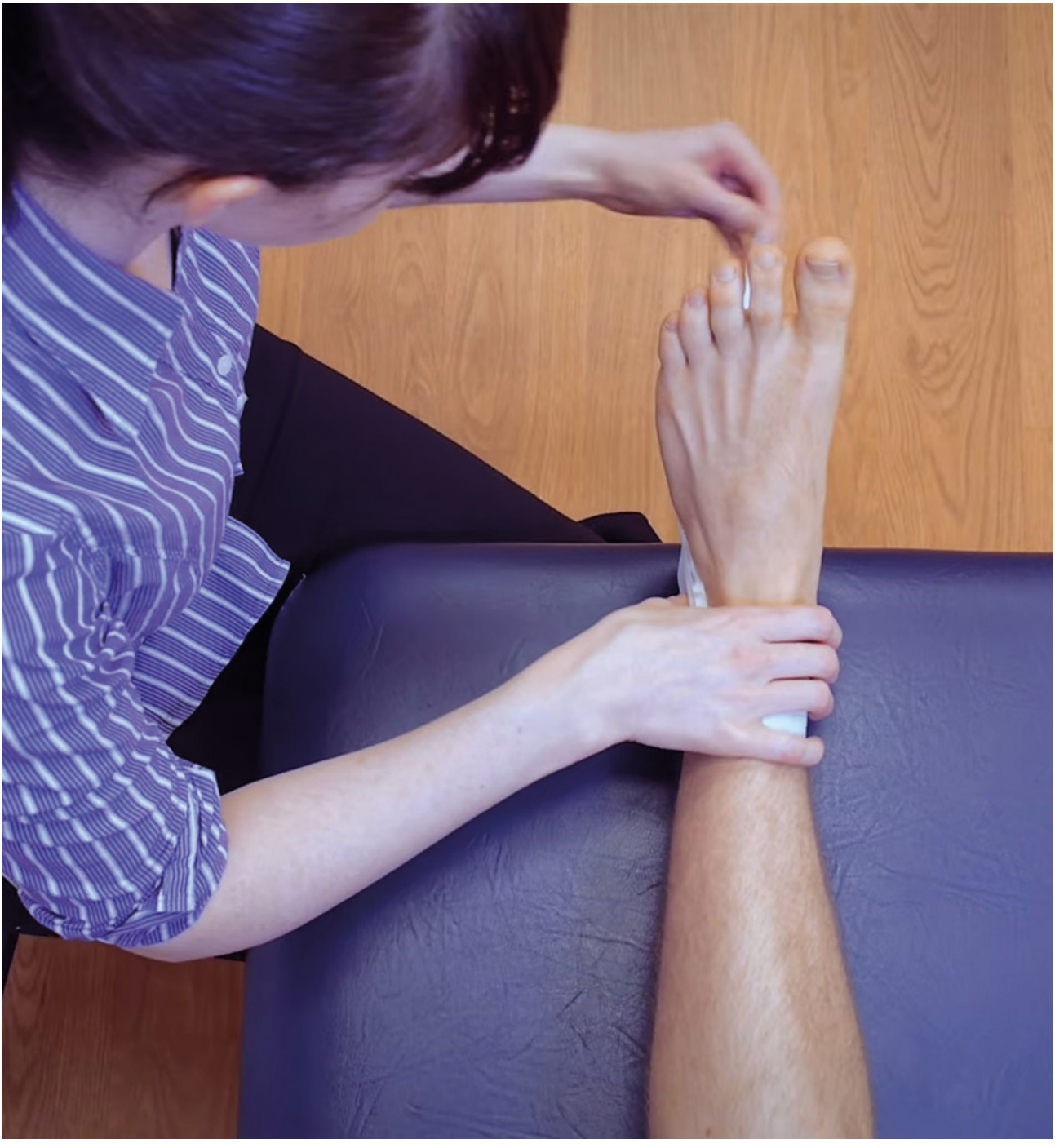


(3) SPECIALIST POSTGRADUATE EDUCATION



STEP 2: ALIGN AND UPLOAD

Key documents can be uploaded to The Centre portal once attained. The accompanying portfolio document outlines how key documents evidence KSA capability in totality. Trainee FCPs are encouraged to build their portfolio until they and their supervisor are happy that all Knowledge, Skills and Attributes are adequately evidenced at a QAA level 7 standard. Once satisfied that all required key document evidence and portfolio detail are mapped, the portfolio can be submitted to The Centre for verification.



8.0 Recognition and supervision process

8.1 Recognition process

- The recognition process provides quality assurance and governance of a role against a standard of practice.

- For FCP and AP, this will be assessed at level 7 master's (M) level (**not to be confused with banding** – see 1.3 for clarification).

- It is critical to have a standardised recognition for FCP roles as a minimum entry level for diagnostic clinicians in Primary Care and AP roles, as clinicians are working with undifferentiated and undiagnosed lower limb conditions, often within the context of multi-morbidity and polypharmacy. This requires the FCP to be working at the top of their clinical scope of practice to ensure patient safety and to be effective in their role.

- The capability documents are standardised in all routes to ensure the level and quality of practice, and to provide governance of the roles for the Care Quality Commission and professional registration bodies..

To gain recognition through a portfolio route, an FCP must have:

1. A recognised Primary Care supervisor as defined in section 9.3

2. Completed the relevant e-learning modules – pre-Stage1

3. Completed a verified portfolio of evidence cross-referenced against the domains of the Knowledge, Skills and Attributes document (see 12.15) – Stage 1

4. Completed a portfolio of triangulated evidence of Primary Care training – Stage 2

Assement Criteria Level 7

Study at master's level 7 will have been at, or informed by working at, the forefront of an academic or professional discipline. Podiatrists will have shown originality in the application of knowledge and they will understand how the boundaries of knowledge are advanced through research. They will be able to deal with complex issues both systematically and creatively, and they will show originality in tackling and solving problems (QAA Framework for Higher Education Qualifications, 2001). Table three outlines the grade attributes applied to level 7 assessment.

Master's level	Knowledge & Understanding (breadth, depth and currency)	Analysis & Argument	Reading & Research (breadth,depth & currency)	Communication & Presentation
85%+ Outstanding	Understanding of complex issues leading to creation of new knowledge	Original insight and depth of critical engagement throughout	No significant addition would improve the piece	Work is of a professional or publishable standard
70-84% Excellent	Addresses and integrates complex issues	Critical insight and depth of engagement	Integration of appropriate research material throughout the work	Works is approaching a professional and publishable standard
60-69% Good	In-depth and critical understanding of a wide range of issues and knowledge appropriate to the task	Evidence of depth of critical engagement	Use of additional appropriate sources outside of those normally expected	Communication and presentation are accurate and clear
50-59% Sound	Clear knowledge and understanding of central and connected issues or tasks	Evidence of critical analysis and argument	Evidence of appropriate independent research and reading which are used to support the argument	Presentation and communication are appropriate to task and audience but may have minor errors
40-49% Adequate	Provides reliable and accurate understanding of the central issues and tasks	Evidence of appropriate analysis and argument	Evidence of sufficient reading and research	Generally sound but with errors in structure/ referencing/ language
20-39% Fail	Provides basic information with some accuracy and understanding	Presents some elements of an appropriate argument but limited analysis	Limited range of relevant material	Adequate but lacks focus, precision and structure. Errors in referencing
0-20% Poor	Limited evidence of study	Minimal evidence of interpretation and analysis	Minimal evidence of engagement with relevant literature	Serious flaws in use of language, structure and referencing

9.0 Roadmap supervision and verification

Roadmap Supervision and Verification is a process of developing a portfolio of evidence academically and the application of that knowledge into practice. This is marked and signed off by a recognised Roadmap Supervisor. For the purpose of this document and the FCP to advanced practice training pathway in Primary Care, two types of supervision have been defined. These forms of supervision happen concurrently but with a different focus (see appendix 12.1). Educational supervision is also defined as below.

Once recognised as an FCP or AP on the directory, relevant regular practice supervision is put into place. Supervision has many definitions across healthcare, with individual professions and regulators often having their own. Definitions can also vary between clinical settings. Supervision is key in developing safe and effective practitioners and promoting patient and practitioner safety. The provision of all supervision is the responsibility of the employer.

9.1 Continuing Professional Development (CPD) supervision

CPD supervision is often described with respect to practitioners working in established roles. It should encompass the supervision requirements of the appropriate professional regulatory body. Regular meetings (such as six-weekly) allow for discussion around ways of working, identifying learning needs/opportunities, opportunities for feedback, peer review, maintaining of standards/capabilities, and embracing life-long learning. CPD supervision provides an excellent opportunity to develop teams and promote self-care, resilience, and wellbeing. Educational opportunities can form part of this and can be inter-professional, uni-professional, or ideally a mix of both.

9.2 Clinical supervision

Clinical supervision is often described within the context of new/emerging roles or in a new clinical setting, involves regular supervision within practice, and includes a debrief (at least daily) to ensure patient and practitioner safety. Clinical supervision should provide good-quality feedback to help with safely managing practitioner and patient uncertainty. Clinical supervision should help to build confidence, capability, clinical reasoning, and critical thinking. Clinical supervision also includes Workplace-Based Assessment (WPBA) to assess the application of knowledge, skills, and behaviours in Primary Care. The WPBA allows for development of a portfolio of triangulated evidence against appropriate frameworks. Clinical supervision is mainly formative but there may be a summative element (see appendix 12.2-12.5).

9.3 Educational supervision

Educational supervision is required for those undertaking educational courses/modules and is the responsibility of the educational provider. Some of the evidence can be captured through clinical supervision and WPBA, and often includes:

- A number of shadowed hours of placements
- Evidence of competence in specific skills

9.4 Supervision requirements

To be able to supervise FCP or AP, supervisors must have undertaken the approved HEE 'Multi-Professional Supervision in Primary Care for FCP & AP' course (see appendix 12.11 for course structure).

This course will include:

- The role of clinical supervision and CPD supervision
- An overview of educational theory
- Creating an educational culture
- Feedback
- The journey to FCP or AP roles
- Supporting trainees in/with difficulties
- How to use WPBA
- Supporting FCP or AP with their portfolio of evidence

9.5 Checklist of recognition processes: Stage 1 and Stage 2

Table four below shows the recognition form to be kept by the Podiatrist for evidence of completion.

Documents for the completion of each section are found in the appendices: **Stage 1**:12.15 (KSA), **Stage 2**:12.2 – 12.12, 12.14

The recognition surveys need to be completed upon completion of both Stage 1 and 2 to log verified FCPs as an interim measure until the Centre for Advancing Practice opens the FCP portal. The details from the surveys will be transferred to the centre at that point and placed on the directory.

FOR FCP – Stage 1 to be completed BEFORE entry to Primary Care. Stage 2 to be completed WITHIN Primary Care. Once both parts are completed, the verification survey can be completed.		
CONTENT	**NUMBER**	**DATE & CS SIGNATURE**
STAGE 1		
Primary care e-learning modules completed	Certificates from modules required	
Personalised care e-learning modules completed	Certificates from modules required	
Knowledge, skills, and attributes section completed	Portfolio of evidence required	
STAGE 2		
Personal Development Plan (PDP) identifying SMART objectives	Evidence of development & regular update	
A record of modules successfully completed at a HEI, stating completion dates		

A record of mandatory training, including Basic Life Support and Safeguarding, stating completion dates	As per mandated requirement	
Reflective log entries, dated	Minimum of one a week over a range of capabilities – verified when capability demonstrated	
Consultation observation tool (COT), to include face-to-face, telephone, and virtual consultation, dated	Minimum of one per month – verified when capability demonstrated	
Case-Based Discussion (CBD), dated	Minimum of one per month – verified when capability demonstrated	
A range of Clinical Examination Procedural skills (CEPs), dated	To reflect any required procedural skills – verified when capability demonstrated	
Evidence of participation in Quality Improvement Projects (QIP)/ service evaluation/ audit/ research	At least one completed project AND demonstration of ongoing involvement	
Patient Satisfaction Questionnaires (PSQ)	At least one full round with 40 respondents	
Multi-Source Feedback (MSF) – at least one full round with 10 respondents; 5 x clinical and 5 x non-clinical	Minimum of one full round	
Significant Event Analysis	Minimum of one, then one per year	
Any patient compliments or complaints		
RECOGNITION SURVEYS TO BE COMPLETED Primary Care Clinical Level 7 - FCP Survey Primary Care Clinical Level 7 - FCP Supervisor Survey		

10.0 Stage 3: Roadmap to AP

There are **two ways** to be verified for AP in Primary Care as part of FCP to AP career progression:

1. To have completed the e-learning modules, have a portfolio of triangulated evidence cross-referencing against the domains of the Knowledge, Skills and Attributes document, and to have completed the outstanding domains as referenced in the 'Linking FCP to AP – Top-up required for AP' document (see 12.16).

2. For the taught AP master's degree, Primary Care training will need to be completed if working in Primary Care along with a portfolio of evidence against the appropriate AP profession specific framework.

Table 5: Summary of items required in addition to FCP to demonstrate AP.

Domain requiring evidence	Evidence example
Clinical: • Evidence of managing clinical complexity/a patient caseload	• WPBA • Reflective logs
Research: • Evidence of critical enquiry, evaluative & improvement methods, and implementation methods	• Completion of full audit cycle/service-improvement or quality-improvement project • Completion of a research project including dissemination (e.g. peer-reviewed journal publication) and implementation • Obtaining of competitive research grant or other award funding research • Local site PI for portfolio research study
Management and leadership: • Evidence of project or team management within a PCN, regional, national, or international context • Evidence of leadership within a PCN, regional, national, or international context	• Public meeting records where AP has acted as chair • External leadership posts held, e.g. committee member/chair, charity trustee • Reflective logs • MSF feedback
Education: • Evidence of contribution to the education of health professionals	• HEI lecture plans/ module templates • Higher Education Academy Accreditation or other independently assessed esteem indicator • Reflective logs • MSF feedback
AP verification: To achieve verification, completion of the Advanced Practice Verification Form is required alongside submission of verified evidence. This is in addition to completion of the FCP Verification Form, if not already recognised as an FCP by the HEE Centre for Advancing Practice. Advanced Practice portfolios will require external verification; this process is currently under development and updates can be found on the HEE website.	

10.1 Demonstrating Advanced Practice in a Podiatry Primary Care portfolio

- The document '**Linking FCP to AP – Top-up required for AP**' (see appendix 12.16) allows evidence to be built against the KSA (**Stage 1**) requirements and as the Podiatrist develops further into Primary Care (**Stage 2**) and on to AP (**Stage 3**).

- Each FCP prerequisite KSA is mapped to the relevant dimensions of the HEE Multi-Professional Advanced Practice Framework for Lower Limb Viability and CoP Foot and Ankle MSK Competency Framework, fulfilling a subset of the clinical standards required by Podiatric Advanced Practice within Primary Care.

- A completed portfolio can therefore be used to evidence fulfilment of a specific subset of the clinical pillar required for recognition as a Podiatrist Advanced Practitioner within Primary Care and can be transferred across to an AP portfolio.

- The Podiatrist then needs to build their evidence against the three other pillars that are not fulfilled during FCP training (either KSA/ Stage 1 or Primary Care/Stage 2). To aid this, the document shows both the FCP and AP capabilities/competencies in one document so that it is explicit as to what is required for FCP roles, and what is needed to become a Podiatrist Advanced Practitioner in Primary Care.

- The required KSA that are essential to FCP, and must be demonstrated as a portfolio of evidence, are detailed within the appendices.

- Following recognition as an FCP, Podiatrists can evidence the remaining FCP Clinical Podiatric Knowledge, Skills and Attributes, plus any additional 'bolt-on Knowledge, Skills and Attributes' required to demonstrate Advanced Practitioner standards, prior to submitting a portfolio to seek Advanced Practitioner status with The Centre. These additional requirements are detailed within the appendices.

When an FCP has completed their FCP portfolio, they can continue to collate their evidence against the additional AP capabilities to work towards AP accreditation. This could be completed through an appropriate registered AP pathway, such as a profession-specific special interest group, or directly via the HEE portal as outlined above.

11.0 Useful resources

11.1 Online learning

Below is a list of e-learning resources that may support 'trainee' FCP or AP learning needs.

Skills for Health is the leading provider of healthcare e-learning across the UK health sector. Their training is aligned with the UK Core Skills Training Framework and is designed to deliver consistency across the healthcare sector. Their e-learning has been developed to meet needs across healthcare organisations, including Primary and Secondary Care.

11.2 Leadership development

NHS Horizons supports leaders of change, teams, organisations, and systems to think differently about large-scale change, improve collaboration, and accelerate change.

The NHS Leadership Academy offer a range of tools, models, programmes, and expertise to support individuals, organisations, and local partners to develop leaders, celebrating and sharing where outstanding leadership makes a real difference.

The NHS Quality, Service Improvement, and Redesign (QSIR) programmes are delivered in a variety of formats to suit different levels of improvement experience and are supported by publications that guide participants in the use of tried and tested improvement tools and featured approaches, and they encourage reflective learning.

NHS England Improvement Fundamentals is a radical programme of online courses for those involved in health and social care. The courses are free to take part in and are delivered entirely online in the form of videos, articles, discussion, and practical exercises that contribute to your own improvement project.

The programme is organised into four essential learning areas or suites.

- Quality improvement theory
- Quality improvement tools
- Measuring for quality improvement
- Spreading quality improvement

NHS Education for Scotland has developed The Quality Improvement Zone, which provides learning, development, and networking opportunities to build skills, knowledge, and confidence, enabling the public and third sector to use QI methodology to deliver better services, care, and outcomes for the people of Scotland. The QI Zone is our online learning platform that provides information and resources to support people at all levels to develop their knowledge of quality improvement.

HSCQI (Health and Social Care Quality Improvement) is a 'movement' in health and social care services in Northern Ireland, working together to focus on improving the quality of the services we provide/use and sharing good practice so that we can all learn from each other and spread improvements.

The Health Foundation Q is a connected community working together to improve health and care quality across the UK.

The Versus Arthritis MSK Champions Programme is a fully funded MSK-focused leadership development programme, created in partnership with one of the top global business schools, Ashridge Executive Education. Through an 18-month programme, people will be supported and coached to develop their personal leadership skills enabling them to drive forward a service improvement project with a local or national focus.

11.3 Charity & third sector resources

British Heart Foundation has resources to support healthcare professionals to deliver best practice in patient care.

British Lung Foundation has lots of resources to help support patients.

Dementia UK has a dedicated page to support healthcare professionals in supporting patients with dementia.

HEE's e-Learning for Healthcare platform contains a huge range of learning resources relevant to FCP.

Mind has a range of training opportunities to support mental health first aid.

Versus Arthritis has lots of useful resources for healthcare professionals and students to help increase their knowledge and confidence in diagnosing and managing patients with MSK conditions.

Arthritis Action provide a range of patient or practitioner-focussed resources to support self-management for people living with musculoskeletal disease.

11.4 Primary Care

Arora Medical Education offers audio book training for those working in Primary Care. Although a full course may not be relevant to an FCP role, there are some sections like MSK, telephone consultation, and mental health, which could be useful. They also run other face-to-face and e-learning courses.

Cost: varies, audio book approximately £49.

The Primary Care Training Centre is an education provider offering education to all members of the primary healthcare team. They offer a range of courses in person, from one day to six months in duration.

Cost: varies, a day course costs approximately £120.

Red Whale offers face-to-face, online learning, and online handbooks for those working in Primary Care. The organisation offers courses on mental health training as well effective consultation and how to have difficult conversations.

Cost: approximately £225.

Some resources require a subscription

NB Medical education

RCGP Learning

GP notebook

There are also free resources which are useful in Primary Care, this list is not exhaustive.

Clinical Knowledge Summaries

e-learning modules supporting medicines management

British National Formulary

Live well with pain

Resources to support physical activity conversations can be found on the **Moving Medicine website**.

The resource outlining **social prescribing in Mendip, Surrey,** is an example of support for CPD in Primary Care and other areas have similar resource.

12.0 APPENDICES

12.1 Roadmap supervision flow chart

Developing safe practitioners is key to ensuring patient safety
ALL SUPERVISION is the responsibility of the employer

Clinical supervision

Must be provided in the clinical setting

- For those in **training or in new/emerging roles/new clinical setting**
- Daily clinical supervision including debrief to ensure patient and practitioner safety
- To provide feedback - managing patient & practitioner uncertainty.
- Workplace based assessment - suggest a minimum of one a month to allow a portfolio of triangulated evidence against the appropriate framework.
- Mainly formative but maybe some summative element.

WHAT?

CPD supervision

Must be provided by the employer

- This **happens alongside Clinical Supervision** but has a different purpose
- For those in **established roles** - need to evidence maintained capabilities and for CPD purposes
- Regular meetings (such as 6 weekly) to touch base, discuss ways of working, developing teams, identify any learning needs/ opportunities, support, feedback, peer review.
- May need to use WPBA to monitor standards/ capabilities are being maintained.

Wellbeing and Practitioner Development

Patient Safety and Practitioner Safety

- Is the patient safe?
- Is the practitioner safe – professionally, physically, and emotionally?
- Acknowledgment & understanding of human factors.
- To promote and facilitate development of core capabilities against the appropriate framework.

Self, Teams & Service Delivery

Is the practitioner & employer:

- Managing the transition to their role and to primary care?
- Promoting self-care, resilience, and wellbeing
- Promoting the engagement in life-long learning?
- Developing self, multi-professional teams & service delivery
- Maintaining a portfolio of evidence (practitioner).

WHY?

WHO?

Clinical Supervisor (CS)

- The CS takes **clinical responsibility** for patient and practitioner safety.
- Need a **flexible approach** – one size does not fit all!
- Primarily focused on the **Clinical Pillar** but can consider the other three
- Often a GP but could be a senior AP level practitioner in primary care.

CPD Supervisor (CPDS)

- The CPDS needs an understanding of ACP, FCP and requirements for **professional registration, revalidation** if appropriate.
- Ideally an AP level practitioner
- **Can be carried out remotely**

- There needs to be robust **induction programme** where the CS undertakes shadowed sessions with the practitioner.
- The level of **day to day supervision** will vary according to the level and rate of progression of the trainee/new practitioner. (Primary Care is generalist and therefore it takes time to develop capabilities).
- **Identify learning needs**
- Initially the CS must be prepared to **debrief** after every patient contact before the patient leaves; this will then evolve to after each session and then to the end of the day. This should be face to face.
- The debrief should focus on clinical safety buy when undertaken by a trained CS affords the opportunity to encourage the **development of clinical reasoning and critical thinking**. It should be a balance of support and challenge.
- As well as regular timetabled debrief the CS will need to undertake **workplace-based assessment** (WPBA) to allow the practitioner to develop a **portfolio of evidence** of capability against the appropriate framework.

HOW?

- CPDS needs to be undertaken by the employer **regularly** (every 6 weeks is good practice)
- The approach can be flexible and can use a variety of Supervisors to best **identify any learning needs and support development of the practitioner.** This approach may be useful in supporting projects such as QIP, audit, education, leadership etc
- This can be done individually, as a group or ideally a mix of both.
- Taking the opportunity to promote **inter professional education** and support would be worthwhile
- Could facilitate **peer review**
- CPDS can be undertaken by experienced practitioners **remotely using digital technology** and platforms such as Project Echo to support.
- Evidence of CPDS should be collated in the practitioner's portfolio of evidence and a record kept by their employer

Educational Supervision

- Traditionally this has been the role of the education provider such as the HEI who sets and marks against learning outcomes.
- It is envisaged that the Primary Care Training Hubs may well play a role in “signing off” evidence of capability against frameworks.
- This process will align with the developing Centre for Advancing Practice

12.2 Case-Based Discussion FCP to Advanced Practice

Practitioner Name:	
Clinical Supervisor Name:	
Presenting Case:	
Date:	

GRADES	**I** – Insufficient evidence	**N** – Needs further development	**C** - Capable	**E** - Excellent

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Communication & consultation skills FCP 1			
Practising holistically to personalise care and promote public and person health FCP 2 ACP 2			

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Working with colleagues and in teams **FCP 13** **AP 13**			
Maintaining an ethical approach & fitness to practice **FCP B3, B4, B5, C**			
Information gathering & interpretation **FCP 3**			

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Clinical examination **FCP 4**			
Making a diagnosis **FCP 5**			
Clinical management **FCP 7, 8, 9,10,11, 12**			

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Managing medical & clinical complexity (For Advanced Practice only) **ACP 15**			
Independent prescribing, pharmacotherapy & treatment **FCP 8, 9, 10, 11, 12** **AP 8, 15**			
Leadership, management, and organisation **FCP 14** **AP 14A**			
Education and development **FCP 14** **AP 14B**			

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Research and evidence-based practice **FCP 14** **ACP 14C**			

FEEDBACK
ACTION PLAN

12.2.1 Case-Based Discussion (CBD) Guidance

Case-Based Discussions (CBD) are a great way to explore capability, clinical reasoning, and critical thinking. The CBD is a structured interview designed to assess your professional judgement in clinical cases. CBD is one of the tools used to collect evidence for your portfolio of evidence of capability, as a Workplace-Based Assessment.

They should be pre-planned and based on the clinical record. The CBD form has an area to write pre-planned questions by the Clinical Supervisor (CS). There is a useful CBD question maker for GPs on the RCGP website**.**

Good practice would be for the Practitioner to send the Clinical Supervisor (CS) three or four cases – they could do this by sending a task on 'SystmOne' or equivalent electronic record system, for example. The CS can have a look at the cases/ records and choose one to discuss. Consultations should be drawn from a range of patient contacts that reflect the scope of the FCP role, e.g. Dermatology, MSK, older adults, etc. The CS should ask the Practitioner to 'present' the chosen case to them. The CS can then ask questions and a discussion can follow

What should be covered in the discussion

The discussion is framed around the actual case rather than hypothetical events. Questions should be designed to elicit evidence of competence /capability. The Clinical Supervisor should aim to cover up to four capabilities in a single CBD, but if there are too few you will not have enough evidence of progress. At the start of the discussion, it is helpful to establish the capability areas the supervisor is expecting to look at. The Clinical Supervisor records the evidence harvested for the CBD in the portfolio, against the appropriate capabilities. It is recommended that each discussion should take about 30 minutes, including the discussion itself, completing the rating form, and providing feedback. At the end of the discussion, the CS should provide some written feedback for the FCP - What went well and why? Any working points's?

12.3 Clinical Examination Procedural (CEPS) Skills Assessment FCP to Advanced Practice Roadmap

Practitioner:	
Clinical Supervisor Name:	
Date:	

TYPE OF PROCEDURE: Please provide a brief description below.
DESCRIPTION OF CEP ASSESSED: With reference to the items on the CEP's guidance sheet.
PLEASE MARK AS **CAPABLE** or **NEEDS FURTHER DEVELOPMENT** (circle)
WHAT WAS DONE WELL?
WORKING POINTS?
LEARNING NEEDS?

12.3.1 Clinical Examination Procedural skills (CEPs) Guidance - FCP to AP

CEPs are a Workplace-Based Assessment. CEPs provide a way of assessing what the trainee does in practice day-to-day and how they apply their Knowledge or Skills etc. CEPs can be used to help gather evidence of capability and include a range of skills/ examinations. While CEPs exist to capture skills, it is important to assess some common shared themes.

Suggested areas for consideration would be:

- Is there a clinical need for the examination?
- Has this been explained appropriately to the person?
- Has consent been granted?
- Has a chaperone been offered?
- Are there good hygiene practices?
- Is there an understanding of the relevant anatomy?
- Is the person treated with respect and provided with privacy?
- Does the Practitioner maintain an empathetic approach throughout?
- Does the Practitioner explain what is going on throughout the procedure?
- Are their findings accurate? Findings should be checked by the Clinical Supervisor.
- Does the Practitioner provide an appropriate explanation of their findings and the implications to the person?
- Is there an appropriate management/personalised care and support plan made with the person?

Please note a grading of **'Needs further development**' is not a fail but a suggestion that more practice and exposure to similar clinical scenarios is required.

Please ensure that your Clinical Supervisor signs off your CEPS.

12.4 Clinical Supervisor's Report

Practitioners Name:	
Clinical Supervisor Name:	
Date:	

GRADES	**I** – Insufficient evidence	**N** – Needs further development	**C** - Capable	**E** - Excellent

RELATIONSHIP	
Explores person's agenda (their Ideas, concerns and expectations) (FCP Capability 1)	Grade
Works in partnership to negotiate a plan (FCP Capability 2, AP 2)	Grade
Recognises the impact of the problem on the person's life (FCP Capabilities 1, 2, 11, AP 2)	Grade
Works co-operatively with team members, using their skills appropriately (FCP 13, AP 13)	Grade
DIAGNOSTICS	
Takes a history and investigates systematically and appropriately (FCP 3)	Grade

Examines appropriately and correctly identifies any abnormal findings (please comment on specific examinations observed) (FCP Capability 4, 5 AP 15)	Grade
Elicits important clinical signs & interprets information appropriately (FCP Capabilities 4, 5, AP 15)	Grade
Suggests an appropriate differential diagnosis (FCP Capability 5, AP 15)	Grade
Refers appropriately and co-ordinates care with other professionals (FCP Capability 13, AP 13)	Grade
MANAGEMENT	
Keeps good medical records (FCP Capabilities 1, 2, 12)	Grade
Uses resources cost-effectively (FCP Capabilities 7, 8, 9, 10, 11, 12, 13, AP 14,15)	Grade
Keeps up-to-date and shows commitment to addressing learning needs (FCP Capability 14, AP 14)	Grade

PROFESSIONALISM	
Identifies and discusses ethical conflicts (FCP Capabilities 2, 3, 4, 5)	Grade
Shows respect for others (FCP Capability 13, AP 13)	Grade
Is organised, efficient, and takes appropriate responsibility (FCP Capability 14, ACP 14a, 15)	Grade
Deals appropriately with stress (FCP Capability 14)	Grade

If you have concerns or are unable to grade, please elaborate further.

Do you have any recommendations that might help the practitioner or the employer?

Are you aware if this practitioner has been involved in any conduct, capability, or Serious Untoward Incidents/Significant Event Investigation, or named in any complaint?

Yes ☐ No ☐

If yes, are you aware if this have been resolved satisfactorily with no unresolved concerns about this practitioner's fitness to practise or conduct? *

Yes ☐ No ☐

12.5 Consultation Observation Tool: marking/notes sheet – FCP to Advanced Practice

Practitioner Name:	
Clinical Supervisor Name:	
Presenting Case:	
Date:	

GRADES	**I** – Insufficient evidence	**N** – Needs further development	**C** - Capable	**E** - Excellent

Criterion	Grade	Evidence
Discovers the reason for the person's attendance		
Encourages the person's contribution FCP Capabilities 1		
Responds to cues FCP Capabilities 1, 2		
Places presenting problem in appropriate psychosocial context FCP Capability 1, ACP 2		

Criterion	Grade	Evidence
Explores person's health understanding FCP Capabilities 1, 2, 6 ACP 2		
Defines the clinical problem		
Includes/excludes likely relevant significant condition FCP Capability 5 ACP 13		
Appropriate physical or mental state examination FCP Capability 6 ACP 13		

Criterion	Grade	Evidence
Makes appropriate working diagnosis FCP Capability 7 ACP 13		
Explains the problem to the person		
Explains the problem in appropriate language FCP Capability 1		
Addresses the person's problem		
Seeks to confirm the person's understanding FCP Capability 1		
Makes an appropriate shared management/personalised care/support plan FCP Capabilities 2,4,8,9,12 ACP 13		

Criterion	Grade	Evidence
Person is given the opportunity to be involved in significant management decisions FCP Capabilities 2, 8, 9 ACP 13		
Makes effective use of the consultation		
Makes effective use of resources FCP Capabilities 3, 9, 10, 12 ACP 14		
Condition and interval for follow-up are specified FCP Capability 8 ACP 14		

Feedback & recommendations for further development:
Agreed action plan:

COT guidance – can be undertaken during a shared surgery or by reviewing a video of a consultation (undertaken with person consent – form signed and scanned into notes).

An audio COT can also be evidenced e.g. to assess telephone consultation skills.

12.5.1 Consultation Observation Tool (COT) Guidance

Clinical Supervisors use the Consultation Observation Tool (COT) to support holistic judgements about the practitioner level of practice in Primary Care. COT is one of the tools used to collect evidence for the FCP portfolio of evidence of capability, as a Workplace-Based Assessment. COT can be undertaken during a shared consultation or by reviewing a video of a consultation (undertaken with person consent, the relevant form to be signed and scanned into patient notes). An audio COT can also be evidenced, e.g. to assess telephone consultation skills.

Person consent

The presenting person must give consent. A consent form can be found below.

Selecting consultations for COT

Either record several consultations on video and select one for assessment and discussion or arrange for your Clinical Supervisor to observe a consultation. Complex consultations are likely to generate more evidence.

Consultations should be drawn from a range of people presentations that reflect the scope of the Practitioner role, e.g. MSK, children, older adults, mental health, etc. The Practitioner can include consultations in different contexts – for example, a home visit.

An audio COT can also be evidenced, for example to assess telephone consultation skills. It's inadvisable for a consultation to be more than 15 minutes in duration, as the effective use of time is one of the performance criteria.

When the practitioner is selecting a recorded consultation, it's natural to choose one where they feel they've performed well. This is not a problem; the ability to discriminate between good and poor consultations indicates professional development.

Collecting evidence from the consultation

The Practitioner will have time to review the consultation with their Clinical Supervisor, who will relate their observations to the appropriate Practitioner framework as identified on the COT form. The Clinical Supervisor then makes an overall judgement and provides formal feedback, with recommendations for further development..

12.5.2 Consent form for recording of Consultations for training purposes

Name		**Date**	
Name of person(s) accompanying patient		**Place of recording**	

We are hoping to make video/digital recordings of some of the consultations between patients and the Practitioner who you are seeing today. The recordings are used by Practitioner to review their consultations with their supervisors. The recording is ONLY of you and the Practitioner talking together. Intimate examinations will not be recorded and the camera/recorder will be switched off on request.

All recordings are carried out according to guidelines issued by the General Medical Council and will be stored securely in line with the General Data Protection Regulation (GDPR). They will be deleted within one year of the recording taking place.

You do not have to agree to your consultation with the Practitioner being recorded. If you want the camera/recorder turned off, please tell reception - this is not a problem, and will not affect your consultation in any way. But if you do not mind your consultation being recorded, please sign below. Thank you very much for your help.

TO BE COMPLETED BY PATIENT

I have read and understood the above information and give my permission for my consultation to be recorded.

Signature of patient BEFORE CONSULTATION:

.....Date.....

Signature of person accompanying patient to the consultation:

.....Date.....

After seeing the Practitioner I am still willing for/I no longer wish for my consultation to be used for the above purposes.

Signature of patient AFTER CONSULTATION:

.....Date.....

Signature of person accompanying patient to the consultation

.....Date.....

12.6 Multi-Source Feedback (MSF)

Practitioner's name:	
Location of MSF undertaken:	
Date of MSF undertaken:	

Part 1

This part should be completed by all respondents

Please state your job title

Please provide your assessment of this Practitioner's overall professional behaviour (please tick)

Very poor	Poor	Fair	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Notes: You may wish to consider the following:

The Practitioner:

- Is caring of people
- Is respectful of people
- Shows no prejudice in the care of people
- Communicates effectively with people
- Respects other colleagues' roles in the healthcare team
- Works constructively in the healthcare team
- Communicates effectively with colleagues
- Speaks good English at an appropriate level for people
- Does not shirk their responsibilities
- Demonstrates commitment to their work as a member of the team
- Takes responsibility for their own learning

Comments (where possible please justify comments with examples)

Highlights in performance areas (areas to be commented)

Suggested areas for development in performance

Part 2

To be completed by clinical staff only

Please provide your assessment of this FCP's overall clinical performance (please tick)

Very poor	Poor	Fair	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

You may wish to consider the following about the Practitioner:

- Ability to identify people's problems
- Takes a diagnostic approach
- People-management skills
- Independent learning habits
- Range of clinical and technical skills

Comments (where possible please justify comments with examples)

Highlights in performance areas (areas to be commented)

Suggested areas for development in performance

12.6.1 Multi-source Feedback (MSF) Guidance

Multi-Source Feedback is collected from colleagues.

Good practice would be to send out a questionnaire to a range of both clinical and non-clinical colleagues. This process requires at least five clinical and five non-clinical responses.

Ideally, the Clinical Supervisor should look at the responses and give feedback to the Practitioner. The Practitioner should reflect on the feedback in a learning log.

12.7 Personal development plan (PDP)

PDPs should have SMART objectives, which help to make them achievable. Think about the following to help you:

S – specific things – be focused and not too general – why has this learning need arisen?

M – measurable – so you know when you have achieved it

A – achievable – be realistic! You can't learn everything in one go! How will you achieve it? What strategies can you use?

R – relevant – make it relevant to your role – how will achieving the goal make a difference to your practice?

T – time lined – so you can tick them off and add new objectives

LEARNING/ DEVELOPMENT NEED	**DEVELOPMENT OBJECTIVE**	**ACHIEVEMENT DATE**	**STRATEGIES TO USE**	**OUTCOMES/ EVIDENCE**
WHAT BROAD AREA DO YOU NEED TO ADDRESS?	WHAT SPECIFIC GOAL ARE YOU SETTING?	WHEN DO YOU HOPE TO ACHIEVE IT?	HOW WILL YOU ACHIEVE IT?	HOW WILL YOU KNOW YOU HAVE ACHIEVED IT?
An example: To manage shoulder pain presentation	*To manage a range of different shoulder presentations.*	*Three months*	*Undertake two CEPS assessments with my Clinical Supervisor*	*When my CS has deemed me capable in 2 CEPS assessments*

FCP - Advanced Practice Roadmap

Date seen	
What happened – brief description - presenting problem	
Differential diagnoses & your clinical reasoning	
Reflection – what did you learn?	

Impact on your practice – what will you do the same or differently next time & why?
Supervisor's comments – competencies demonstrated, learning points?

Practitioner: .....

Supervisor: .....

12.8 Patient Satisfaction Questionnaire (PSQ) for an FCP or Advanced Practitioner

Hello,

*We would be grateful if you would complete this questionnaire about your visit to the Practitioner today. The Practitioner you have seen is a fully qualified practitioner who had further training to **work in this role** in general practice/ Primary Care.*

Feedback from this survey will enable them to identify areas that may need improvement. Your opinions are therefore very valuable.

Please answer all the questions below. There are no right or wrong answers and your FCP will not be able to identify your individual responses.

Thank you.

Please rate the Practitioner at:

Please tick your response

Making you feel at ease...(being friendly and warm towards you, treating you with respect, not cold or abrupt).

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Letting you tell “your” story… (giving you time to fully describe your illness in your own words, not interrupting or diverting you

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Really listening… (paying close attention to what you were saying, not looking at the notes or computer as you were talking).

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Being interested in you as a whole person… (asking/knowing relevant details about your life, your situation; not treating you as ‘just a number’).

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Fully understanding your concerns… (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything).

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Showing care and compassion… (seeming genuinely concerned, connecting with you on a human level, not being indifferent or 'detached').

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Being positive… (having a positive approach and a positive attitude, being honest but not negative about your problems).

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Explaining things clearly… (fully answering your questions, explaining clearly, giving you adequate information, not being vague).

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Helping you to take control… (exploring with you what you can do to improve your health yourself, encouraging rather than 'lecturing' you).

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Making a plan of action with you… (discussing the options, involving you in decisions as much as you want to be involved, not ignoring your views).

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Overall, how would you rate your consultation today?

Poor to fair	Fair	Fair to good	Good	Very good	Excellent	Outstanding
☐	☐	☐	☐	☐	☐	☐

Many thanks for your assistance

NB. it is advised that local service user feedback mechanisms are also used to enhance this, particularly with opportunities for open comments

12.8.1 Person Satisfaction Questionnaire (PSQ) Guidance

A PSQ has been included for use because people's feedback is very important. Good practice would be to select a time to undertake the questionnaire with the support of the Clinical Supervisor and reception staff.

Ask reception to give out a questionnaire and a pen to every person who attends to see the FCP and ask the person to hand the questionnaire back to reception after their appointment. This process should continue until a minimum of 40 completed responses have been received. Ideally, the Clinical Supervisor should look at the responses and give feedback to the FCP. The FCP should reflect on the feedback in a learning log.

Please note, this is a minimum requirement. Any compliments/ complaints should also be recorded and reflected upon.

12.9 Tutorial record

Practitioner's name:	
Tutorial leader:	
Date of tutorial:	

Learning aims:	
Items covered:	
Any further areas for development:	
Time spent:	
Signed by tutorial leader	
Signed by Practitioner	

12.10 Tutorial evaluation

Date of tutorial:		**With:**	
Tutorial aims:			

Tutorial style: CBD, presentation, discussion, brainstorming etc
Was the style appropriate/helpful?
What did you learn/achieve from the tutorial?
What were the good aspects of the tutorial?
In what way could tutorial be improved?

Signed:	

12.11 Multi-professional supervision in Primary Care for First Contact & Advanced Practitioners - course overview

To supervise a practitioner through the roadmap to FCP and onward to Advanced Practice via the portfolio routes, there is a two-session multi-professional Roadmap supervisor course tmust be completed. To train to be a supervisor, you will need to work as a HEE Centre for Advancing Practice recognised Advanced Practitioner, Consultant Practitioner, or as a GP.

Once you have completed both sessions of training, you will be put on a list of verified Advanced Practice roadmap supervisors regionally.

Once trained, there will be an opportunity to train as a trainer so that you will be able to train supervisors in your local area. These dates will be made available in due course and as the need dictates.

Course overview

Session 1	Session 2
• Welcome • Introductions – backgrounds, experience of supervision to date • National update re First Contact (FC) & Advanced Practice (AP) • What are FCP & AP roles? • What is supervision in Primary Care? • CPD supervision • Clinical supervision • Educational culture/ learning environment • Induction • Timetables/ rotas • Introduction to some educational theory • The trainee/ practitioner journey to FCP or AP • Meeting the trainee/ practitioner's needs • Supervisor and supervisee wellbeing • Feedback • Debriefing • The four pillars of advanced practice	• Portfolios of evidence – contents & why • Professional Development Plans (PDP) • Being a reflective practitioner • Overview of learning and teaching styles • Supporting trainees/ practitioners in difficulty • Poorly performing trainees • Effective use of WPBA tools • Reflective learning logs • Consultation Observation Tools (COTs) • Case-Based Discussion (CBD) • Clinical Examination & Procedural skills (CEPS) • Audit/ QIP expectations • Educational, leadership & management evidence for AP • Reviewing progression • Verification processes with Centre for Advancing Practice

12.12 FCP Verification of Evidence Form Example form

CAPABILITY	KSA LINKS
COMMUNICATION & CONSULTATION SKILLS	
TRAINEE SELF RATING & COMMENTARY **Underperforming** **Needs further development** **Capable** * **Excellent** *Vulnerable adult learning log shows how I am able to adopt my communication skills to respect the patient's needs and wants, in order to create and maintain a positive practitioner-patient relationship. I also demonstrate my ability to elicit psychological and social information to place the patient's presenting problem in context.* *CBD entry shows my ability to use a variety of communication techniques and materials to adapt interactions and explanations to best meet the needs of the patient. It also evidences how I am able to appropriately adapt and use a variety of consultation skills to achieve better patient outcomes, consulting in a focused manner and taking a holistic view of the patient's needs.* *CSR entry shows how I have a wide-range of appropriate verbal and non-verbal communication skills and consultation techniques, which respects for and values diversity alongside active listening.*	*List KSA as appropriate*
EVIDENCE TYPE & DATE(S) *Professional Conversation learning log date;* *Vulnerable Adult learning log date* *CBD date; 21/09/20 CBD date; 24/08/20 COT date; 26/10/20 CSR date; 27/11/20*	

CAPABILITY	KSA LINKS
COMMUNICATION & CONSULTATION SKILLS	
SUPERVISOR RATING & COMMENTARY **Underperforming** **Needs further development** **Capable** * **Excellent** *I agree with FCP self-rating: CSR comment shows good communication in a home visit setting, which is reflected in a COT in a surgery also indicating communication is a capable area.* *CBD & COT comments in feedback section states: explores the patient's understanding of what has taken place Recommendations: Manages consultations effectively with patients who have different languages, cultures, beliefs and educational backgrounds*	
EVIDENCE TYPE & DATE(S) *CBD date; 01/09/20 CBD date; 21/08/20 COT date; 26/10/20 CSR date; 27/11/20*	

CAPABILITY	KSA LINKS
COMMUNICATION & CONSULTATION SKILLS	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
COMMUNICATION & CONSULTATION SKILLS	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
PRACTICING HOLISTICALLY TO PERSONALISE CARE & PROMOTE HEALTH	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
PRACTICING HOLISTICALLY TO PERSONALISE CARE & PROMOTE HEALTH	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
WORKING WITH COLLEAGUES & IN TEAMS	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
WORKING WITH COLLEAGUES & IN TEAMS	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
MAINTAINING AN ETHICAL APPROACH & FITNESS TO PRACTICE	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
MAINTAINING AN ETHICAL APPROACH & FITNESS TO PRACTICE	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
INFORMATION GATHERING & INTERPRETATION	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
INFORMATION GATHERING & INTERPRETATION	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
CLINICAL EXAMINATION	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
CLINICAL EXAMINATION	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
MAKING A DIAGNOSIS	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
MAKING A DIAGNOSIS	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
CLINICAL MANAGEMENT	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
CLINICAL MANAGEMENT	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
INDEPENDENT PRESCRIBING/PHARMACOTHERAPY/PRESCRIBING THERAPIES	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
INDEPENDENT PRESCRIBING/PHARMACOTHERAPY/PRESCRIBING THERAPIES	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
LEADERSHIP, MANAGEMENT & ORGANISATION	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
LEADERSHIP, MANAGEMENT & ORGANISATION	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
EDUCATION & DEVELOPMENT	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
EDUCATION & DEVELOPMENT	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	
EVIDENCE TYPE & DATE(S)	

PRACTITIONER

I confirm that this portfolio contains my own work & evidence related to my own capability. I confirm no patient-identifiable information is included.

FCP SIGNATURE ……

FCP HCPC REGISTRATION NUMBER……DATE……..

VERIFYING SUPERVISOR please tick where required, supply information and sign to verify evidence

I CONFIRM I HAVE COMPLETED THE PRIMARY CARE ROADMAP SUPERVISOR TRAINING YES ☐ NO ☐

I HAVE REVIEWED THE EVIDENCE OF CAPABILITY IN THIS PORTFOLIO YES ☐ NO ☐

I CONFIRM I AM UP TO DATE WITH EQUALITY & DIVERSITY TRAINING YES ☐ NO ☐

OVERALL RATING OF CAPABILITY FOR STAGE TWO (PLEASE TICK)

Underperforming ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐

SUPERVISOR SIGNATURE……DATE……..

SUPERVISOR REGISTRATION NUMBER (GMC/HCPC/NMC)……DATE……..

PLEASE ENSURE STAGE ONE CHECKLIST IN ROADMAP IS VERIFIED & SIGNED AND THEN

PLEASE ENSURE STAGE TWO CHECKLIST IN ROADMAP IS VERIFIED & SIGNED, READY FOR SUBMISSION VIA THE HEE WEBSITE

12.13 Advanced Practice Verification of Evidence Form

CAPABILITY	AP LINKS
PRACTICING HOLISTICALLY TO PERSONALISE CARE & PROMOTE HEALTH	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 2
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
PRACTICING HOLISTICALLY TO PERSONALISE CARE & PROMOTE HEALTH	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 2
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
WORKING WITH COLLEAGUES & IN TEAMS	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 13
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
WORKING WITH COLLEAGUES & IN TEAMS	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 13
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
MANAGING MEDICAL & CLINICAL COMPLEXITY	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 15
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
MANAGING MEDICAL & CLINICAL COMPLEXITY	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 15
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
INDEPENDENT PRESCRIBING, MEDICINES SUPPLY & PHARMACOTHERAPY	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 8
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
INDEPENDENT PRESCRIBING, MEDICINES SUPPLY & PHARMACOTHERAPY	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 8
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
LEADERSHIP, MANAGEMENT & ORGANISATION	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 14a
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
LEADERSHIP, MANAGEMENT & ORGANISATION	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 14a
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
EDUCATION & DEVELOPMENT	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 14b
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
EDUCATION & DEVELOPMENT	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 14b
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 14c
EVIDENCE TYPE & DATE(S)	

CAPABILITY	AP LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	AP 14c
EVIDENCE TYPE & DATE(S)	

PRACTITIONER

I confirm that this portfolio contains my own work & evidence related to my own capability. I confirm no patient-identifiable information is included.

PRACTITIONER SIGNATURE …… ……

PRACTITIONER HCPC REGISTRATION NUMBER……DATE……..

VERIFYING SUPERVISOR please tick where required, supply information and sign to verify evidence

I CONFIRM I HAVE COMPLETED THE PRIMARY CARE ROADMAP SUPERVISOR TRAINING YES ☐ NO ☐

I HAVE REVIEWED THE EVIDENCE OF CAPABILITY IN THIS PORTFOLIO YES ☐ NO ☐

I CONFIRM I AM UP TO DATE WITH EQUALITY & DIVERSITY TRAINING YES ☐ NO ☐

OVERALL RATING OF CAPABILITY FOR STAGE TWO (PLEASE TICK)

Underperforming ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐

SUPERVISOR SIGNATURE……DATE……..

SUPERVISOR REGISTRATION NUMBER (GMC/HCPC/NMC)……DATE……..

PLEASE ENSURE STAGE ONE CHECKLIST IN ROADMAP IS VERIFIED & SIGNED AND THEN

PLEASE ENSURE STAGE TWO CHECKLIST IN ROADMAP IS VERIFIED & SIGNED, READY FOR SUBMISSION VIA THE HEE WEBSITE

12.14 Reflection Template – First Contact Practitioner or Advanced Practitioner

Date of tutorial:	

What happened – brief description - presenting problem
Differential diagnoses & your clinical reasoning
Reflection – what did you learn?

Impact on your practice – what will you do the same or differently next time & why
Supervisor's comments – competencies demonstrated, learning points?

SUPERVISOR SIGNATURE: ……

CLINICAL SUPERVISOR SIGNATURE: ……

12.15 Knowledge, Skills, and Attributes - FCP

The Health Education England Multi-Professional Advanced Capabilities Framework for Lower Limb Viability (MPACF-LLV) and College of Podiatry (CoP) Foot and Ankle MSK Competency Framework (CF) have been cross-referenced to the Podiatry FCP Knowledge, Skills, and Attributes (KSA) as in the following table

Domain A: personalised approaches

Capability 1. Communication Capability 2. Personalised care			
Essential knowledge: specific knowledge underpinning capabilities 1 & 2	MPACF-LLV	CoP Foot & Ankle MSK CF	FCP Capabilities
Demonstrate advanced critical understanding of the processes of verbal and non-verbal communication, clinical documentation, and the common associated errors of communication e.g. use of inappropriate closed questions, appropriate use of lay and professional terminology.	B1	A1	1a
Demonstrate comprehensive advanced knowledge of the influence of the clinician's behaviour on a patient's behaviour and vice versa.	B1	A1	A1
Critical skills: specific skills underpinning capabilities 1 & 2			
Demonstrate an advanced level in the ability to enhance and promote the rights of a person to actively participate in their healthcare management through shared decision making by taking into consideration the patient's wishes, goals, attitudes, beliefs, and circumstances.	A1 B1	A1 A2	A1 A2

Demonstrate advanced use of interpersonal and communication skills in the effective application of practical skills for assessment, diagnosis, and management of individuals with lower limb conditions, including in the obtaining of consent, and in the interpretation and discussion of test results.	A1 A2 B1 B2	A1	A1
Demonstrate advanced use of interpersonal and communication skills in the effective application of practical skills for assessment, diagnosis, and management of individuals with lower limb conditions, including in the obtaining of consent, and in the interpretation and discussion of test results.	A1 A2 B1 B2	A1	A1
Demonstrate advanced self–awareness to mitigate against the impact of a clinician's own values, beliefs, prejudices, assumptions, and stereotypes when interacting with others.	B1	A1	A1
Demonstrate effective advanced communication skills when applying behavioural principles e.g. modifying conversations based on an individual's levels of activation and health literacy, providing appropriate and accessible information and support to ensure understanding of the podiatry condition's current and potential future impact on their lives.	B1	A1	A1
Demonstrate advanced use of interpersonal and communication skills during the history taking, physical examination, reassessment, and management of individuals, including all documentation e.g. consideration of verbal and non-verbal communication, adapting to individual preferences, cognitive and sensory impairment, and language needs. Avoids jargon and negative assumptions.	A2 B1 B2	A1 A2	A1 A2

Demonstrate efficient and effective use of advanced active listening skills throughout the individual's encounter, e.g. both are involved in an active, two-way process.	A2 B1 B2	A1	A1
Demonstrate effective documentation of informed consent from the individual for assessment and management procedures as appropriate.	B1	B4	A1
Record all pertinent information gathered in history and from examination concisely and accurately for clinical management, and in compliance with local guidance, legal and professional requirements for confidentiality, data protection, and information governance.	B1	A1	A1 A2 C12
Demonstrate effective and efficient communication and shared decision making with all individuals involved in determining and managing goals, clinical interventions, social prescribing, and measurable outcomes to ensure integrated patient care, e.g. verbal, written, and digital communication to serve the individual's best interest.	B1	A1	A1 A1 A2
Demonstrate an advanced level of effective, direct, person-centred approach to practice, responding and rapidly adapting the assessment and intervention to the emerging information and the patient's perspective, e.g. enabling individuals to make and prioritise decisions about their care, exploring risks, benefits, and consequences of options on their lower limb condition and life, such as paid/unpaid work, including doing nothing.	A1 A2 B1 B2	A2 B3 C6 C7	A1 A2

Demonstrate advanced use of clinical reasoning to integrate scientific evidence, clinical information, the individual's perceptions and goals, and factors related to the clinical context and the individual's circumstances, e.g. using clinical outcome measures such as pain, function, and quality of life to progress meaningful goals, and offering regular appointments to monitor other healthcare needs associated with podiatry related long-term conditions and co-morbidities, and their potential impact upon physical activity and healthy living.	B2 B3	A2 B3 C6 C7	A2
Demonstrate effective advanced communication skills when identifying opportunities for peer, social or other community-based support mechanisms available to promote or enhance foot health.	B1	A1 B3 C6 C7	A1

Domain B: assessment, investigation, and diagnosis

Capability 3. History-taking Capability 4. Assessment Capability 5. Investigations and diagnosis			
Essential knowledge: general knowledge underpinning capabilities 3, 4 & 5	MPACF-LLV	CoP Foot & Ankle MSK CF	FCP Capabilities
Demonstrate critical understanding of the process of complex hypothetico-deductive clinical reasoning, including complex hypothesis generation and testing.	B2 B3	B3 B4	B4 B5
Demonstrate an advanced level of effective use of the process of complex pattern recognition, including the importance of organising advanced clinical knowledge in patterns.	B2 B3	B3 B4 B5	B3
Demonstrate comprehensive knowledge of the theoretical physiological systems underpinning assessment of the lower limb, and the interpretation of assessment findings within the context of differential diagnosis.	B2	B3 B4 B5 Appendix 1	B4 B5
Demonstrate advanced evaluation of common clinical reasoning errors.	B2	B3 B4 B5 Appendix 1	B5
Demonstrate integration of advanced knowledge and clinical reasoning in the evaluation of complex clinical information obtained, e.g. infectious causes or metabolic causes manifesting as joint pain and muscle pain.	A2 B2	B4 B5	B3
Demonstrate comprehensive advanced knowledge of the relevant clinical sciences as applied to podiatric conditions, such as clinical anatomy, physiology, pain science, biomechanics, tissue viability, and epidemiology in assessment.	A2 B2	B4 B5.	B4 B5

Demonstrate comprehensive advanced knowledge of the interrelationship of anatomical structures in lower limb function and dysfunction.	A2 B2	B3 B4 B5	B4 B5
Demonstrate comprehensive advanced knowledge of pathology and pathogenesis of mechanical dysfunction of the MSK, neurological, and vascular systems presenting to podiatrist first contact practitioners.	A2 A3	B3 B4 B5	B4 B5
Demonstrate comprehensive advanced knowledge of assessment, diagnosis, and management of non-mechanical dysfunction related to complex multi-system pathology, e.g. local and national guidelines, pathways, and policies for tumours and metastatic disease, fractures, autoimmune/ inflammatory diseases, infections, endocrinology, haematology, and other associated red flags.	A2 B2	B3 B4 B5 Appendix 1	B3 B4 B5 Appendix 1
Demonstrate comprehensive advanced knowledge of neurological and cardiovascular dysfunctions linked with the podiatry related conditions.	A2 B2	Appendix 1	B3 B4 B5
Demonstrate comprehensive advanced knowledge of pain sciences related to the lower limb conditions	A2	B4 B5 Appendix 1	B4 B5
Demonstrate comprehensive advanced knowledge of examination procedures to enable differential diagnosis of the MSK, neurological, vascular, and lymphatic dysfunction, while additionally exploring co-morbidities, mental health, and social health impacts as seen within the FCP podiatry role.	A2	B5	B5

Demonstrate comprehensive advanced knowledge of the specific diagnostic and evaluative qualities of assessment tools likely to be used within the FCP podiatry role, including reliability, validity, responsiveness, positive likelihood, negative likelihood, and diagnostic accuracy.	A2 B2	B5	B5
Demonstrate comprehensive advanced knowledge of static, dynamic, and functional posture in the assessment of the MSK system and interpretation of this assessment.	A2 A3	B4 B5 Appendix 1	B4 B5
Demonstrate comprehensive advanced knowledge of the biomechanics and principles of active and passive movements of the articular system, including the joint surfaces, ligaments, joint capsules, and associated bursae in the assessment of the MSK system and interpretation of this assessment.	A2 A3	B4 Appendix 1	B4
Demonstrate comprehensive advanced knowledge of the specific tests for functional status of the muscular, nervous, and vascular system in the assessment of the MSK system and interpretation of this assessment.	A2 A3	B5	B4 B5
Demonstrate comprehensive advanced knowledge of the specific special/screening tests for the assessment of the muscular, skeletal, integumentary, nervous, and vascular systems and interpretation of these assessments.	A2 B2	B3 B5	B4 B5
Demonstrate comprehensive advanced knowledge of appropriate medical diagnostic tests and their integration required to make a podiatric clinical diagnosis, e.g. able to select the appropriate investigative tests, interpret results, and inform assessment and decision making.	A2 B2	B5	B5

Demonstrate comprehensive advanced knowledge of the specific indications and contraindications (including behavioural principles) for the use of diagnostic tools including imaging, blood tests, etc.	A2 B2	B5	B5
Critical skills: Specific skills underpinning capabilities 3, 4 & 5			
Demonstrate an evidence-informed approach to the advanced assessment of individuals with lower limb conditions.	A2 A3 B2 B3	B3 B4 B5	B3 B4 B5
Demonstrate advanced application of comprehensive knowledge of the examination and management of individuals with lower limb conditions e.g. able to assess and manage commonly seen patterns and syndromes and the causes to which they relate: joint, bone pain, muscle pain and weakness, systemic extra-skeletal problems related to trauma, degenerative, neoplastic, developmental/congenital, and psychological causes etc.	A2 B2	B3 B4 B5 C11	B4 B4 B5
Demonstrate advanced professional judgements when selecting assessment, diagnostic, and treatment techniques; evaluating benefit and risk; and adapting practice to meet the needs of different groups and individuals e.g. cognitive impairment, learning difficulties, remote consultation, chaperones, and interpreters.	B2	B5	B5
Demonstrate an advanced level of critical and evaluative collection of clinical information to ensure reliability and validity, ensuring concise and accurate documentation for clinical management, and in accordance with local protocols, legal and professional requirements.	B2	A1 B3 B4 B5	B5

Demonstrate application of comprehensive advanced knowledge of the biomedical, clinical, and behavioural sciences in the assessment of individuals with lower limb conditions e.g. presentation of pathological and psycho- social presentations affecting the structure, function, inflammation, and pain, including wounds.	A1 A2 B1 B2	B3 B4 B5	B3 B4 B5
Demonstrate effective application of assessment and outcomes to evaluate aspects of the complex clinical behavioural principles in the management of individuals whilst addressing any queries or concerns they may have.	A1 B1 B2	A2 B3 B4 C7	B5
Demonstrate advanced level of efficient and effective questioning strategies to obtain reliable and valid information from history taking, while demonstrating the ability to explore and appraise an individual's perceptions, ideas, and beliefs about their symptoms e.g. appropriate and sensitive communication styles, exploring, synthesising, and distilling relevant information about relationships between social activities, work, and health (biological and psycho-social barriers to recovery, frailty, dementia, other determinants of health).	A1 A2 B1 B2	A1 A2 B3	A1 A2
Demonstrate an advanced level of accurate and efficient selection of inquiry strategies, based on early recognition and correct interpretation of relevant complex clinical cues e.g. gather, synthesise, and appraise from various sources, sometimes incomplete or ambiguous information relating to current and past history, their activities, any injuries, falls, frailty, multi-morbidity, or other determinants of health and wellbeing and characteristics of podiatric conditions (pain, stiffness, deformity, weakness, sensory loss, and impact on tasks and occupation etc.).	A1 A2 B1 B2	A1 A2 B3	A1 A2 B3

Demonstrate the advanced ability to simultaneously monitor multiple complex dimensions of information while maintaining a professional and appropriate communication style throughout contact with the individual e.g. some lower limb symptoms have the potential to be features of serious pathology, compounded by psychological and mental health factors, and affected by lifestyle factors (including smoking, alcohol, and drug misuse).	B1 B2 B3	A1 A2 B3	A1 A2 B3
Demonstrate the ability to efficiently and effectively gain an individual's consent, respecting and maintaining privacy and dignity, complying with infection control procedures.	B1	A1	A1
Demonstrate advanced prioritisation in the physical assessment and management of individuals with complex lower limb conditions, adapting to the needs of individuals and potential limitations of the clinical environment e.g. cognitive impairment, chaperone, remote consultations, and local policy (social distancing, PPE).	A2 B1 B2	A2 B3 B4	A2 B3 B4
Demonstrate advanced level of sensitivity and specificity in the physical and functional assessment of the articular, muscular, fascial, nervous, vascular, and cardiorespiratory systems.	A1 B1	B5	B5
Demonstrate accurate physical diagnosis of lower limb dysfunctions e.g. identify, analyse, and interpret significant information from the assessment, including any ambiguities.	A2 B2	B3 B4 B5	B3 B4 B5

Domain C: condition management, interventions, and prevention

Capability 6. Prevention and lifestyle intervention **Capability 7. Self-management and behaviour change** **Capability 8. Pharmacotherapy** **Capability 9. Injection therapy** **Capability 10. Surgical interventions** **Capability 11. Rehabilitative interventions** **Capability 12. Interventions and care management** **Capability 13. Referrals and collaborative work**			
Essential knowledge: generic knowledge underpinning capabilities 6, 7, 12 & 13	MPACF-LLV	CoP Foot & Ankle MSK CF	FCP Capabilities
Demonstrate comprehensive advanced knowledge of prognostic, risk, and predictive factors of relevant health problems in relation to all podiatric management strategies e.g. adequate vitamin D for bone health, and the effects of smoking, obesity, mental health, frailty, inactivity etc.	A3 B3	C6	C6
Demonstrate comprehensive knowledge of the relevant theories of behaviour health change e.g. the transtheoretical model and patient activation (behavioural reactions to pain and limitations, coping strategies, personal goal setting etc) related to podiatric assessment and management.	B3	C7	C7
Demonstrate comprehensive knowledge of the role of the biopsychosocial model, e.g. risk factors for the persistence of lower limb conditions and the role of MDT management strategies.	A1 A3 B1 B3	C7	C7
Demonstrate comprehensive advanced knowledge of all possible interventions for management of lower limb conditions e.g. where agreed in partnership and acting in the individual's best interest, refer and/or signposting for relevant investigations, local and national services, including self-help, counselling, and coaching support.	B3	C6 C7 C11 C12 C13	C6 C7 C11 C12 C13

Demonstrate comprehensive advanced knowledge including indications and contraindications of all available multimodal therapeutic interventions for management of lower limb conditions e.g. the safety and appropriateness of referral for rehabilitation and/or specific interventions (manual techniques, electrotherapy, social prescribing, injection therapy, and pharmacotherapy etc.).	A3 B3	C6 C7 C8 C9 C10 C11 C12	C6 C7 C8 C9 C10 C11 C12 C13
Demonstrate comprehensive advanced knowledge of ergonomic strategies and advice to assist the individual/ relevant agencies on effective risk assessments and provision of appropriate working conditions. This may include adaptation to meet the individual's needs in their work environment to prevent lower limb-related work loss e.g. appropriate recommendation of FIT note.	A2 A3 B2 B3	C6 C11 C12 C13	C6 C11 C12 C13
Demonstrate comprehensive advanced knowledge of preventative programmes for podiatric associated health conditions e.g. knowledge of and referral pathways for all local ex. groups, smoking cessation, and weight management programmes.	B3	C6 C13	C6 C13
Critical skills: specific skills underpinning capabilities 6,7,12 & 13			
Demonstrate an advanced level in the ability to retrieve, integrate, and apply evidence-based knowledge from the medical, and behavioural sciences in the clinical setting, recognising the limitations of incorporating evidence when managing individuals with lower limb conditions e.g. considering social, economic, and environmental factors on an individual's behaviour, intervention, and management plan decision-making.	A3 B3	C12 C13 D14	C12 C13 D14

Demonstrate an advanced ability to integrate and apply evidence-informed approaches in the presentation of health promotion and preventative care programmes e.g. work in partnership utilising behaviour change principles to promote and support the individual with continuing work/exercise participation and the importance of social networks, and clinical and non-clinical groups and services.	A1 A3 B1 B3	C6 C7 C11 C12 C13	C6 C7 C11 C12 C13
Demonstrate advanced effective interpersonal and communication skills in the application of knowledge of complex biomedical sciences in the management of podiatric conditions to facilitate communication and behaviour change that enables self-management, independence, risk assessment, and health and wellbeing promotion for individuals, carers, communities, and populations.	A1 B1 B3	A1 A2 C6 C7 C12 C13	A1 A2 C6 C7 C12 C13
Demonstrate an advanced ability to identify the nature and extent of an individual's functional abilities, pain, and complex multidimensional needs in relation to their management plan e.g. advising individuals, carers, and relevant agencies on living with frailty and how to adapt the environment to reduce the risk of falls, manage pain, and maintain independence etc.	A2 B2 B3	C12 C13	C12 C13
Demonstrate advanced effective interpersonal skills to inform the individual about their clinical presentation and all their management options e.g. supports the individual to engage in identifying the risks, prognosis, potential side effects, and likely benefits of interventions related to their personal needs and health goals.	A1 A3 B1 B3	A2 C12 C13	A2 C12 C13

Demonstrate advanced effective application of aspects of behavioural principles in the management of individuals to optimise their physical activity, mobility, fulfilment of personal goals and independence relevant to their lower limb condition e.g. supports and recognises when to discharge the individual with self-management.	B1 B3	A2	A2
Demonstrate effective implementation of the biopsychosocial model e.g. able to identify risk factors for the persistence of podiatric conditions and advise, signpost, and refer individuals to psychological therapies, counselling, and pain services as appropriate.	B1 B3	B3 B5 C13	B3 B5 C13
Demonstrate an advanced level of skill in implementing and educating individuals in appropriate rehabilitation programmes, supporting individuals to engage and explore personal goals, the consequences of their actions and inactions on these goals, and their health status and independence relevant to their lower limb condition.	B3	A2 C11	A2 C11
Demonstrate efficient and effective management of patients with multiple complex inter-related or separate problems and/or co-morbidities e.g. communicate and collaborate with inter-professionals, educating and advising on management interventions and plans for individuals who are off work with foot ulceration but restricted by regular hospital appointments or footwear and concerned about a loss of employment.	B3	C12 C13	C12 C13
Demonstrates effective MDT working to optimise service delivery of the management of lower limb conditions and health, prevention, and wellbeing for the benefit of individuals, carers, professionals, and agencies e.g. evidence of shared learning, development, audit, referral pathways.	B3	C12 C13	C12 C13

Make recommendations to employers regarding individuals' fitness to work, including through the appropriate recommendation of fit notes and seeking of appropriate occupational health advice.		C12 C13	C12 C13

Capability 8. Pharmacotherapy			
Essential knowledge: general knowledge underpinning capability 8	MPACF-LLV	CoP Foot & Ankle MSK CF	FCP Capabilities
Demonstrate comprehensive knowledge of indications, contraindications, effects, and side-effects of therapeutic drugs, understanding local and national formularies, resources, guidelines, and policies including the podiatrist's exemptions list, related to their use in the examination and management of podiatric conditions e.g. analgesics, non-steroidal and anti-inflammatory drugs, corticosteroid, and drugs used in treating individuals with metabolic bone disease, gout, inflammatory arthritis, and in the management of persistent pain.	B3	C8 C9	C8 C9
Critical skills: specific skills underpinning capability 8			
Advise patients on the most common medications used in the management of podiatric disorders, to advise individuals for medicines management of their lower limb problem, including the expected benefit, limitations, advantages, and disadvantages of pharmacotherapy and the importance of an impartial approach to the information shared in the context of other management options e.g. address and allay individuals' fears, beliefs, and concerns.	B3	C8 C9	C8 C9

Keep individuals' responses to medication under review, recognising differences in the balance of risks and benefits that may occur in the context of polypharmacy, multi-morbidity, frailty, and cognitive impairment. Seeking appropriate support or onward referral for pharmacotherapy where required, and utilising available resources to further complement advice given e.g. signpost to websites, leaflets, pharmacists, MHRA yellow card scheme.	B3	C8 C9 C10 C11 C13	C8 C9 C10 C11 C13

Capability 9. injection Therapy			
Essential knowledge: Specific knowledge underpinning capability 9	MPACF-LLV	CoP Foot & Ankle MSK CF	FCP Capabilities
Understand the role of joint injections, informed by the evidence base in podiatric practice, local and national guidelines, pathways, and policy.		C9	C9
Critical skills: specific skills underpinning capability 9			
Work in partnership to explore the suitability for injection therapy, including the expected benefit, limitations, advantages, and disadvantages of injection therapy and the importance of an impartial approach to the information shared in the context of other management options. Seeking advice and local referral for injection where required.		C9	C9

Capability 10. Surgical interventions			
Essential knowledge: specific knowledge underpinning capability 10	MPACF-LLV	CoP Foot & Ankle MSK CF	FCP Capabilities
Demonstrate comprehensive advanced knowledge of indications for, and the nature of, 'minor' surgical intervention in the management of podiatric conditions, such as nail surgery, including the expected benefits, limitations, advantages, and disadvantages of surgical interventions and the importance of an impartial approach to the information shared in the context of other management options e.g. conservative management, interventions, and social prescribing.	A3	C10	C10
Critical skills: specific skills underpinning capability 10			
Work in partnership with individuals to explore suitability of surgical intervention e.g. to allay individuals' fears, beliefs, and concerns, seeking assistance where required, referring appropriately and with consideration of local and national pathways, guidelines, resources, and policies.	A3	A2 C10	A2 C10

Capability 11. Rehabilitative Interventions			
Essential knowledge: specific knowledge underpinning capability 11	MPACF-LLV	CoP Foot & Ankle MSK CF	FCP Capabilities
Demonstrate comprehensive knowledge and understanding of rehabilitative interventions for podiatric conditions commonly seen within the FCP role, including the expected benefit, limitations, advantages, and disadvantages of surgical interventions, and the importance of an impartial approach to the information shared in the context of other management options, for example surgery.	A3 B3	C10 C11 C12	C10 C11 C12

Demonstrate comprehensive knowledge of various manual exercise therapy approaches, including the expected benefits, limitations, advantages, and disadvantages, and of other therapeutic adjuncts e.g. taping, acupuncture, and electrotherapy modalities including those in physiotherapy, medicine, osteopathy, and podiatry etc used in the rehabilitative management of MSK conditions.	A3	C11	C11
Demonstrate comprehensive knowledge of the role of digital technology to support adherence to rehabilitation and/ or self-care interventions for individuals with lower limb conditions e.g. apps and wearables and have an appreciation for potential barriers or limitations to their use.	A3	A2 C11	A2 C11
Demonstrate comprehensive knowledge of evidence- informed outcome measures appropriate to the management of podiatric conditions.	B3	C11 D14	C11 D14
Critical skills: specific skills underpinning capability 11			
Work in partnership with individuals to explore suitability of rehabilitation intervention (referrals to physiotherapy, occupational therapy, exercise instructors, and self- management resources etc.), seeking assistance where required, referring appropriately and with consideration of local and national pathways, guidelines, resources, and policies.	A1 A3 B1 B3	A2 C11 C13 D14	A2 C11 C13 D14
Demonstrate integration of principles of patient education as a component of multi-modal therapy intervention for the management of lower limb conditions.	B1 B3	A2 C12	A2 C12

Demonstrate integration of principles of exercise physiology as it applies to therapeutic rehabilitation exercise programmes, including gait rehabilitation, as a component of multi-modal intervention for management of MSK conditions e.g. an exercise programme with orthotist referral.	B3	C11 Appendix	C11 Appendix
Demonstrate sensitivity and specificity of handling in the implementation and instruction of individuals in appropriate therapeutic rehabilitation exercise programmes e.g. graded return to normal activity, modifying activity advice and programmes.	B3	A2 C11	A2 C11

Domain D: service and professional development

Capability 14. Evidence-based practice and service development			
Essential knowledge: specific knowledge underpinning capability 14	MPACF-LLV	CoP Foot & Ankle MSK CF	FCP Capabilities
Demonstrate advanced critical evaluative application of evidence-informed practices e.g. uses clinical audit to evidence the use of best practice/ national guidelines within podiatric care and service delivery, identifying where modifications are required.	B3 L & M in ACP Research in ACP	D14	D14
Demonstrate evaluative understanding of appropriate outcome measures e.g. data collection and analysis, satisfaction feedback, and stakeholder engagement to improve quality of care, service delivery, and health inequalities.	L & M in ACP	B3 B4 B5 C11 D14	B3 B4 B5 C11 D14
Demonstrate effective integration of comprehensive knowledge, and cognitive and metacognitive proficiency e.g. understands the importance of reflective practice and supervision on professional and service development.	Education in ACP	C11 D14 Appendix 1 Appendix 2	C11 D14 Appendix 1 Appendix 2
Evaluate the existing and changing professional, social, and political influences on the breadth and scope of advanced podiatric practice within the context of delivery of services to continuously improve podiatric healthcare.	L & M in ACP Education in ACP	A2 D14	A2 D14
Evaluate the extent to which advanced podiatric practice contributes to strategies related to collaborative inter- professional working and person-centred care.	A1 B1 L & M in ACP	A2 D14	A2 D14

Critical skills: specific skills underpinning capability 14			
Demonstrate ability to critically review the recent literature of the basic and applied sciences relevant to lower limb conditions, to draw inferences for practice and present appraised, synthesised, material logically in verbal and written forms.	Research in ACP	D14	D14
Demonstrate the advanced use of outcome measures to evaluate the effectiveness of clinical interventions and services and uses outcomes to inform future planning and development.	B3 L & M in ACP	D14	D14
Demonstrate effective critical appraisal of research relevant to podiatric practice.	Research in ACP	D14	D14
Demonstrate ability to consult skilfully with peers, other professionals, and legislative and regulatory organisations as appropriate.	A2 B2 L & M in ACP	A1 C13 D14	A1 C13 D14
Critically analyse leadership practice through self- awareness of ability to lead, influence, and negotiate with others.	L & M in ACP	C13 D14	C13 D14
Critically apply changes to their behaviour relating to underpinning theory on leadership and analyse and reflect on these changes.	L & M in ACP Education in ACP	D14	D14

Personal attributes

FPC Podiatrist Core Competency: attributes of an FCP Podiatrist	
Essential personal attributes: generic attributes underpinning all 14 capabilities	FCP
Ensure own work is within professional and personal scope of practice and access advice when appropriate.	B3 B4 B5 C
Be confident in and take responsibility for own decisions while being able to recognise when a clinical situation is beyond own capability or competence and escalate appropriately	B3 B4 B5 C
Demonstrate advanced professional judgement, empathy, and cultural competence within clinical practice.	A2 B3 B4 B5 C
Advocate and utilise the expertise and contribution to peoples' care of other 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.	C13
Demonstrate a critical and evaluative approach to all aspects of advanced practice	-
Demonstrate adaptability of comprehensive knowledge of biomedical sciences in the context of personalised care.	A2
Demonstrate criticality, creativity, and innovation of practice in the application of knowledge of biomedical sciences in the examination and management of individuals with lower limb conditions.	D14
Demonstrate an objective and analytical attitude in the application of complex knowledge of the clinical sciences.	D14
Demonstrate an advanced level of sensitivity to changes in an individual's behaviour.	A1 A2
Demonstrate critical awareness of the central role of communication skills in the development of advanced clinical expertise.	A1 D14
Demonstrate empathy in the application of advanced communication skills.	A1 A2

Demonstrate critical awareness of person-centred communication as being central to effective advanced clinical practice.	A1 A2 D14
Demonstrate a critical understanding of the key role of person-centred complex clinical reasoning skills in all aspects of advanced clinical practice.	A1 A2 B5 D14
Demonstrate critical awareness of public health strategies and guidelines on the promotion of wellness and prevention through the education of individuals, the public, and health and social care professionals.	A1 A2 C6 C7
Demonstrate an advanced level in the application of complex biopsychosocial principles.	C6 C11 C12
Demonstrate adaptability of knowledge of lower limb management in the context of personalised care.	A2
Demonstrate criticality of evidence-informed practice in the application of knowledge of podiatric management and rehabilitation, in the context of personalised care.	A2 C11
Demonstrate an advanced level of effective collaborative and advanced communication skills in requesting further investigation or referral to another health or social care professional.	C13
Demonstrate criticality, creativity, adaptability, and innovation of practice in the application of practical skills in the context of personalised care.	A2
Demonstrate an advanced level of learning through critical reflection during and after the clinical encounter.	D14
Demonstrate an advanced level of reflection and self-evaluation in managing individuals.	C12
Demonstrate an advanced level of learning through precise and timely reassessment.	B3 B4
Demonstrate critical awareness of the role of research in advancing the body of knowledge in podiatric practice.	D14
Demonstrate a commitment to lifelong learning with continuous professional development.	D14
Demonstrate a commitment to contributing to professional development through teaching and mentoring and assisting in the advancement of podiatric provision across health and social care to the benefit of the public.	D14

12.15.1 Core clinical skills, core indicative knowledge, key clinical presentations, investigations, and referrals – FCP

FCP Podiatry can manage acute patient presentations and existing diagnoses as listed in the table below.

Cardiovascular system Demonstrate knowledge of normal and abnormal presentations of the cardiovascular system affecting the lower limb and the impact on related systems. Demonstrate knowledge and skill in the identification and assessment of influencing factors, such as psychosocial wellbeing, risk factors, and prognostic indicators.		
Core clinical skills	**Indicative presentations**	**Key clinical investigations / referrals (may include but not be limited to)**
• Demonstrate knowledge of the aetiology, pathophysiology, and treatment of any new or existing circulatory disorder affecting the lower limb • Identify the need for and initiate immediate investigation, treatment, or referral for: suspected critical limb ischaemia suspected venous thromboembolism (VTE) chest pain of suspected cardiac origin suspected vascular emergency with risk to lower limb viability suspected sepsis	**Patient presentations** • Sudden onset pain in the lower limb • increasing or extensive swelling in the lower limb • unusually cold feet or legs • colour changes in the lower limb • prominent or painful veins • sudden/ increasing pain in the calf when walking • heat and/ or swelling in the calf	• Lower limb vascular examination, inc. temperature, colour, tissue viability • Pulse palpation • Doppler ultrasound • ABPI, blood pressure • Heart rate • Respiration rate • Temperature • Oxygen saturation • ECG with MDT interpretation • Pain assessment • Quality of life assessment

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Take a structured and appropriate history of a person presenting with any suspected vascular pathology • Perform appropriate assessment(s) • Initiate appropriate tests based upon differential diagnoses • Accurately interpret, analyse, and synthesise test results to inform treatment planning • Identify the need for additional professional support/ referral • Initiate appropriate referral based upon differential diagnoses • Accurately interpret, analyse, and synthesise test results to inform treatment planning • Identify the need for additional professional support/ referral • Initiate appropriate referral based upon differential diagnoses • Initiate appropriate management / personalised care plan based upon differential diagnoses • Initiate, review, instruct and support service users in the use of medicines and devices	**Existing conditions** • Acute lower limb ischemia • Critical/ chronic lower limb ischemia • Other peripheral arterial disease inc. all causes, e.g. atherosclerosis • Acute or Chronic venous disease • Vasospastic conditions • Vasculitis • Cardiac arrhythmia	• Use of validated assessment scores • Use of validated risk calculators • Diagnostic or monitoring blood tests – U&E's, D-Dimer, LFT's, haematinics, vitamin D, HbA1c, triglycerides/ cholesterol, with MDT interpretation • Imaging – x-ray, CT, MRI, US, and use of appropriate/ related scoring or diagnostic criteria, with MDT interpretation • Use of personalised approaches to care, e.g. inc. advanced communication skills Possible referral to: • Podiatry • Foot protection team • Vascular services • Rheumatology • Physiotherapy • Personal health budget assessment • Mental health and wellbeing coach

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Ensure records are accurate, concise, and contemporaneous using appropriate terminology • Recognise the effect that the environment, lifestyle, and genetics can have on cardiovascular conditions, provide lifestyle and health promotion advice or referral. • Recognise and discuss the impact of the presenting problem on the lifestyle and day to day living of the person • Advise and explain self-care measures where treatment is not routinely provided by the NHS		• Healthy living services e.g. weight management, smoking cessation, eating well, substance misuse • Community assets e.g. Park Run, food bank • Care navigators

Dermatology

Demonstrate knowledge of normal and abnormal dermatological presentations affecting the lower limb and the impact on related systems.

Demonstrate knowledge and skill in the identification and assessment of influencing factors such as psychosocial wellbeing, risk factors, and prognostic indicators

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Demonstrate knowledge of the aetiology, pathophysiology, and treatment of any new or existing dermatological disorder affecting the lower limb • Identify the need for and initiate immediate investigation, treatment, or referral for: pigmented skin lesions where malignancy is suspected suspected vascular emergency suspected risk to limb viability suspected sepsis • Take a structured and appropriate history of a person presenting with any suspected dermatological (nail or skin) pathology, including swelling, wounds, or infection • Perform appropriate assessment(s) • Initiate appropriate tests based upon differential diagnosis • Accurately interpret, analyse, and synthesise test results to inform treatment planning	**Patient presentations** • Toenail problems: swelling, discolouration, thickening, malodour, weeping, or ingrowing • Undiagnosed skin problem on lower leg: rashes or changes in skin colour, spots, blisters, lumps, problems or changes to moles/ existing marks, corns, hard skin, infections, splits in the skin or wounds, significant itching, or excessive sweating of the foot • Wound(s) to lower leg • Acute colour and/ or temperature change to lower limb	• Lower limb dermatological examination • Pain assessment • Quality of life assessment • Use of validated assessment scores • Use of validated risk calculators • Use of appropriate skin related tests, e.g. wound swab • Diagnostic or monitoring blood tests - ESR & CRP, urate, AST, ALT, FBC (neutrophils, Hb, platelets), eGFR, HbA1C, with MDT interpretation • Imaging – x-ray, CT, MRI, US, and use of appropriate/ related scoring or diagnostic criteria, with MDT interpretation • Use of personalised approaches to care, e.g. inc. advanced communication skills

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for additional professional support/ referral • Initiate appropriate referral based upon differential diagnosis • Initiate appropriate management / personalised care plan based upon differential diagnosis • Initiate, review, instruct and support service users in the use of medicines and devices • Ensure records are accurate, concise, and contemporaneous using appropriate terminology • Recognise the effect that the environment, lifestyle, and genetics can have on skin and/or nail conditions, provide lifestyle and health promotion advice or referral. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person • Advise and explain self-care measures where treatment is not routinely provided by the NHS	**Patient presentations** • Diagnosed skin problems: e.g. flares of eczema, psoriasis, or cellulitis • Wound issues: e.g. acute or chronic ulceration, necrosis • Ischemia or localised infarcts, vasospastic changes • Pathological callus or corns e.g. heloma durum • Pathological skin condition common to the lower limb e.g. hyperhidrosis/ bromhidrosis, bullous pemphigus, diabetic foot (pre-)ulceration • Pathological nail condition e.g. onychomycosis	Possible referral to: • Podiatry services • Foot protection team • Dermatology • Tissue viability nurse • Rheumatology • Vascular services • Personal health budget assessment • Mental health and wellbeing coach • Healthy living services e.g. weight management, smoking cessation, eating well, substance misuse • Community assets e.g. Park Run, food bank • Care Navigators

Musculoskeletal (MSK)

Demonstrate knowledge of normal and abnormal presentations of the musculoskeletal system affecting the lower limb and the impact on related systems.

Demonstrate knowledge and skill in the identification and assessment of influencing factors such as psychosocial wellbeing, risk factors, and prognostic indicators.

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Demonstrate knowledge of the aetiology, pathophysiology, and treatment of any new or existing MSK disorder affecting the lower limb • Identify the need for and initiate immediate investigation, treatment, or referral for: suspected rheumatic disease or related condition suspected connective tissue disease suspected gout suspected osteoarthritis other MSK condition • Take a structured and appropriate history of a person presenting with any suspected MSK pathology • Perform appropriate assessment(s) • Initiate appropriate tests based upon differential diagnoses • Accurately interpret, analyse, and synthesise test results to inform treatment planning	**Patient presentations** • Pain, stiffness, or change in appearance in the joints or soft tissues of the lower limb • Change in ability to stand or walk, e.g. limping, moving abnormally • Injury (or repeated sprains) to the lower limb caused by trauma or falls • Joint pain – single or multiple • Regional pain that has been present for four weeks or longer	• Lower limb MSK examination, inc. weight-bearing (WB), non-WB, and gait analysis • Pain assessment • Quality of life assessment • Use of validated assessment scores • Use of validated risk calculators • Diagnostic or monitoring blood tests - ESR & CRP, ANA, RF/CCP, urate, AST, ALT, FBC (neutrophils, Hb, platelets), eGFR, with MDT interpretation • Imaging – x-ray, CT, MRI, US, DEXA and use of appropriate/ related scoring or diagnostic criteria, with MDT interpretation

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for additional professional support/ referral • Initiate appropriate referral based upon differential diagnoses • Initiate appropriate management / personalised care plan based upon differential diagnoses • Initiate, review, instruct and support service users in the use of medicines and devices • Ensure records are accurate, concise, and contemporaneous using appropriate terminology • Recognise the effect that the environment, lifestyle, and genetics can have on MSK conditions, provide lifestyle and health promotion advice or referral. • Recognise and discuss the impact of the presenting problem on the lifestyle and day to day living of the person • Advise and explain self-care measures where treatment is not routinely provided by the NHS	**Patient presentations** • Regional or joint pain/ stiffness (lasting longer than 30 minutes)/ swelling/ redness/ warmth of foot/ lower leg • Reduced range, quality, or direction of foot/ lower leg joint motion **Existing conditions** • Joint pain associated with suspected JIA*, IA, CTD or osteomyelitis: • X-ray confirmed erosion at least one joint • US confirmed synovitis in at least one joint • gait change	• Use of personalised approaches to care, e.g. inc. advanced communication skills Possible referral to: • Podiatry • Physiotherapy • Occupational Therapy • Rheumatology • Orthopaedics • Podiatric Surgery • Vascular services • Personal health budget assessment • Mental health and wellbeing coach • Healthy living services e.g. weight management, smoking cessation, eating well, substance misuse • Community assets e.g. Park Run, food bank • Care navigators

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
	Existing conditions • regional or diffuse pain concomitant dermatological/ connective tissue presentation (e.g. Raynaud's phenomena, sudden nail changes) • Joint pain associated with suspected crystal arthropathy/ gout • possible presence of ulceration • possible presence of tophi • Joint pain associated with osteoarthritis (OA) • palpable osteophytic change at joint margins • non-painful change in joint appearance or function • joint effusion • Non-rheumatic 'other' MSK, including but not limited to: • plantar heel pain • undiagnosed metatarsalgia (fragility/stress fracture) • soft tissue trauma (e.g. tendinopathy/ ligament injury) • bursitis • paediatric MSK disorders (e.g. Severs disease)	

Neurology

Demonstrate of knowledge of the nervous system, analysing potential severity and the impact of poor neurological health on related systems.

Demonstrate knowledge of the influencing factors such as psycho-social and family history, risk factors, prognostic indicators, symptoms, and clinical signs.

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Demonstrate knowledge of the aetiology, pathophysiology, and treatment of any new or existing neurological disorder affecting the lower limb • Identify the need for, and initiate immediate investigation, treatment, or referral for: suspected motor neuropathy suspected sensory neuropathy suspected autonomic neuropathy • Take a structured and appropriate history of a person • Perform appropriate assessment(s) • Initiate appropriate tests based upon differential diagnoses • Accurately interpret, analyse, and synthesise test results to inform treatment planning • Identify the need for additional professional support/ referral	**Patient presentations** • Pain • Numbness, altered sensation • Change in strength/ function/ appearance in foot/ lower leg • Change in ability to stand/ walk • Falls • Change in temperature - hot/ cold foot/ lower leg • Change in colour foot/ lower leg	• Lower limb neurological examination, inc. • neurocutaneous markers, muscle bulk, tone/hypotonia, strength/ wastage, hyper-sensation/ neuropathy, reflex abnormality, tremor, balance, gait assessment, dyskinesia, and coordination • Pulse palpation • Blood pressure • Pain assessment • Quality of life assessment • Use of validated assessment scores • Use of validated risk calculators, with MDT interpretation, inc.: • Falls: FRAT • Stroke: CHADS2, QRISK3,

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Initiate appropriate referral based upon differential diagnoses • Initiate appropriate management / personalised care plan based upon differential diagnoses • Initiate, review, instruct and support service users in the use of medicines and devices • Ensure records are accurate, concise, and contemporaneous using appropriate terminology • Recognise the effect that the environment, lifestyle, and genetics can have on neurological conditions, provide lifestyle and health promotion advice or referral. • Recognise and discuss the impact of the presenting problem on the lifestyle and day to day living of the person • Advise and explain self-care measures where treatment is not routinely provided by the NHS	**Existing conditions** • Peripheral neurological disease impacting the lower limb inc. e.g. peripheral diabetic neuropathy, chronic pain syndrome, spinal cord injury, post-polio disease, Parkinson's disease, post-Stroke, Charcot neuroarthropathy, Cauda Equina • Change in gait, balance, coordination, or proprioception	• HAS BLED • Frailty: Electronic frailty index, Rockwood frailty scale • Dementia: GPCOG • Malnutrition: MUST • Mental health: PHQ2 • Diagnostic or monitoring blood tests – U & E's, LFT's, HbA1C, with MDT interpretation • Imaging – x-ray, CT, MRI, US, and use of appropriate/ related scoring or diagnostic criteria, with MDT interpretation • Use of personalised approaches to care, e.g. inc. advanced communication skills Possible referral to: • Podiatry • Physiotherapy • Orthotist • Neurology • Vascular services

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
		Possible referral to: • Stroke services • Continence services • Memory Clinic • Personal health budget assessment • Mental health and wellbeing coach • Healthy living services e.g. weight management, smoking cessation, eating well, substance misuse • Community assets e.g. Park Run, food bank • Care navigators • Neurology • Vascular services • Stroke services • Continence services • Memory Clinic • Personal health budget assessment • Mental health and wellbeing coach • Healthy living services e.g. weight management, smoking cessation, eating well, substance misuse • Community assets e.g. Park Run, food bank • Care navigators

The older adult

Demonstrate knowledge of age-related pathology affecting the lower limb in the older adult and their individual needs.

Demonstrate knowledge and skill in the identification and assessment of influencing factors such as psychosocial wellbeing, risk factors, and prognostic indicators

Core clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Demonstrate knowledge of the aetiology, pathophysiology, and treatment of any new or existing age-related condition affecting the lower limb • Identify the need for, and initiate immediate investigation, treatment, or referral for the older adult presenting with: acute and suspected limb or life-threatening symptoms changes in mobility multi-morbidity polypharmacy for conditions impacting the lower limb • Take a structured and appropriate history of an older adult presenting with any new or existing pathology which affects the lower limb or mobility • Perform appropriate assessment(s), including falls risk where appropriate • Initiate appropriate tests based upon differential diagnosis • Accurately interpret, analyse, and synthesise test results to inform treatment planning	**Patient presentations** • Reduced mobility, balance or strength affecting the lower limb • increased fall risk or recent fall • foot/lower limb fracture • change in sensation or increased pain affecting the lower limb • Hard skin (callus), corns or other break in the skin or skin lesion • Nail changes such as thickened or painful nails	• Lower limb musculoskeletal examination and gait analysis • Pain assessment • Quality of life assessment • Use of validated assessment scores • Use of validated risk calculators • Diagnostic or monitoring blood tests - ESR & CRP, urate, vitamin D, AST, ALT, FBC (neutrophils, Hb, platelets), eGFR, HbA1C, with MDT interpretation • Imaging – x-ray, CT, MRI, US, and use of appropriate/ related scoring or diagnostic criteria, with MDT interpretation • Use of personalised approaches to care, e.g. inc. advanced communication skills

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for additional professional support/ referral • Initiate appropriate referral based upon differential diagnosis • Initiate appropriate management / personalised care plan based upon differential diagnosis • Initiate, review, instruct and support service users in the use of medicines and devices • Ensure records are accurate, concise, and contemporaneous using appropriate terminology • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person • Advise and explain self-care measures where treatment is not routinely provided by the NHS	**Existing conditions** • Cardiovascular pathology • Skin and nail pathology • Musculoskeletal pathology • Neurological pathology	Possible referral to: • Podiatry • Physiotherapy • Occupational Therapy • Orthotist • Frailty services • Rheumatology • Orthopaedics • Podiatric Surgery • Vascular services • Social Care team • Personal health budget assessment • Mental health and wellbeing coach • Healthy living services e.g. weight management, smoking cessation, eating well, substance misuse • Community assets e.g. Park Run, food bank • Care navigators

Children and young people

Demonstrate knowledge of age-related pathological differences in children and young people and their individual needs.

Demonstrate knowledge and skill in the identification and assessment of influencing factors such as psychosocial wellbeing, risk factors, and prognostic indicators

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Demonstrate knowledge of the aetiology, pathophysiology, and treatment of paediatric conditions affecting the lower limb • Identify the need for, and initiate immediate investigation, treatment, or referral for children or young people presenting with: Acute and suspected limb or life-threatening symptoms Atypical gait, posture, balance, coordination, or proprioception • Take a structured and appropriate history of a child or young person presenting with any new or existing pathology which affects the lower limb or mobility • Perform appropriate assessment(s) • Initiate appropriate tests based upon differential diagnosis • Accurately interpret, analyse, and synthesise test results to inform treatment planning	**Patient presentations** • Walking problems • Pain in foot/ lower leg • Excessive joint movement (hypermobile) • Limp • Concern about appearance/ shape of the developing foot	• Identification of what matters to the child/young person and family/ carer(s) • Identification of values, beliefs, and motivations of the child/ young person and their family/ carer(s) as appropriate • Age-appropriate lower limb physical assessment, inc. weight-bearing (WB) and non-WB • Age-appropriate activity/ participation and wellbeing assessment • Age-appropriate mental health assessment • Age-appropriate speech and cognition assessment • Age-appropriate pain assessment

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for additional professional support/ referral • Initiate appropriate referral based upon differential diagnosis • Initiate appropriate management / personalised care plan based upon differential diagnosis • Initiate, review, instruct and support service users/ parents/guardians in the use of medicines and devices • Ensure records are accurate, concise, and contemporaneous using appropriate terminology • Recognise the impact of the presenting problem on the lifestyle and day to day living of the child or young person, and their family or carers • Recognise when a child or young person is ready to transition from paediatric to adult services if appropriate • Ensure the service user has adequate support at home, school, and other setting important to them • Advise and explain self-care measures where treatment is not routinely provided by the NHS	**Existing conditions** • Atypical growth or developmental delay affecting the lower limb • Gait abnormality • Musculoskeletal structural abnormality • Hypermobility • Congenital foot conditions • Unexplained pain or malaise that may be indicative of undiagnosed systemic illness • Developmental foot/ ankle conditions, e.g. Severs Disease	• Use of validated assessment scores • Use of validated risk calculators • Diagnostic or monitoring blood tests - FBC, ferritin, folate, vitamin D, HbA1C, ESR, CRP, creatine kinase, with MDT interpretation • Imaging - x-ray, CT, MRI, US, and use of appropriate/ related scoring or diagnostic criteria, with MDT interpretation • Use of personalised approaches to care, e.g. inc. advanced communication skills Possible referral to: • Podiatry • Physiotherapy • Occupational Therapy • Orthotist • Rheumatology • Orthopaedics • Paediatrics

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
		Possible referral to: • Social Care services • Mental health and wellbeing coach • Healthy living services e.g. weight management, smoking cessation, eating well, substance misuse • Community assets e.g. Park Run, food bank. • Care navigators

12.16 Linking to Advanced Practice Portfolio – top up required to Advanced practice status

The capabilities below are the remaining capabilities, once the Knowledge, Skills and Attributes document has been completed and the FCP Podiatrist is on the Directory at The Health Education England Centre for Advancing Practice, that need to be assessed with triangulated Masters' level evidence to be recognised as an Advanced Practitioner (AP).

Domain A: Person-centred Collaborative Working

Capability 1. Communication and consultation skills This section is completed in the FCP capabilities
Essential knowledge: specific knowledge underpinning capabilities
Critical skills

Capability 2. Practicing holistically to personalise care and promote public and person health	
Essential knowledge: specific knowledge underpinning capabilities	AP 2
Critical skills	
Analyse data and intelligence to critically appraise a 'practice population' to help identify needs of the people who are served, to add value and be mindful of the need to mitigate the impact of health inequalities on individuals and diverse communities. A2(c)	

Capability 3. Working with colleagues and in teams	
Essential knowledge: specific knowledge underpinning capabilities	AP 13
Critical skills	
Initiate effective multi-disciplinary team activity as a lead member and understand the importance of effective team dynamics. This may include but is not limited to the following: service delivery processes, research such as audit/ quality improvement, significant event review, shared learning and development.	

Capability 4. Maintaining an ethical approach and fitness to practice This section is completed in the FCP capabilities
Essential knowledge: specific knowledge underpinning capabilities
Critical skills

Domain B: Assessment, investigations and diagnosis

Capability 5. Information gathering and interpretation This section is completed in the FCP capabilities
Essential knowledge: specific knowledge underpinning capabilities
Critical skills

Capability 6. Clinical examination and procedural skills This section is completed in the FCP capabilities
Essential knowledge: specific knowledge underpinning capabilities
Critical skills

Capability 7. Making a diagnosis This section is completed in the FCP capabilities
Essential knowledge: specific knowledge underpinning capabilities
Critical skills

Domain C: Condition management, treatment, and prevention

Capability 8. Clinical management This section is completed in the FCP capabilities
Essential knowledge: specific knowledge underpinning capabilities
Critical skills

Capability 13. Managing medical and clinical complexity	
Essential knowledge: specific knowledge underpinning capabilities	AP 15
Understand the complexities of working with people who have multiple health conditions whether physical, mental, or psychosocial	A
Understand and be able to manage practitioner and patient uncertainty	B
Critical skills	
Simultaneously manage acute and chronic problems, including for people with multiple problems and take steps to adjust care appropriately.	C
Recognise the inevitable conflicts that arise when managing people with multiple problems and take steps to adjust care appropriately.	D
Communicate risk effectively to people and involve them appropriately in management strategies.	E

Capability 8. Independent prescribing, medicines supply and pharmacotherapy	
Essential knowledge: specific knowledge underpinning capabilities	AP 8
Safely prescribe and/ or administer therapeutic medications relevant and appropriate to scope of practice, including (where appropriate) an applied understanding of pharmacology which considers relevant physiological and/ or pathophysiological changes and allergies.	A
Where a non-medical prescriber (NMP), critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental wellbeing and healthcare provision.	B
Demonstrate knowledge of, and use appropriate source literature where required (e.g. British National Formulary)	C
Understand the legal mechanisms by which drugs may be administered or supplied by Podiatrists and the advantages and limitations of each. Understand the basis on which you may be administering or supplying drugs in your setting.	D
Critical skills	
Advocate personalised shared decision making to support adherence leading to concordance	E
Keep up-to-date and apply the principles of evidence-based practice, including clinical and cost-effectiveness and associated legal frameworks for prescribing. Follow Royal Pharmaceutical Framework guidelines (e.g. medicines optimisation).	F

Where an NMP, or when using Patient Group Directions, practice in line with the principles of antibiotic stewardship and antimicrobial resistance using available national resources.	G
Where an NMP, appropriately review response to medication, recognising the balance of risks and benefits which may occur. Take account of context including what matters to the person and their experience and impact for them and preferences in the context of their life as well as polypharmacy, multimorbidity, frailty, existing medical issues such as kidney or liver issues and cognitive impairment.	H
When prescribing, or supplying/ administering medication, be able to confidently explain and discuss risk and benefit of medication with people using appropriate tools to assist as necessary.	I
Recognise adverse drug reactions and manage appropriately, including reporting where required.	J
When prescribing, or supplying/ administering medication, advise people on medicines management, including compliance and the expected benefits and limitations and inform them impartially on the advantages and disadvantages in the context of other management options.	K
Identify sources of further information (e.g. websites or leaflets) and advice (e.g. pharmacists) and be able to signpost people as appropriate to compliment the advice given.	L
Understand a range of options available other than drug prescribing (e.g. not prescribing, promoting self-care, advice regarding over-the-counter medicines).	N
Facilitate and or prescribe non-medicinal therapies such as psychotherapy, lifestyle changes and social prescribing.	O
Where an NMP, support people to only take medications they require and de-prescribe where appropriate.	P
Maintain accurate, legible, and contemporaneous records of medication prescribed and/ or administered and advice given in relation to medicine or treatments.	Q

Domain D: Leadership and management, education, and research

Capability 14a. Leadership, management, and organisation	
Essential knowledge: specific knowledge underpinning capabilities	AP 14a
Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working.	A
Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit).	B
Demonstrate the impact of advanced clinical practice on service function and effectiveness, and quality (i.e., outcomes of care, experience, and safety).	C
Lead new practice and service redesign solutions with others in response to feedback, evaluation, data analysis and workforce and service need, working across boundaries and broadening sphere of influence.	D
Critically and strategically apply advanced clinical expertise across professional and service boundaries to enhance quality, reduce unwarranted variation and promote the sharing and adoption of best practice.	E
Demonstrate leadership, resilience, and determination, managing situations that are unfamiliar, complex, or unpredictable and seeking to build confidence in others.	F
Lead actively on developing practice in response to changing population health need, engaging in horizon scanning for future development and to add value (e.g. impact of genomics, new treatment, and changing social challenges).	G

Capability 14b. Education and development	
Essential knowledge: specific knowledge underpinning capabilities	AP 14b
Critical skills	
Engage in self-directed learning, critically reflecting on practice to maximise advanced clinical skills and knowledge, as well as own potential to lead and develop both care and services.	A
Promote and utilise clinical supervision for self and other members of the healthcare team to support and facilitate advanced professional development.	B

Advocate for and contribute to a culture of organisational learning to inspire future and existing staff.	C
Facilitate collaboration of the wider team and support peer review processes to identify individual and team learning and support team to address these.	D
Enable the wider team to build capacity and capability through work-based and interprofessional learning, and the application of learning to practice.	E
Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities.	F
Act as a role model, educator, supervisor, coach, and mentor, seeking to instil and develop the confidence of others, actively facilitating the development of others.	G
Actively seek to share best practice, knowledge, and skills with other members of the team, for example through educational sessions and presentations at meetings.	H

Capability 14c. Research and development	
Essential knowledge: specific knowledge underpinning capabilities	AP 14c
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.	A
Evaluate and audit own and others' clinical practice, selecting and applying valid, reliable methods, then act on the findings by critically appraising and synthesising the outcome and using the results to underpin own practice and to inform that of others.	B
Critically appraise and synthesise the outcome of relevant research, evaluation, and audit, using the results to underpin own practice and to inform that of others.	C
Critical skills	
Take a critical approach to identify gaps in the evidence base and its application to practice, altering appropriate individuals and organisations to these and how they might be addressed in a safe and pragmatic way. This may involve acting as an educator, leader, innovator, and contributor to research activity and/ or seeking out and applying for research funding.	D

Lead on quality improvement initiatives/ projects – sharing outcomes and leading change.	E
Develop and implement robust governance systems documentation processes, keeping the need for modifications under critical review.	F
Disseminate best practice research findings and quality improvement project through appropriate media and for a (e.g. presentations and peer review research publications).	G
Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical, and other active researchers.	H

12.17 Advanced practice skills required in addition to FCP KSA

MEDICATION REVIEW & MEDICATION ISSUES Understand the necessary monitoring requirements of medicines and how to act on the results. Understand how to document the details of a medication review on the clinical record system. Have a sound understanding of how repeat prescribing works within the general practice/ primary care and wider teams, e.g. community teams or pharmacy.		
• Be able to review medication in terms of efficacy, need, side effects, safety, clinical cost, and in line with prescribing guidelines and relevant standards. • Assess for concordance and compliance issues considering the people individual circumstances and requirements. • Help people to understand what medication they have been prescribed (or not prescribed) and why. • Act appropriately on alters issued by the MHRA. • Understand the traffic light system for local formulary and medications issued only under shared care agreements.	• Adverse side effects • Ineffective medication • Poor compliance • Overuse of medication • Misuse of medication • Issues with polypharmacy • Abnormal blood test monitoring results • Higher risk groups – requiring risk reduction medicines	• Blood monitoring – U & E, LFT, FBC, drug levels, CRP, TFT • Referral back to secondary care when required

12.18 Agreed Scope of Practice Table - FCP

All FCPs need to evidence capability against the 14 capabilities detailed in the roadmap. In addition to the 14 capabilities, each FCP or trainee needs to agree their scope of practice with their employer. The scope of practice will vary dependent upon the role they are employed for. This tool is to assist that process and document the agreement.

Appendix 12.15.1 above, details key clinical presentations that often present in general practice/ primary care settings. If your role includes being able to assess and manage any of the presentations listed under a system, then that clinical system should be included in your scope of practice and evidence of managing all the presentations listed under that system should be included in your portfolio.

Aspect of clinical presentation	In scope of role? (Y/N)	Rationale:	Agreed between FCP & employer? (Y/N)
Cardiovascular			
Dermatology			
Musculoskeletal			
Neurological			
Older Adult			
Children & Young People			

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