Health Education England

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

A Roadmap to Practice

Developing people for health and healthcare

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Acknowledgements

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Development of the Roadmap to First Contact practice and Advanced practice in Primary Care was project managed by Amanda Hensman-Crook (Health Education England). The Roadmap was led by Dr Neil Langridge (Southern Health NHS Foundation Trust). The development of the clinical and governance frameworks and the Knowledge Skills and Attributes was led by Dr Tim Noblet (St Georges University Hospitals NHS Foundation Trust) with Jodie Smith (Somerset NHS Foundation Trust). Supervision content was led Julia Taylor (Lister House Surgery and Health Education England). Matthew Low (Royal Bournemouth and Christchurch NHS Foundation Trust) provided expertise and support throughout the roadmap's development.

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Glossary

ABBREVIATION	FULL TEXT
AP	Advanced Practice Advanced Practitioner
ARMA	Arthritis and Musculoskeletal Alliance
Band 7 Band 8a	Agenda for Change pay bands 7 = FCP 8a =Advanced Practitioner
CBE	Case Based Examination
CCF	Core Capability Framework
CCG	Clinical Commissioning Group
The Centre	Centre for Advancing Practice
CEP	Clinical Examination Procedure
COT	Consultation Observation Tool
CPD	Continuing Professional Development
CSP	Chartered Society of Physiotherapy
FCP	First Contact Practitioner
FTE	Full time Equivalent
GP	General Practitioner
HEE	Health Education England
HEI	Higher Education Institution
ICS	Integrated Care System
IFOMPT	International Federation of Orthopedic Manipulative Physiotherapists
KSA	Knowledge Skills and Attributes
Level 7 Level 8	Academic level of practice. 7 = Master's 8 = Doctorate
MO	Member Organisation
MPFACP	Multi-Professional Framework for Advanced Clinical Practice in England
MSc	Master of Science
MSF	Multi-Source Feedback
MSK	Musculoskeletal
NHSE	NHS England

ABBREVIATION	FULL TEXT
QAA	Quality Assurance Agency
QIP	Quality Improvement Programme
PCN	Primary Care Network
PDP	Personal Development Plan
PSQ	Patient Satisfaction Questionnaire
RCGP	Royal College of General Practitioners
SMART	Specific, Measurable, Attainable, Relevant, Timebound
WPBA	Workplace-Based Assessment

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 the link to Health Education England's Centre for Advancing Practice.

This is the MSK version of the educational pathway to FCP and AP in Primary Care and is relevant to all experienced professionals specialising in MSK. The framework presented is applicable across adults and children dependent on the scope of practice, appropriate knowledge and skills that may apply to specific patient groups, 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 https://gettingitrightfirsttime.co.uk/.
- As the FCP role evolved (see A retrospective review of the influences, milestones, policies and practice developments in the First contact MSK model), 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 MSK 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 will help to recruit and retain them in Primary Care.

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

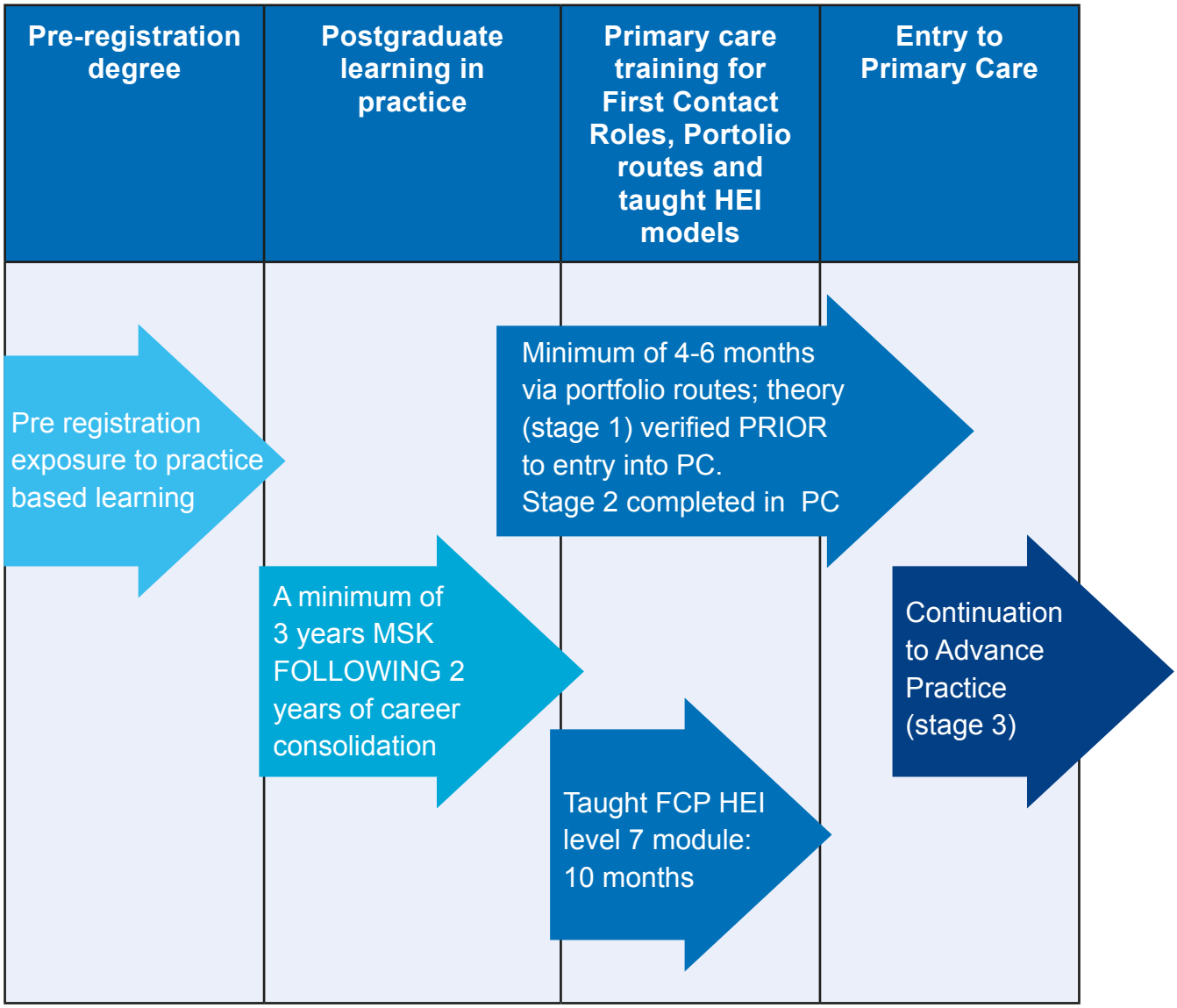


Diagram to illustrate career progression of Primary Care roles.

- Clinicians will need to be supported by a verified FCP AP roadmap 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 Chartered Society of Physiotherapy (CSP), Health Education England (HEE) and NHS England (NHSE).

1. First Contact Physiotherapy posts in General Practice. A guide for implementation in England.
2. Musculoskeletal First Contact Practitioner Services.
3. A retrospective review of the influences, milestones, policies and practice developments in the First contact MSK model.
4. 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 Advanced Practitioners in England.

It is now agreed that FCP roles will also be supported by The Centre in the following ways;

- There will be portfolio routes and taught routes to recognition as an FCP on the directory.
- There will be portfolio routes and taught routes to recognition as an FCP in the Centre directory.
- 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 choose to continue to AP. However, any evidence collected in the FCP portfolio relevant to the AP portfolio domains will be available for further submission, with evidence for the required unmet domains needed for AP status (see appendix 12.13).

- The Knowledge Skills and Attributes (KSA) document describes the prerequisite knowledge, skills, and attributes stipulated for clinical professionals moving into MSK FCP roles within Primary Care (appendix 12.12). Mapping against the KSA document with a portfolio of evidence is the recognition requirement for Stage 1 (see section 5) prior to entry to Primary Care, alongside the eight Primary Care e-learning modules and three personalised care e-learning modules later (see section 5.1).

- Regions will hold a directory of roadmap supervisors. Supervisors will be required to have completed an approved Primary Care two-day training programme (see appendix), 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 masters 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 MSK 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.

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

✔ FCPs refer patients to GPs for the medical management of a patient with non MSK presentations and pharmacology outside their agreed scope of practice

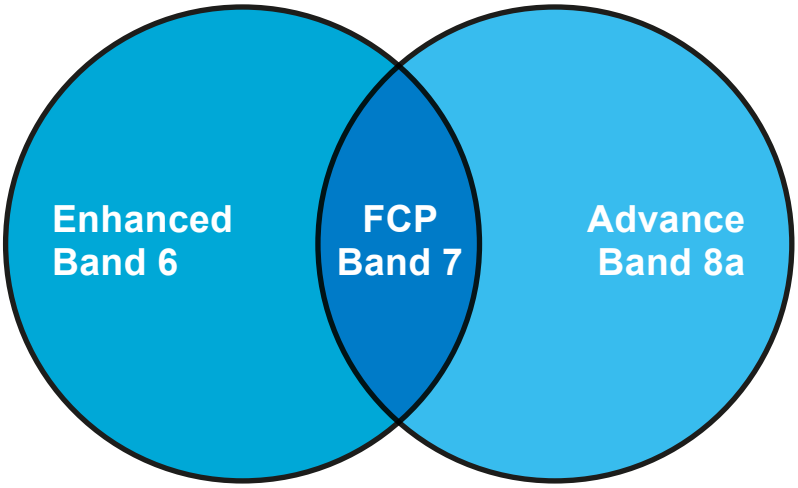


Diagram illustrating the relationship between Bands 6, 7, 8a (AfC), and Enhanced, FCP, and AP.

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

✔ 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.

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 of AP are: Research, Leadership and Management, Education, and Clinical Practice.

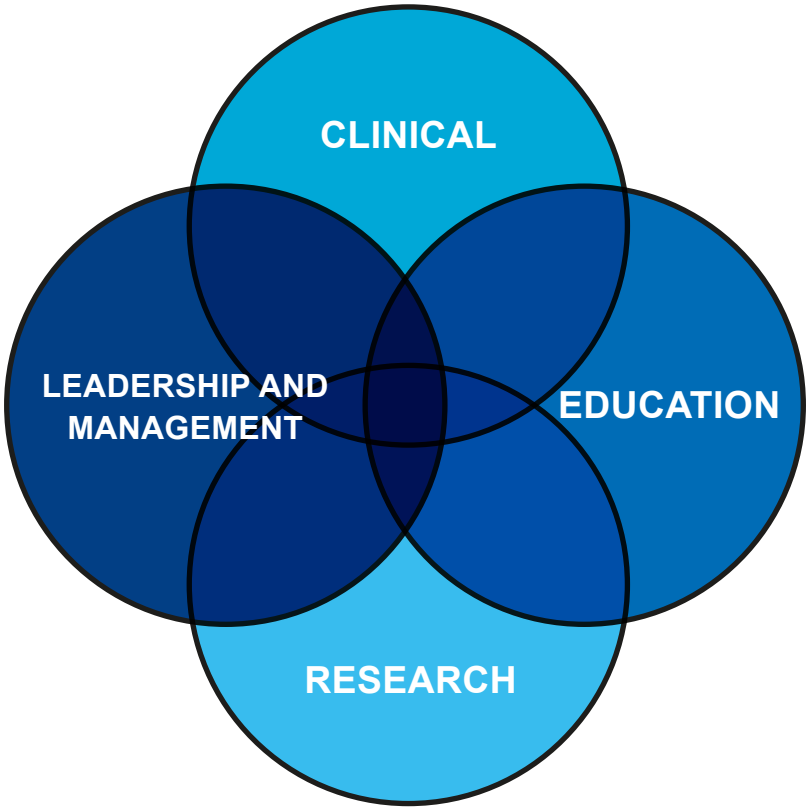


Diagram that illustrates interlinkage of the four pillars of advanced practice.

- An AP works at Agenda for Change band 8a (see 1.3) and above.

- An AP in MSK can be developed from a range of specialties, as long as the evidence (either through an HEI or portfolio route) are mapped against the IFOMPT level 7 standards (See 3.1.2).

1.3 Agenda for Change (AfC) Band 7 and Band 8a – How do they differ?

- 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.

- 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.

- 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 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 practice, across PCN, multi-organisational, cross professions and across care pathways and systems including health, social care, and the the voluntary sectors. • High level complex decision making to inform the diagnosis, investigation, management, and on referral within scope of practice. • Actively takes a personalised care approach to enable shared decision making with the presenting person. • Contributes to audit and research projects. • Contributes to education and supervision within their scope of practice for the multi-professional team. • Facilitates interprofessional 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 practice, across PCN, CCG and ICS, multi organisational, cross professionals and across care pathways and systems including health, social care, and the voluntary sectors. • High-level of complex decision making to inform diagnosis, investigation complete management of episodes of care within a broad scope of practice. • Flexible skill set to adapt to and meet needs of the PCN Population and support public health • Manages medical complexity. • Actively takes a personalised care and population-centered care approach to enable shared decision making with the presenting person. • Actively engages in care from a Population care viewpoint. • Leads audit and research projects. • Leading audit within areas of capability. • Provides multi-professional AP clinical and CPD supervision across all four pillars with relevant training. • Leads education in their area of expertise. • Enables, facilitates, and supports change across care pathways and traditional boundaries • Working toward level 8.

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 of practice, 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 12.13).
- Level 7 practice requires complex clinical reasoning skills and critical thinking.
- The QAA (2010) MSc Level 7 descriptors are found below (table *) and via the 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.** Generic attributes (including skills relevant to an employment-setting): A range of generic abilities and skills 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.

*TABLE *: Assurance Agency (2010) MSc Level 7 descriptors*

2.0 Primary Care Educational Pathways

There are two main educational pathways to practice in Primary Care:

- FCP portfolio and taught routes with onward portfolio route or a taught AP master's to AP in Primary Care.

- AP portfolio or taught routes with the addition of the required Primary Care KSA training.

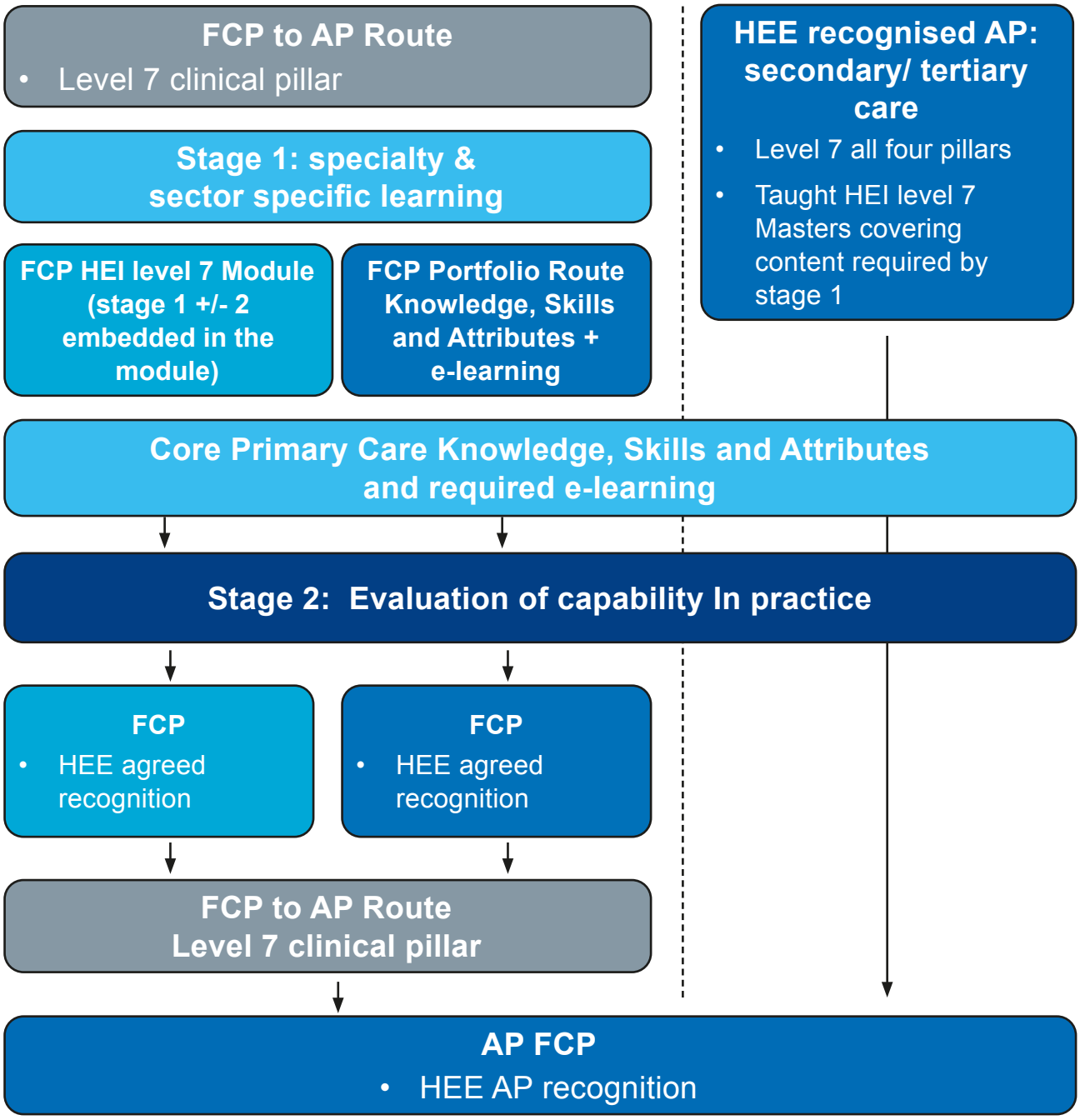


Diagram to illustrate pathways to FCP and AP in Primary Care

3.0 National standards and frameworks for MSK practitioners

- There are a number of important frameworks that underpin this roadmap.
- It should be noted that the KSA is built upon these national frameworks that support MSK FCP and AP.
- 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 is important as it ensures evidence is used systematically, in a time-efficient way to ensure duplication is minimised.
- The MSK frameworks are relevant to all MSK professions.

3.1 MSK Core Capabilities Framework (MSK CCF)

MSK Core Capabilities Framework

- Within Primary Care, the particular capabilities required to be safe and competent in musculoskeletal practice have been assessed and published. The standard of competency within this environment has been formally addressed by the "MSK Core Capabilities Framework" (2018), which was a joint collaborative project involving Skills for Health, Health Education England, NHS England, Public Health England, and the Arthritis and Musculoskeletal Alliance (ARMA).
- The MSK CCF was aimed at practitioners who will be the first point of contact for people with musculoskeletal conditions.
- The work was built around clear research principles (Delphi Consensus) and the methods/methodology has been published (Chance-Larsen et al 2019).
- It was aimed at any practitioner who, with the suitable professional skills and knowledge, was able to provide a first point of contact MSK assessment and management plan within a Primary Care environment.

- It sets out a number of clear domains of practice. 14 capabilities are housed within the four domains (Person-Centred Approaches; Assessment, Investigation and Diagnosis; Condition Management, Interventions and Prevention; and Service and Professional Development).

- The QAA level 7 framework (master's) allows clinicians and relevant stakeholders to understand the clinical requirements of the role, and further cements the governance in terms of competence and capability (see 1.4).

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

- The MPFACP (2017) was a vital publication as it standardised the domains of practice at this high level of advanced clinical skill, incorporating clinical skills, leadership, education, and research pillars.

3.1.2 IFOMPT

- The International Federation of Orthopaedic Manipulative Physiotherapists (IFOMPT) represents physical therapists around the world who have completed post-registration/post-graduation specialisation programmes in the field of neuro-musculoskeletal disorders.

"It is a Federation that sets educational and clinical standards in this area of physical therapy. IFOMPT actively encourages improved patient management by its Standards Document and by actively endorsing evidence-based practice. IFOMPT is a subgroup of World Physiotherapy and was formed in 1974." (www.IFOMPT.org)

- IFOMPT developed international educational standards that detail the learning objectives and competencies for specialist MSK physiotherapy practice. These educational standards are the foundation of the UK MSK Advanced Practice Standards.

- The standards cover theoretical, practical, and clinical knowledge required by practitioners working across the MSK specialties.

- The acceptance and implementation of the educational standards, both theoretical and practical, are a mandatory minimum in meeting the requirements.

- The standards have been mapped against the MPFACP (which is generic and not specific to MSK) and were found to fulfil all of the framework's requirements (both at QAA level 7) (Noblet, Heneghan, Hindle, Rushton 2020, in press).

3.1.3 Linking the Frameworks

- The MSK CCF recognition process aligns the clinician across the majority of the **Clinical Practice Pillar** in advanced practice and partially across the other three. This is an important differentiation (see appendix 12.13).

- The MSK CCF does not equate to advanced practice; its focus is to be the framework supporting FCP and therefore the majority of a clinical pillar within AP.

- To help the clinician navigate this, the clinician should utilise the **"Knowledge, Skills and Attributes"** (KSA) document that offers the initial (Pre-Primary Care Stage 1) MSK recognition (see appendix 12.12).

- This document signposts the 'trainee' FCP to domains of practice that can be fulfilled through the supervision process, and the evidence produced can be cross-referenced against the MSK CCF and the IFOMPT standards.

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

- The diagrams below highlight the building of the documentation and evidence, and how evidence in practice can be built towards further competency and learning.

- The KSA builds evidence that underpins the MSK CCF. As the 'trainee' FCP achieves this, the documentation highlights to the 'trainee' FCP how this evidence also adds evidence to the IFOMPT capabilities, which have been mapped as the MSK standards of advanced practice underpinning the MPFACP.

- This takes the trainee FCP with their portfolio through levels of practice that start in MSK practice, work into Primary Care, and ultimately support the final completion of an AP portfolio ready for submission and recognition.

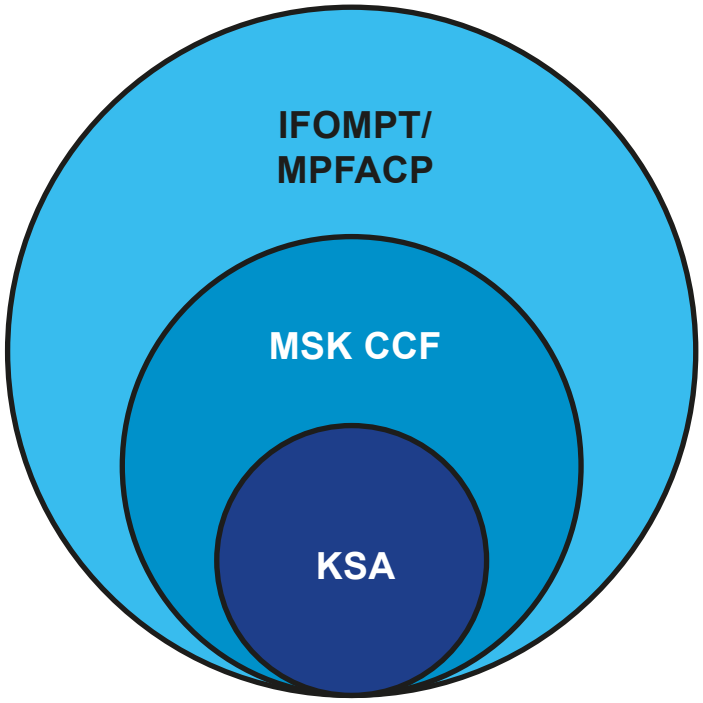


Diagram to show the relationships between the frameworks.

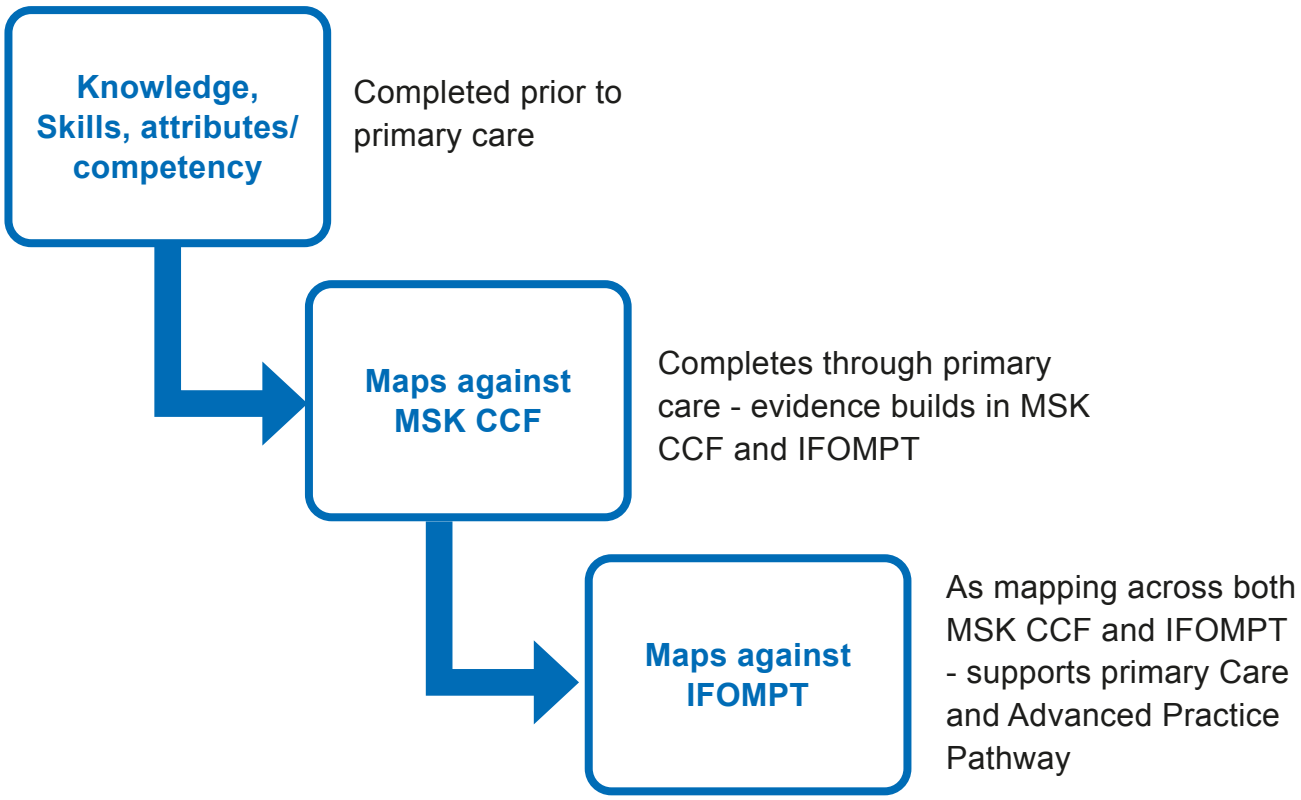


Diagram to show the building of evidence towards the frameworks.

- **The Musculoskeletal (MSK) Core Capability Framework**
- **The Multi-Professional Framework for Advanced Clinical Practice**
- **The International Federation of Orthopaedics Manipulative Physiotherapists (IFOMPT) standards**

3.2 Building the evidence

In order to develop a coherent professional career infrastructure, the MSK workplace should include several key features.

- 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 8.0).
- Clinicians and supervisors should familiarise themselves with the national frameworks concerning FCP and AP (see 3.0), on which the structure of a portfolio of evidence can be based. The KSA can be evaluated in order to determine any immediate learning needs prior to any FCP role. The learning needs can be traced dependent upon whether the clinician is working towards FCP or AP.
- Essential requirements of the clinician in their journey are ongoing reflective practice, peer review, patient feedback, and the monitoring of personal wellbeing in order to provide an enriched learning experience. The appendices of this document provide further information on 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 and ACP where indicated.
- The ‘trainee’ FCP will be positioned ready for recognition once a portfolio of evidence has been developed alongside the support from the supervisor.

- As the practitioner 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 practitioner 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, MSK CCF, IFOMPT, and MPFACP will inform the learner and supervisor of capabilities and standards that the learner can work towards even prior to attaining a role as an FCP and AP.

- The KSA document aids the learner to build their evidence prior to embarking on their FCP recognition process (Stage 1), working up to Primary Care (Stage 2), and also allows the learner to build evidence against the MSK QAA level 7 international standards (IFOMPT) (Stage 3) (see below for further details).

- FCPs need to maintain a portfolio of evidence to demonstrate their progress and evidence which capabilities they have met. As FCPs they need evidence across all the FCP capabilities for their profession and scope.

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. All 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 a FCP or AP in Primary Care to assure patient safety. For MSK clinicians 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 6 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 Centre for Advancing Practice Directory 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 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 an optional 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 for Advancing Practice is operational.

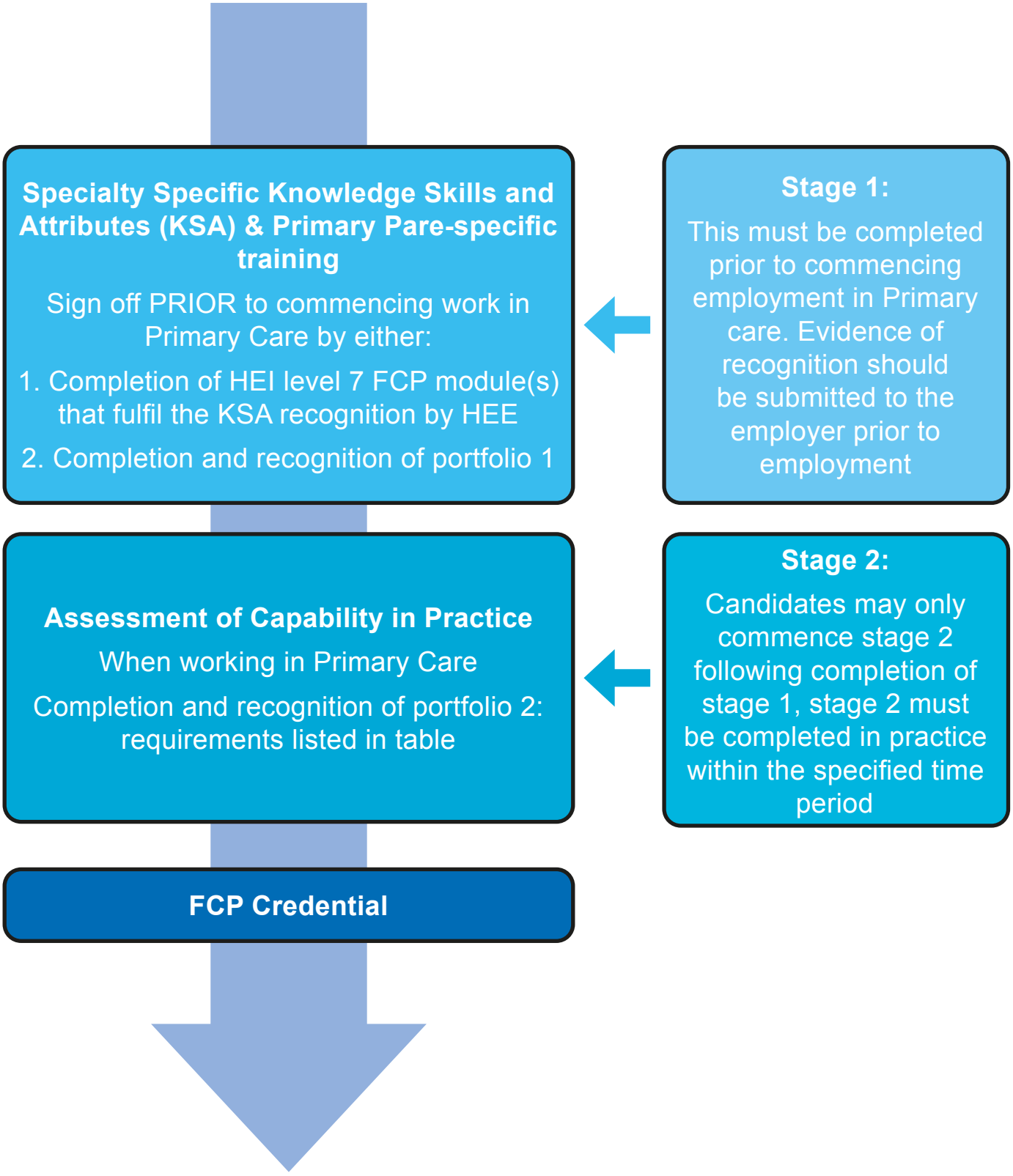


Diagram to illustrate the process of FCP recognition.

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 a number of important electronic modules, which are housed within the E-Learning For Health portal. These are free to access for NHS staff and can be accessed by external partners for a small fee (e-integrity).

- The Primary Care modules cover areas such as managing complexity, mental and public health, illness identification, and red flags, and are also complemented by the personalised care modules. Clinicians are required to complete all modules associated with both programmes. For external partners, links the clinician to an external annual licence agreement.

- Once these e-learning programmes have been completed, the learner must access an appropriately trained AP supervisor (see section 5 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 12.12).

5.2 Next steps

- The supervisor and 'trainee' FCP will create a plan that will be based on their profession and/or speciality-specific KSA and AP frameworks as required.

- The 'trainee' FCP is advised to register with the HEE advanced practice process once launched (date TBC) and utilise the online portal and CPD portfolio. This will allow the 'trainee' FCP to upload evidence against this pathway, which can be transferable across all CPD including Primary Care. In the interim, they are advised to keep a folder of evidence ready to transfer to the portal once live.

- The ‘trainee’ FCP then begins the process of portfolio of evidence development against the KSA document prior to embarking into Primary Care. This evidence can be cross-referenced against the advanced practice MSK standard (IFOMPT) and will allow the ‘trainee’ FCP to build evidence towards Primary Care (FCP) and AP. Evidence can be from practice, from educational institutions, or from both as required. Once these processes are complete, the individual can embark into Primary Care.

- If an individual does not wish to complete a portfolio route to FCP, they could access an HEI FCP MSc level 7 module for MSK. They will still be expected to complete the online e-learning modules and have their KSA verified, but their Primary Care recognition will occur within the module itself and will 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 on their learning/career journey towards AP.

- 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 12.12** is for use for as part of the process of recognition of an FCP. Each capability is described. To the left of each capability there is a cross reference to the MSK CCF and to the right of each capability there is a cross reference to the IFOMPT standard. This allows the trainee FCP to build evidence for their portfolio for Primary Care and towards AP if indicated.

6.0 Stage 2: Moving into Primary Care

On completion of the KSA recognition (Stage 1), the trainee FCP can then build their Primary Care portfolio in practice (Stage 2). These tasks comprise the core Primary Care knowledge and skills (appendix 12.12 outlines the requirements for Stage 1 and Stage 2 as a checklist).

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 need to maintain a portfolio of evidence to demonstrate their progress and evidence the capabilities they have met. As FCPs they need evidence across all the FCP competency for their profession and scope, using the portfolio and WPBA materials.

Each FCP and AP should keep a Learning Log that includes regular reflection on cases where they have identified learning needs. Detailed evidence that they have achieved competency should then be provided within the log.

While specific evidence may be suggested at the advice of the supervisor to support recognition, it is advised that the portfolio for recognition includes the following:

For FCP (see appendices for tools)

- Personal Development Plan (PDP) identifying SMART objectives (with formal six-month and yearly reviews)

- A record of modules successfully completed at university

- A contemporary record of mandatory training, including BLS and Safeguarding
- Reflective learning logs – minimum of one a week
- A record of Workplace-Based Assessments to include a minimum of:
    - *consultation observation tool (COT) – one per month (FTE)*
    - *a case-based discussion (CBD) – one per month (FTE)*
    - *a range of clinical examination procedural skills (CEPs) (including any mandatory for the profession)*
- Quality Improvement Projects/Audit - showing ongoing engagement with QIP/audit – audits follow the audit cycle, shows systematic change/leaves a legacy
- Any 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

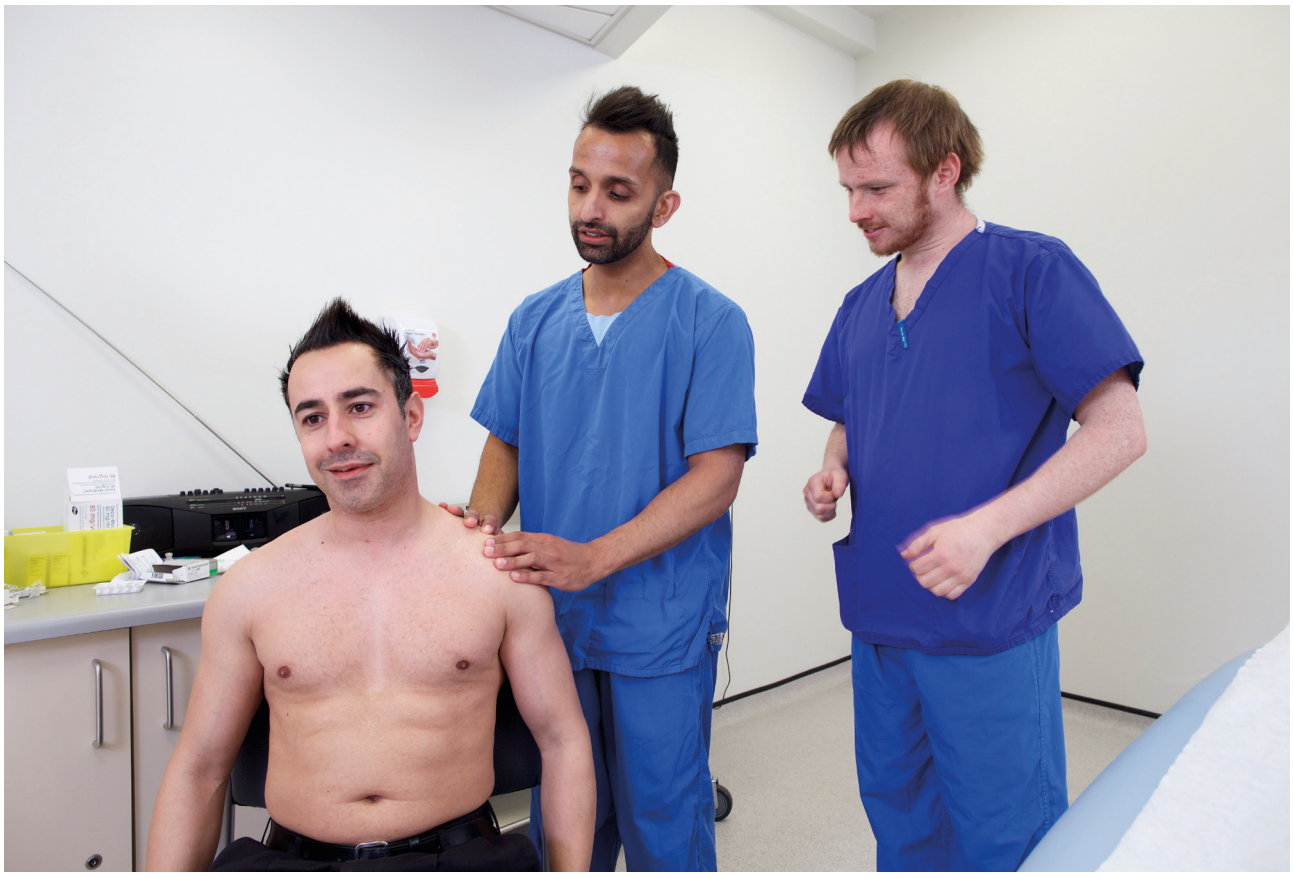
7.0 Building the portfolio

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.'

The Chartered Society of Physiotherapy (CSP) has produced a portfolio guide linked to an outcomes approach to CPD (CSP, 2016), which provides an overview of the different stages of the portfolio from a practical perspective as well as useful self-assessment tools and proformas, which may help you to identify and evaluate your learning.

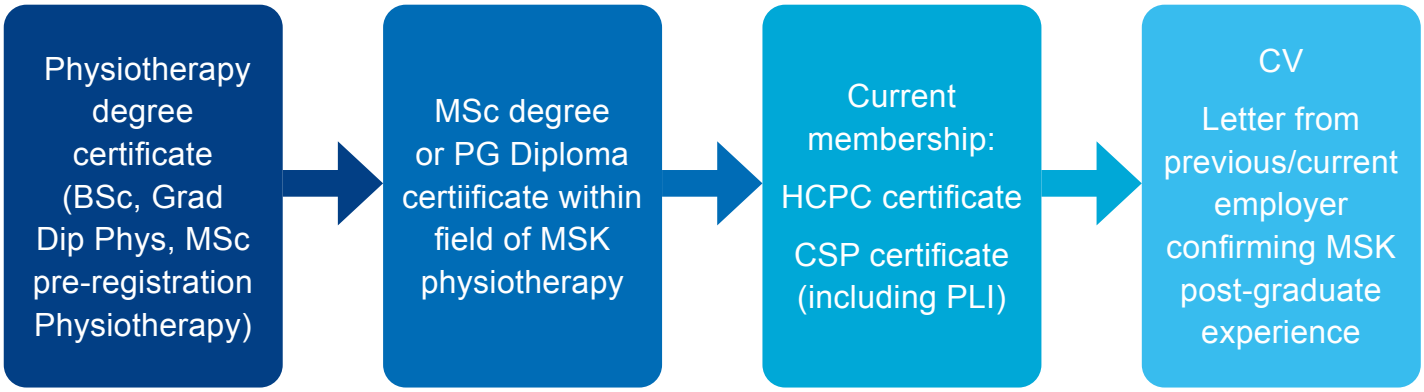
Recommended reading on reflective practice and the development of a portfolio of evidence can be read ont he CSP website under 'Keeping a CPD portfolio'.



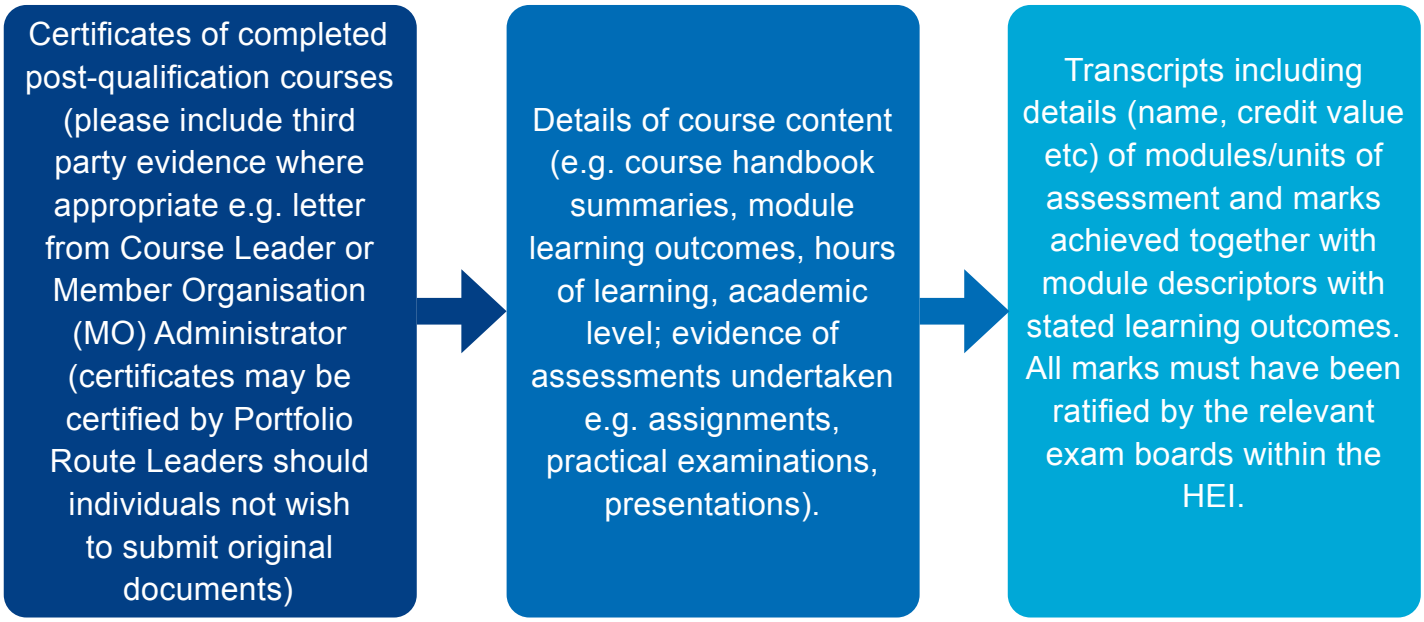
STEP 1: COLLATE KEY DOCUMENTS TO INCLUDE IN YOUR PORTFOLIO

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

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



(3) MUSCULOSKELETAL EDUCATION



STEP 2: COLLATE AND DOCUMENT

Upload your key documents to the digital portfolio online and use the portfolio to link the evidence to the specific knowledge, skill, and/or attribute. Build your portfolio until you and your supervisor are happy that all Knowledge, Skills and Attributes are adequately evidenced at a QAA level 7 standard. Once you are satisfied that all competencies are adequately evidenced and mapped, submit your portfolio for assessment.

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 undiagnosed MSK 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 requirements - Stage 1

3. A verified portfolio of evidence cross-referencing against the domains of the Knowledge, Skills and Attributes document (see KSA section – Stage 1) - Stage 1

4. A portfolio of triangulated evidence of Primary Care training - Stage 2

Assement Criteria Level M

Study at masters level will have been at, or informed by the forefront of an academic or professional discipline. Students 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 wlil show originality in tackling and solving problems (QAA Framework for Higher Education Qualifications, 2001)

Masters 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

Levels are inclusive of all citeria below that level and also assessed against module learning outcomes.

9.0 Roadmap supervision and verification

Roadmap Supervision and Verification is a process of developing a portfolio of evidence both academically and 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 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 (see appendix 12.1).

9.2 Clinical supervision

Clinical supervision is often referenced 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. It should provide good-quality feedback to help with safely managing practitioner and patient uncertainty. Clinical supervision should help to build confident capability, clinical reasoning, and critical thinking. It also includes Workplace-Based Assessment (WPBA) to assess the application of knowledge, skills, and behaviours in Primary Care. The WPBA allows for a portfolio of triangulated evidence against the appropriate framework. Clinical supervision is mainly formative but there may be a summative element (see appendix 12.1).

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 work-place based assessments (WPBA) and often includes:

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

9.3 Supervision requirements

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

This course will include:

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

9.4 Checklist of recognition processes: Stage 1 and Stage 2

The table below shows the recognition form to be kept by the clinician for evidence of completion.

Documents for the completion of each section are found in appendices: **Stage 1:**12.12 (KSA), **Stage 2:**12.2 – 12.10

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 in Primary Care Once both parts are completed, the recognition survey must be completed		
CONTENT	**NUMBER**	**DATE & CS SIGNATURE**
STAGE 1		
1. Knowledge, Skills and Attributes verified	Portfolio of evidence required	
2. All eight Primary Care e-learning modules completed	Certificates from modules required	
3. Personalised care e-learning modules	Certificates from modules required	
STAGE 2		
Personal Development Plan (PDP) identifying SMART objectives	Need evidence that it has been developed – regularly updated	
A record of modules successfully completed at university – dates of completion		

A record of mandatory training including BLS and Safeguarding – dates of completion	As per mandated requirement. Can be from Blue Stream or equivalent	
Reflective log entries	Minimum of one a week over a range of capabilities – verified when capable	
Consultation observation tool (COT)		
To include face-to-face, telephone, and video	Minimum of one per month – verified when capable	
Case-based discussion (CBD)	Minimum of one per month – verified when capable	
A range of clinical examination procedural skills	To reflect any required procedural skills or any required for the profession – verified when capable	
Participation in Quality Improvement Projects (QIP)/audit – showing ongoing engagement with QIP/audit – audits follow the audit cycle, shows systematic change/leaves a legacy	At least one completed audit or QIP but demonstrating an 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 – five clinical and five non-clinical	Minimum of one round	
Significant Event Analysis	At least 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. Have a portfolio of triangulated evidence cross-referencing against the domains of the Knowledge, Skills and Attributes document, having completed the e-learning modules plus the outstanding domains as referenced in the **'Linking KSA/Primary Care Recognition to AP Capabilities'** document (see below).

2. For the taught ACP 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.

Checklist for recognition from FCP to AP

FOR ADVANCED PRACTICE – ALL OF THE ABOVE FOR FCP PLUS		
Evidence of managing medical/clinical complexity/ case load	Range of WPBA & reflective learning logs	
Leading audit/QIP and sharing the learning, impact on PCN practice	At least one full audit cycle/ QIP	
Evidence of management and leadership pillars E.g. chairing meetings, leading teams, working across PCN teams, across boundaries with other settings	Reflective learning log entries - minimum of one per week over a range of capabilities & all four pillars MSF feedback	
Evidence relating to the education pillar E.g. teaching, working with HEI, faculties of AP	Reflective learning log entries - minimum of one per week over a range of capabilities & all four pillars MSF feedback	
MSK ONLY: Completion of the MSK Advanced Practice Standards	As per MSK Advanced Practice Standards documentation	

10.1 Linking to Advanced Practice in Primary Care portfolio (MSK)

- The document **'Linking KSA/Primary Care Recognition to AP Capabilities' (see appendix 12.13)** allows evidence to be built against the KSA **(Stage 1)** requirements and as the clinician develops further into Primary Care **(Stage 2)** and on to AP **(Stage 3).**

- At this stage the use of the IFOMPT framework becomes important and this document supports the process.

- Each FCP prerequisite KSA is mapped to the relevant IFOMPT dimension (learning outcome and/or competency), fulfilling a subset of the clinical standards required by MSK advanced practitioners.

- A completed portfolio can therefore be used to evidence fulfilment of a specific subset of the clinical pillar required for recognition as an MSK AP, and can be transferred across to an AP portfolio.

The clinician 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 an MSK Advanced Practitioner in Primary Care on completion of the AP level of practice.

- The required Knowledge, Skills and Attributes that are essential to First Contact practice, and must be demonstrated as a portfolio of evidence, are highlighted in blue.

- Following recognition as an FCP, practitioners must evidence the remaining IFOMPT Knowledge, Skills and Attributes, plus the additional 'bolt-on Knowledge, Skills and Attributes' required by the UK-specific musculoskeletal advanced practice standards, prior to submitting a portfolio to seek advanced practitioner status. These are highlighted in white.

When an FCP has completed their FCP portfolio, they would then need to build the evidence against the competencies shown in white to work towards AP. This could be completed through an appropriate registered AP pathway, such as a special interest group or directly via the HEE portal. This is to be determined.

11.0 Useful resources

11.1 Online learning

Below is a list of e-learning packages that may support your learning needs in an FCP role.

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.

Cost: varies.

11.2 Leadership development

The CSP Leadership Development Programme is a two-semester modular programme delivered using a variety of stimulating, engaging, and interactive learning methods to help develop your leadership skills.

Cost: Applicants can apply for places via the CSP.

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 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.

NHS has a range of self-help resources.

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.

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 around £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 around £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.

12.0 APPENDICES

12.1 Roadmap supervision flowchart

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.

WHY?

- **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).

Clinical Supervisor (CS)

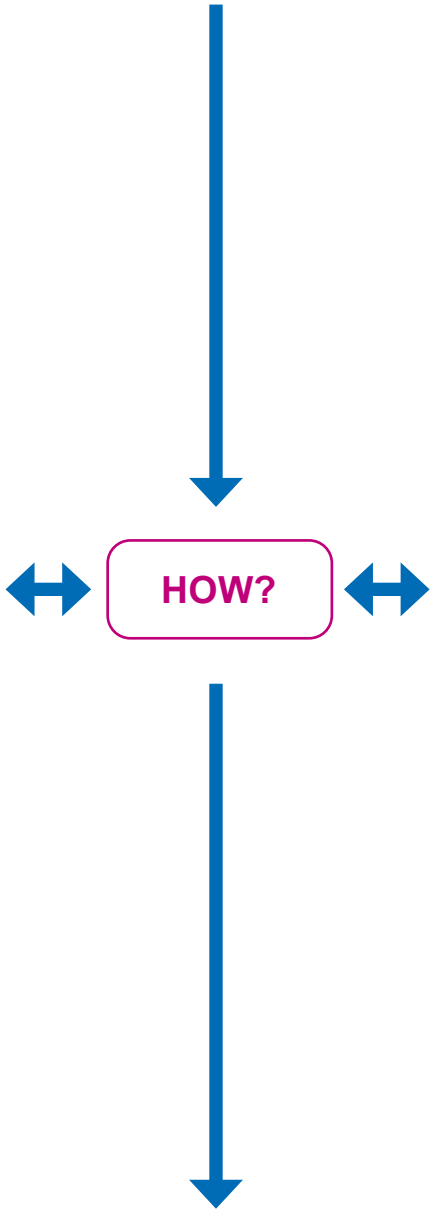
- The CS takes **clinical responsibility** for patient and practitioner safety.
- Need a **flexible approach** – one size does not fit all!
- Primarily focused on the **Clinical Pillar** but can consider the other three
- Often a GP but could be a senior ACP level practitioner in primary care.

WHO?

CPD Supervisor (CPDS)

- The CPDS needs an understanding of ACP, FCP and requirements for **professional registration, revalidation** if appropriate.
- Ideally an ACP 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.



- 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

FCP Name:	
Clinical Supervisor Name:	
Presenting Case:	
Date:	

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

CAPABILITIES	QUESTIONS	EVIDENCE OBTAINED	GRADE
Communication & consultation skills **A1** **B3** **B4**			
Practising holistically to personalise care and promote public and personal health **A2** **B3** **C6, C7, C12, C13**			

CAPABILITIES	QUESTIONS	EVIDENCE OBTAINED	GRADE
Working with colleagues and in teams **C10** **D14**			
Maintaining an ethical approach & fitness to practice **A1**			
Information gathering & interpretation **A1**			

CAPABILITIES	QUESTIONS	EVIDENCE OBTAINED	GRADE
Clinical examination **B5**			
Making a diagnosis **B3, B4, B5**			
Clinical management **B3, B4, B5** **C6, C7, C12, C13**			

CAPABILITIES	QUESTIONS	EVIDENCE OBTAINED	GRADE
Independent prescribing, pharmacotherapy & treatment **B3, B4, B5** **C6, C7, C8 C9, C12, C13**			
Leadership, management, and organisation **D14**			
Education and development **C11**			

CAPABILITIES	QUESTIONS	EVIDENCE OBTAINED	GRADE
Research and evidence-based practice D14			

FEEDBACK
ACTION PLAN

Cased-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 https://www.rcgp.org.uk/training-exams/training/mrcgp-workplace-based-assessment-wpba/cbd-for-mrcgp-workplace-based-assessment.aspx.

Good practice would be for the FCP to send the Clinical Supervisor (CS) three or four cases – they could do this by sending a task on SystmOne, 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. MSK, children, older adults, mental health, etc.

The CS should ask the FCP 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; the discussion should not shift into a test of knowledge. The Clinical Supervisor should aim to cover as many relevant capabilities as possible in the time available. It is unrealistic to expect all capabilities to be covered in a single CBD, but if there are too few you won't 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 the CS should provide some written feedback for the FCP - What went well and why? Any working points?

12.3 Clinical Examination Procedural (CEP) Skills Assessment FCP

FCP Name:	
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?

Guidance when assessing clinical examination procedural skills (CEPs) for FCP

CEPs is a Workplace-Based Assessment.

It provides a way of assessing what the trainee does in practice day-to-day, how they apply their knowledge, skills, communication skills etc. 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 FCP maintain an empathetic approach throughout?
- Does the FCP explain what is going on throughout the procedure?
- Are their findings accurate? Findings should be checked by the Clinical Supervisor.
- Does the FCP 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.

CEPs can be used to help gather evidence of capability and include a range of skills/ examinations.

12.4 Clinical Supervisor's Report

FCP 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) (Capability A1)	Grade
Works in partnership to negotiate a plan (Capability A1)	Grade
Recognises the impact of the problem on the person's life (Capabilities A1, A2, C10)	Grade
Works co-operatively with team members, using their skills appropriately (Capabilities A1, C10)	Grade
DIAGNOSTICS	
Takes a history and investigates systematically and appropriately (Capability A1)	Grade

Examines appropriately and correctly identifies any abnormal findings (please comment on specific examinations observed) (Capabilities B3, B4, B5)	Grade
Elicits important clinical signs & interprets information appropriately (Capabilities B3, B4, B5)	Grade
Suggests an appropriate differential diagnosis (Capabilities B3, B4, B5)	Grade
Refers appropriately and co-ordinates care with other professionals (Capabilities C6, C7, C10, C12, C13, D14)	Grade
MANAGEMENT	
Keeps good medical records (Capabilities A1, D14)	Grade
Uses resources cost-effectively (Capabilities B3, B4, B5, C9, C10)	Grade
Keeps up-to-date and shows commitment to addressing learning needs (Capability D14)	Grade

PROFESSIONALISM	
Identifies and discusses ethical conflicts (Capability A1)	Grade
Shows respect for others (Capabilities C10, D14)	
Is organised, efficient, and takes appropriate responsibility (Capability D14)	
Deals appropriately with stress (Capabilities D14)	

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

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

Are you aware if this FCP 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 FCP's fitness to practise or conduct? *

12.5 Consultation Observation Tool: marking/notes sheet – FCP

FCP Name:	
Clinical Supervisor Name:	
Presenting Case:	
Date:	

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

Criterion	Grade	Evidence
<u>Discovers the reason for the person's attendance</u>		
Encourages the person's contribution **Capabilities A1, B3**		
Responds to cues **Capabilities A1, B3**		
Places presenting problem in appropriate psychosocial context		

Criterion	Grade	Evidence
Capabilities A1, B3, B4, B5		
Explores person's health understanding Capabilities A1, B3		
<u>Defines the clinical problem</u>		
Includes/excludes likely relevant significant condition Capabilities B3, B4, B5		
Appropriate physical or mental state examination Capability B3, B4, B5		

Criterion	Grade	Evidence
Makes appropriate working diagnosis **Capabilities B3, B4, B5**		
<u>Explains the problem to the person</u>		
Explains the problem in appropriate language **Capabilities A1, B3**		
<u>Addresses the person's problem</u>		
Seeks to confirm the person's understanding **Capabilities A1, B3, C11**		
Makes an appropriate shared management/personalised care/support plan **Capabilities A1, C6, C7, C10, C11 C12, C13**		

Criterion	Grade	Evidence
Person is given the opportunity to be involved in significant management decisions Capabilities A1, C6, C7, C10, C11 C12, C13		
<u>Makes effective use of the consultation</u>		
Makes effective use of resources Capabilities B3, B4, B5, C9, C10		
Condition and interval for follow up are specified Capabilities A1, B3, B4, B5, C11		

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.

Consultation Observation Tool (COT) – guidance & consent form

Clinical Supervisors use the Consultation Observation Tool (COT) to support holistic judgements about the FCP 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.

Person consent

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

Selecting consultations for COT

Either record a number of 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 FCP role, e.g. MSK, children, older adults, mental health, etc. The ACP (Primary Care Nurse) 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 FCP 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. But don't spend a lot of time recording different consultations. COT is not a pass/fail exercise; it's part of a wider picture of FCP.

Collecting evidence from the consultation

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

Consent form for recording 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 FCP who you are seeing today. The recordings are used by FCP to review their consultations with their supervisors. The recording is ONLY of you and the FCP 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 FCP 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 FCP 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)

FCP'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 FCP's overall professional behaviour (please tick)

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

Notes: You may wish to consider the following:

The FCP:

- 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 FCPs overall clinical performance (please tick)

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

You may wish to consider the following about the ACP (Primary Care Nurse):

- 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

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 FCP. The FCP 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 be capable in shoulder injections*	*Three months*	*Undertake two CEPS assessments with my Clinical Supervisor*	*When my CS has signed off two shoulder injection CEPs as capable*

FCP - portfolio reflection.

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?

FCP: .....

Supervisor: .....

12.8 Person Satisfaction Questionnaire (PSQ) for an FCP

Hello,

We would be grateful if you would complete this questionnaire about your visit to the First Contact Practitioner (FCP) today. The FCP 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 FCP 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

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

Person Satisfaction Questionnaire (PSQ) Guidance

A PSQ has been included for use as 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

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

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

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 clinician through the roadmap to FCP and onward to AP via the portfolio routes, there is a two-session multi-professional supervisor course that will soon be available. 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 supervisors regionally and regions will hold a directory of Roadmap supervisors.

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 FC & AP? 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 FC 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) - how to write a SMART PDP Being a reflective practitioner Overview of learning and teaching styles Supporting trainees/practitioners in/with 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 (requirements for FC & AP) Educational, leadership & management evidence for AP Reviewing progression Verification processes with Centre for Advancing Practice

12.12 Knowledge, Skills and Attributes document

Domain A: personalised approaches

DOMAIN A: PERSONALISED APPROACHES https://www.england.nhs.uk/personalisedcare/ **Capability 1. Communication** **Capability 2. Personalised care**		
Cross-referenced MSK CCF	**Essential knowledge: Specific knowledge underpinning capabilities 1 & 2**	Cross-referenced IFOMPT
A.1	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.	D7.K1 D7.K2 D7.K3 D7.K4
A.2	Demonstrate comprehensive advanced knowledge of the influence of the clinician's behaviour on a patient's behaviour and vice versa.	D4.K5
Critical skills: Specific skills underpinning capabilities 1 & 2		
A.1 A.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.	D1.S7
A.1 A.2	Demonstrate advanced use of interpersonal and communication skills in the effective application of practical skills for assessment, diagnosis, and management of individuals with MSK conditions.	D8.S10
A.1	Demonstrate advanced self–awareness to mitigate against the impact of a clinician's own values, beliefs, prejudices, assumptions, and stereotypes when interacting with others.	D7.S3 D7.A4

A.1	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 MSK condition's current and potential future impact on their lives.	D4.S2
A.1	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.	D5.S9
A.1	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.	D7.S2
A.1	Demonstrate effective documentation of informed consent from the individual for assessment and management procedures as appropriate.	D7.S6
A.1	Demonstrate maintenance of clear, accurate, and effective records of assessment and management to meet clinical and legal requirements.	D7.S7
A.2	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.	D6.S5 D7.S4 D10.S3
A.2	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 MSK condition and life, such as paid/unpaid work, including doing nothing.	D10.S2 D10.S10

A.2	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 MSK long-term conditions and co-morbidities.	D6.S3

Domain B: Assessment, investigation and diagnosis

DOMAIN B: ASSESSMENT, INVESTIGATION AND DIAGNOSIS Capability 3. History-taking Capability 4. Physical assessment Capability 5. Investigations and diagnosis		
Cross-referenced MSK CCF	**Essential knowledge: General knowledge underpinning capabilities 3, 4 & 5**	Cross-referenced IFOMPT
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of the theoretical basis of the assessment of the MSK system and interpretation of this assessment towards a clinical diagnosis.	D5.K2
B.3 B.4 B.5	Demonstrate critical understanding of the process of complex hypothetico-deductive clinical reasoning, including complex hypothesis generation and testing.	D6.K1
B.3 B.4 B.5	Demonstrate an advanced level of effective use of the process of complex pattern recognition, including the importance of organising advanced clinical knowledge in patterns.	D6.K2
B.3 B.4 B.5	Demonstrate advanced application of the various categories of hypotheses used in MSK healthcare, including those related to diagnosis, treatment, and prognosis. For example, understand where early referral and diagnosis may affect long-term outcome, such as ruptured Achilles tendon, internal derangement of the knee, and cauda equina.	D6.K3
B.3 B.4 B.5	Demonstrate advanced evaluation of common clinical reasoning errors.	D6.K5
B.3 B.4 B.5	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.	D8.K4
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of the relevant clinical sciences as applied to MSK conditions, such as clinical anatomy, physiology, pain science, biomechanics, and epidemiology in assessment and management.	D3.K1

B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of the interrelationship of anatomical structures in MSK function and dysfunction.	D5.K1
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of pathology and pathogenesis of mechanical dysfunction of the MSK, neurological, and vascular systems presenting to MSK first contact practitioners.	D2.K4
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of assessment, diagnosis, and management of non-mechanical dysfunction of the MSK system, MSK masquerades, and 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.	D2.K5
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of neurological, internal visceral, cardio-vascular, dental, and orthodontic dysfunctions linked with the MSK system.	D2.K6 D2.K7 D2.K8 D2.K9
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of pain sciences related to the MSK system.	D2.K10
B.3 B.4 B.5	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 MSK FCP role.	D2.K11
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of the specific diagnostic and evaluative qualities of assessment tools likely to be used within the MSK FCP role, including: reliability, validity, responsiveness, positive likelihood, negative likelihood, and diagnostic accuracy.	D3.K3

B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of static, dynamic, and functional posture in the assessment of the MSK system and interpretation of this assessment.	D5.K3
B.3 B.4 B.5	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.	D5.K4
B.3 B.4 B.5	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.	D5.K5 D5.K6 D5.K7
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of the specific special/screening tests for the assessment of the MSK system and interpretation of this assessment.	D5.K8
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of appropriate medical diagnostic tests and their integration required to make a MSK clinical diagnosis e.g. able to select the appropriate investigative tests, interpret results, and inform assessment and decision making.	D5.K9
B.3 B.4 B.5	Demonstrate comprehensive advanced knowledge of the specific indications and contraindications (including behavioural principles) of the use of diagnostic tools including imaging, blood test, neurophysiology etc.	D4.K3
Critical skills: Generic skills underpinning capabilities 3, 4 & 5		
B.3 B.4 B.5	Demonstrate an evidence-informed approach to the advanced assessment of individuals with MSK conditions.	D1.S3
B.3 B.4 B.5	Demonstrate advanced application of comprehensive knowledge of the examination and management of individuals with MSK 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.	D5.S1

B.3 B.4 B.5	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.	D10.S6
B.3 B.4 B.5	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.	D6.S2
B.3 B.4 B.5	Demonstrate application of comprehensive advanced knowledge of the biomedical, clinical, and behavioural sciences in the assessment of individuals with MSK conditions e.g. presentation of pathological and psycho-social presentations affecting the structure, function, inflammation, and pain.	D2.S1 D4.S1 D3.S1
B.3 B.4 B.5	Demonstrate effective application of assessment and outcomes to evaluate aspects of the complex clinical behavioural principles in the management of individuals e.g. fear of movement.	D4.S1 D4.S4
B.3	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).	D7.S1

B.3	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 MSK conditions (pain, stiffness, deformity, weakness, sensory loss, and impact on tasks and occupation etc.).	D6.S1
B.3	Demonstrate the advanced ability to simultaneously monitor multiple complex dimensions of information while maintaining a professional but relaxed communication style throughout contact with the individual e.g. MSK symptoms have the potential to be features of non-MSK serious pathology, compounded by psychological and mental health factors and affected by lifestyle factors (including smoking, alcohol, and drug misuse).	D10.S7
B.4	Demonstrate the ability to efficiently and effectively gain an individual's consent, respecting and maintaining privacy and dignity, complying with infection and control procedures.	D7.S3 D7.S6
B.4	Demonstrate advanced prioritisation in the physical assessment and management of individuals with complex MSK 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).	D6.S6
B.4	Demonstrate advanced level of sensitivity and specificity in the physical and functional assessment of the articular, muscular, fascial, nervous, vascular, and cardiorespiratory systems.	D8.S1 D8.S2 D8.S3 D8.S4 D8.S5
B.4	Demonstrate accurate physical diagnosis of MSK dysfunctions e.g. identify, analyse and interpret significant information from the assessment, including any ambiguities.	D5.S2

Domain C: Condition management, interventions and prevention

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		
Cross-referenced MSK CCF	**Essential knowledge: Generic knowledge underpinning capabilities 6, 7, 12 & 13**	Cross-referenced IFOMPT
C.6 C.7 C.12 C.13	Demonstrate comprehensive advanced knowledge of prognostic, risk, and predictive factors of relevant health problems in relation to MSK management strategies e.g. adequate vitamin D for bone health, and the effects of smoking, obesity, mental health, frailty, inactivity etc.	D3.K4
C.6 C.7 C.12 C.13	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 MSK assessment and management.	D3.K4
C.6 C.7 C.12 C.13	Demonstrate comprehensive knowledge of the role of the biopsychosocial model, e.g. risk factors for the persistence of MSK conditions and the role of MDT management strategies.	D3.K4
C.6 C.7 C.12 C.13	Demonstrate comprehensive advanced knowledge of all possible interventions for management of MSK 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.	D5.K10 D6.K4

C.6 C.7 C.12 C.13	Demonstrate comprehensive advanced knowledge including indications and contraindications of all available multimodal therapeutic interventions for management of MSK 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.).	D5.K11 D5.K14 D5.K15 D8.K1 D8.K2
C.6 C.7 C.12 C.13	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 MSK-related work loss e.g. appropriate use of FIT note.	D5.K17
C.6 C.7 C.12 C.13	Demonstrate comprehensive advanced knowledge of preventative programmes for MSK-associated health conditions e.g. knowledge of and referral pathways for all local ex groups, smoking cessation, and weight management programmes.	D5.K18
Critical skills: Generic skills underpinning capabilities 6,7,12 & 13		
C.6 C.7 C.12 C.13	Demonstrate an advanced level in the ability to retrieve, integrate, and apply evidence-based knowledge from the clinical, medical, and behavioural sciences in the clinical setting; recognising the limitations of incorporating evidence when managing individuals with MSK conditions e.g. social, economic, and environmental factors on an individual's behaviour, intervention, and management plan.	D1.S1 D1.S3 D1.S6 D10.S1
C.6 C.7 C.12 C.13	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.	D1.S6

A.1 C.6 C.7 C.12 C.13	Demonstrate advanced effective interpersonal and communication skills in the application of knowledge of complex biomedical sciences in the management of MSK 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.	D2.S3
C.6 C.7 C.12 C.13	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.	D3.S1
C.6 C.7 C12 C.13	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.	D3.S4 D7.S3
C.6 C.7 C12 C.13	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 MSK condition e.g. supports and recognises when to discharge the individual with self-management.	D4.S1
C.6 C.7 C.12 C.13	Demonstrate effective implementation of the biopsychosocial model e.g. able to identify risk factors for the persistence of MSK conditions and advise, signpost, and refer individuals to psychological therapies, counselling, and pain services as appropriate.	D4.S3
C.6 C.7 C.12 C.13	Demonstrate an advanced level of skill in implementing and educating individuals in appropriate rehabilitation exercise 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 MSK condition.	D7.S5

C.6 C.7 C.12 C.13	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 back and knee pain but restricted to exercise due to COPD and concerned about a loss of employment.	D6.S5 D10.S11
C.6 C.7 C.12 C.13	Demonstrates effective MDT working to optimise service delivery of the management of MSK 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.	D10.S12

DOMAIN C: CONDITION MANAGEMENT, INTERVENTIONS AND PREVENTION **Capability 8. Pharmacotherapy**		
Cross-referenced MSK CCF	**Essential knowledge: Specific knowledge underpinning capability 8**	Cross-referenced IFOMPT
C.8	Demonstrate comprehensive knowledge of indications, contraindications, effects, and side-effects of therapeutic drugs, understanding local and national formularies, resources, guidelines, and policies related to their use in the examination and management of MSK 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.	D2.K12
Critical skills: Generic skills underpinning capabilities 6,7,12 & 13		
C.8 C.12	Advise patients on the most common medications used in MSK and pain disorders to advise individuals for medicines management of their MSK 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.	AP MSK bolt-on D2.S1

C.8	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.	AP MSK bolt-on D2.S2

DOMAIN C: CONDITION MANAGEMENT, INTERVENTIONS AND PREVENTION CAPABILITY 9. INJECTION THERAPY		
Cross-referenced MSK CCF	**Essential knowledge: Specific knowledge underpinning capability 9**	Cross-referenced IFOMPT
C.9	Understand the role of joint injections, informed by the evidence base in MSK practice, local and national guidelines, pathways and policy.	AP MSK bolt-on
Critical skills: Generic skills underpinning capabilities 6,7,12 & 13		
C.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.	AP MSK bolt-on

DOMAIN C: CONDITION MANAGEMENT, INTERVENTIONS AND PREVENTION CAPABILITY 10. SURGICAL INTERVENTIONS		
Cross-referenced MSK CCF	**Essential knowledge: Specific knowledge underpinning capability 10**	Cross-referenced IFOMPT
C.10	Demonstrate comprehensive advanced knowledge of indications for and the nature of surgical intervention in the management of MSK conditions, 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. rehabilitative interventions and social prescribing.	D2.K13
Critical skills: Specific skills underpinning capability 10		
C.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.	AP MSK bolt-on
C.10	Make recommendations to employers regarding individuals' fitness to work, including through the appropriate use of fit notes and seeking of appropriate occupational health advice.	AP MSK bolt-on

DOMAIN C: CONDITION MANAGEMENT, INTERVENTIONS AND PREVENTION CAPABILITY 11. REHABILITATIVE INTERVENTIONS		
Cross-referenced MSK CCF	**Essential knowledge: Specific knowledge underpinning capability 11**	Cross-referenced IFOMPT
C.11	Demonstrate comprehensive knowledge and understanding of rehabilitative interventions for MSK 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.	D5.K12

C.11	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.	D5.K13 D8.K6
C.11	Demonstrate comprehensive knowledge of the role of digital technology to support adherence to rehabilitation interventions for individuals with MSK conditions e.g. apps and wearables.	D7.K1 D8.K4 D8.K5
C.11	Demonstrate comprehensive knowledge of evidence-informed outcome measures appropriate to the management of MSK conditions.	D5.K16
Critical skills: Specific skills underpinning capability 11		
C.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.	D6.S5
C.11	Demonstrate integration of principles of patient education as a component of multi-modal therapy intervention for the management of MSK conditions.	D5.S7
C.11	Demonstrate integration of principles of exercise physiology as it applies to therapeutic rehabilitation exercise programmes, as a component of multi-modal intervention for management of MSK conditions e.g. an exercise programme with podiatry referral.	D5.S5
C.11	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.	D8.S9

Domain D: Service and professional development

DOMAIN D: SERVICE AND PROFESSIONAL DEVELOPMENT Capability 14. Evidence-based practice and service development		
Cross-referenced MSK CCF	**Essential knowledge: Specific knowledge underpinning capability 14**	Cross-referenced IFOMPT
D.14	Demonstrate advanced critical evaluative application of evidence-informed practices e.g. uses clinical audit to evidence the use of best practice/national guidelines within MSK care and service delivery, identifying where modifications are required.	D1.K1
D.14	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.	D1.K2
D.14	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.	D10.K1
D.14	Evaluate the existing and changing professional, social, and political influences on the breadth and scope of advanced MSK practice within the context of delivery of services in order to continuously improve MSK healthcare.	ACP MSK bolt-on
D.14	Evaluate the extent to which advanced MSK practice contributes to strategies related to collaborative inter-professional working and person-centred care.	ACP MSK bolt-on
Critical skills: Specific skills underpinning capability 10		
D.14	Demonstrate ability to critically review the recent literature of the basic and applied sciences relevant to MSK conditions, to draw inferences for practice and present material logically in verbal and written forms.	D1.S2

D.14	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.	D1.S5
D.14	Demonstrate effective critical appraisal of research relevant to MSK practice.	D9.S1
D.14	Demonstrate ability to consult skilfully with peers, other professionals, and legislative and regulatory organisations as appropriate.	D10.S12
D.14	Critically analyse leadership practice through self-awareness of ability to lead, influence, and negotiate with others.	AP MSK bolt-on
D.14	Critically apply changes to their behaviour relating to underpinning theory on leadership, and analyse and reflect on these changes.	AP MSK bolt-on

Personal attributes

MSK FCP CORE COMPETENCY: ATTRIBUTES OF AN MSK FCP CLINICIAN		
Cross-referenced MSK CCF	**Essential personal attributes: Generic attributes underpinning all 14 capabilities**	Cross-referenced IFOMPT
A.1-2 B.3-4 C.6-13	Demonstrate a critical and evaluative approach to all aspects of advanced practice	D1.A1
A.1-2 B.3-4 C.6-13	Demonstrate adaptability of comprehensive knowledge of biomedical sciences in the context of person-centred practice.	D2.A1
A.1-2 B.3-4 C.6-13 D.14	Demonstrate criticality, creativity, and innovation of practice in the application of knowledge of biomedical sciences in the examination and management of individuals with MSK conditions.	D2.A2 D2.A3
A.1-2 B.3-4 C.6-13 D.14	Demonstrate an objective and analytical attitude in the application of complex knowledge of the clinical sciences.	D3.A1
A.1	Demonstrate an advanced level of sensitivity to changes in an individual's behaviour.	D4.A1
A.1	Demonstrate critical awareness of the central role of communication skills in the development of advanced clinical expertise.	D7.A2
A.1	Demonstrate empathy in the application of advanced communication skills.	D7.A4
A.1 A.2	Demonstrate critical awareness of person-centred communication as being central to effective advanced clinical practice.	D7.A1
A.2	Demonstrate a critical understanding of the key role of person-centred complex clinical reasoning skills in all aspects of advanced clinical practice.	D6.A1 D6.A2
C.6 C.7	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.	D7.A3

C.6-13	Demonstrate an advanced level in the application of complex biopsychosocial principles.	D4.A3
C.11	Demonstrate adaptability of knowledge of MSK management and rehabilitation in the context of person-centred practice.	D5.A1
C.6-13	Demonstrate criticality of evidence-informed practice in the application of knowledge of MSK management and rehabilitation, in the context of person-centred care.	D5.A2
A.1 B.5	Demonstrate an advanced level of effective collaborative and advanced communication skills in requesting further investigation or referral to another health or social care professional.	D6.A3
A.2 B.3-5 C.6-13	Demonstrate criticality, creativity, adaptability, and innovation of practice in the application of practical skills in the context of person-centred practice.	D8.A1 D8.A2 D8.A3
A.1-2 B.3-4 C.6-13 D.14	Demonstrate an advanced level of learning through critical reflection during and after the clinical encounter.	D6.A4
A.1-2 B.3-4 C.6-13 D.14	Demonstrate an advanced level of reflection and self-evaluation in managing individuals.	D4.A2
B.3-5 C.6-13	Demonstrate an advanced level of learning through precise and timely reassessment.	D6.A5
D.14	Demonstrate professional, ethical, and autonomous practice.	D10.A1
D.14	Demonstrate advanced professional judgement, empathy, and cultural competence within clinical practice.	D10.A5
D.14	Demonstrate critical awareness of the role of research in advancing the body of knowledge in MSK practice.	D9.A1 D9.A2
D.14	Demonstrate a commitment to life-long learning with continuous professional development.	D10.A2
D.14	Demonstrate a commitment to contributing to professional development through teaching and mentoring, and assisting in the advancement of MSK provision across health and social care to the benefit of the public.	D10.A3 D10.A4

12.13 Linking to Advanced Practice Portfolio (MSK) document

Key:
Blue = mandatory FCP domains
White = domains to upskill to AP in addition to completing the mandatory FCP domains

Dimension 1	**Demonstration of critical and evaluative evidence-informed practice.**
Competencies relating to knowledge	
Competency D1.K1	Demonstrate critical and evaluative application of evidence-informed practices relevant to the field of OMT.
Competency D1.K2	Demonstrate evaluative understanding of appropriate outcome measures.
Competencies relating to skills	
Competency D1.S1	Demonstrate ability to retrieve, integrate, and apply knowledge from the clinical, medical, and behavioural sciences in the clinical setting, recognising the limitations of incorporating evidence into practice.
Competency D1.S2	Demonstrate ability to critically review the recent literature of the basic and applied sciences relevant to NMS dysfunction, to draw inferences for OMT practice, and present material logically in both verbal and written forms.
Competency D1.S3	Demonstrate an evidence-informed approach to the assessment and management of patients with NMS dysfunctions.
Competency D1.S4	Demonstrate the ability to evaluate the results of treatment accurately, and modify and progress treatment as required using evidence.
Competency D1.S5	Demonstrate the use of outcome measures to evaluate the effectiveness of OMT.
Competency D1.S6	Demonstrate an ability to integrate and apply evidence-informed approaches in the presentation of health promotion and preventative care programmes.
Competency D1.S7	Demonstrate an ability to enhance and promote the rights of a patient to actively participate in their healthcare management by taking into consideration the patient's wishes, goals, attitudes, beliefs, and circumstances.

Competencies relating to attributes	
Competency D1.A1	Demonstrate a critical and evaluative approach to all aspects of practice.
Dimension 2	Demonstration of critical use of a comprehensive knowledge base of the biomedical sciences in the speciality of OMT.
Competencies relating to knowledge	
Competency D2.K1	Demonstrate comprehensive knowledge of anatomy of the musculoskeletal, neurological, vascular, and lymphatic systems to enable evaluation of normal and abnormal function.
Competency D2.K2	Demonstrate comprehensive knowledge of physiology of the musculoskeletal, neurological, vascular, and lymphatic systems to enable evaluation of normal and abnormal function.
Competency D2.K3	Demonstrate comprehensive knowledge of biomechanical properties of visco-elastic tissues to enable evaluation of normal and abnormal function.
Competency D2.K4	Demonstrate comprehensive knowledge of pathology and pathogenesis of mechanical dysfunction of the NMS system.
Competency D2.K5	Demonstrate comprehensive knowledge of non-mechanical dysfunction of the NMS system.
Competency D2.K6	Demonstrate comprehensive knowledge of neurological dysfunctions of the NMS system.
Competency D2.K7	Demonstrate comprehensive knowledge of internal visceral dysfunction to differentiate from dysfunction of the NMS system.
Competency D2.K8	Demonstrate comprehensive knowledge of cardio-vascular dysfunction to differentiate from dysfunction of the NMS system.
Competency D2.K9	Demonstrate comprehensive knowledge of dental and orthodontic dysfunctions related to the NMS system.
Competency D2.K10	Demonstrate comprehensive knowledge of pain sciences related to the NMS system.
Competency D2.K11	Demonstrate comprehensive knowledge of examination procedures to enable differential diagnosis of NMS, neurological, vascular, and lymphatic dysfunction.

Competency D2.K12	Demonstrate comprehensive knowledge of indications, contraindications, effects, and side effects of therapeutic drugs related to the examination and management of mechanical and non- mechanical NMS dysfunction.
Competency D2.K13	Demonstrate comprehensive knowledge of indications for, and the nature of, surgical intervention in the management of NMS dysfunction.
Competencies relating to skills	
Competency D2.S1	Demonstrate application of comprehensive knowledge of the biomedical sciences in the examination and management of patients with NMS dysfunction.
Competency D2.S2	Demonstrate critical evaluation of the contribution of the biomedical sciences to the patient's presentation.
Competency D2.S3	Demonstrate effective interpersonal and communication skills in the application of knowledge of biomedical sciences in the examination and management of patients with NMS dysfunction.
Competencies relating to attributes	
Competency D2.A1	Demonstrate adaptability of comprehensive knowledge of biomedical sciences in the context of patient-centred practice.
Competency D2.A2	Demonstrate criticality of practice in the application of knowledge of biomedical sciences in the examination and management of patients with NMS dysfunction.
Competency D2.A3	Demonstrate creativity and innovation in the application of knowledge of biomedical sciences in the examination and management of patients with NMS dysfunction.
Dimension 3	**Demonstration of critical use of a comprehensive knowledge base of the clinical sciences in the specialty of OMT.**
Competencies relating to knowledge	
Competency D3.K1	Demonstrate comprehensive knowledge of the relevant clinical sciences as applied to OMT, such as clinical anatomy, physiology, biomechanics, and epidemiology in OMT assessment and management.
Competency D3.K2	Demonstrate comprehensive knowledge of effectiveness, risks, and efficacy of OMT interventions.

Competency D3.K3	Demonstrate comprehensive knowledge of the specific diagnostic and evaluative qualities of assessment tools, including: reliability, validity, responsiveness, positive likelihood, negative likelihood, and diagnostic accuracy.
Competency D3.K4	Demonstrate comprehensive knowledge of prognostic, risk, and predictive factors of relevant health problems in relation to OMT management strategies.
Competencies relating to skills	
Competency D3.S1	Demonstrate the ability to identify the nature and extent of patients' functional abilities, pain, and multidimensional needs in relation to the ICF classification and planned OMT management.
Competency D3.S2	Demonstrate the ability to determine which assessment and intervention tools are most appropriate and to interpret outcomes.
Competency D3.S3	Demonstrate accurate prediction of expected changes and progress towards realistic outcomes.
Competency D3.S4	Demonstrate effective interpersonal skills to inform the patient about the risks, prognosis, potential side effects, and likely benefits of an OMT treatment intervention.
Competencies relating to attributes	
Competency D3.A1	Demonstrate an objective and analytical attitude in the application of knowledge of the clinical sciences.
Dimension 4	**Demonstration of critical use of a comprehensive knowledge base of the behavioural sciences in the speciality of OMT.**
Competencies relating to knowledge	
Competency D4.K1	Demonstrate comprehensive knowledge of the relevant theories on behaviour and changes of behaviour, such as behavioural reactions to pain, and limitations, coping strategies etc. relevant to OMT assessment and management.
Competency D4.K2	Demonstrate comprehensive knowledge of behaviour-related processes that could be relevant during management of a patient.
Competency D4.K3	Demonstrate comprehensive knowledge of the specific indications, diagnostic tools, and interventions based on behavioural principles.

Competency D4.K4	Demonstrate comprehensive knowledge of the role of the biopsychosocial model in relation to OMT, for example multidisciplinary management strategies.
Competency D4.K5	Demonstrate comprehensive knowledge of the influence of the OMT physical therapist's behaviour on a patient's behaviour and vice versa.
Competencies relating to skills	
Competency D4.S1	Demonstrate effective application of aspects of behavioural principles in assessment and management of patients.
Competency D4.S2	Demonstrate effective communication skills when applying behavioural principles.
Competency D4.S3	Demonstrate effective implementation of the biopsychosocial model in OMT management.
Competency D4.S4	Demonstrate effective use of sufficient outcomes to evaluate the clinical behavioural aspects, for example, fear of movement.
Competencies relating to attributes	
Competency D4.A1	Demonstrate sensitivity to changes in patient behaviour.
Competency D4.A2	Demonstrate reflection and self-evaluation in managing patients.
Competency D4.A3	Demonstrate application of biopsychosocial principles in OMT management.
Dimension 5	**Demonstration of critical use of a comprehensive knowledge base of OMT.**
Competencies relating to knowledge	
Competency D5.K1	Demonstrate comprehensive knowledge of the interrelationship of the NMS structures in normal function and NMS dysfunction.
Competency D5.K2	Demonstrate comprehensive knowledge of the theoretical basis of the assessment of the NMS system, and interpretation of this assessment towards a clinical physical diagnosis.
Competency D5.K3	Demonstrate comprehensive knowledge of static, dynamic, and functional posture in the assessment of the NMS system and interpretation of this assessment.

Competency D5.K4	Demonstrate comprehensive 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 NMS system and interpretation of this assessment.
Competency D5.K5	Demonstrate comprehensive knowledge of the specific tests for functional status of the muscular system in the assessment of the NMS system and interpretation of this assessment.
Competency D5.K6	Demonstrate comprehensive knowledge of the specific tests for the function and dynamic mobility of the nervous system in the assessment of the NMS system and interpretation of this assessment.
Competency D5.K7	Demonstrate comprehensive knowledge of the specific tests for functional status of the vascular system in the assessment of the NMS system and interpretation of this assessment.
Competency D5.K8	Demonstrate comprehensive knowledge of the specific special/ screening tests for the safe practice of OMT in the assessment of the NMS system, and interpretation of this assessment.
Competency D5.K9	Demonstrate comprehensive knowledge of appropriate medical diagnostic tests and the integration required to make an NMS clinical physical diagnosis.
Competency D5.K10	Demonstrate comprehensive knowledge of possible interventions for management of NMS dysfunction.
Competency D5.K11	Demonstrate comprehensive knowledge of multimodal Physical Therapy intervention for management of NMS dysfunction.
Competency D5.K12	Demonstrate comprehensive knowledge of the Physical Therapy theory of manipulative therapy practice in the management of NMS dysfunctions.
Competency D5.K13	Demonstrate comprehensive knowledge of various manipulative therapy approaches, including those in medicine, osteopathy, and chiropractic
Competency D5.K14	contraindications for OMT Physical Therapy interventions used in the management of NMS dysfunction.
Competency D5.K15	Demonstrate comprehensive knowledge of safety/screening tests appropriate to the choice of management interventions in NMS dysfunction.
Competency D5.K16	Demonstrate comprehensive knowledge of evidence-informed outcome measures appropriate to the management of NMS dysfunction.

Competency D5.K17	Demonstrate comprehensive knowledge of appropriate ergonomic strategies and advice to assist the patient to function effectively in their work environment.
Competency D5.K18	Demonstrate comprehensive knowledge of preventative programmes for NMS dysfunctions.
Competencies relating to skills	
Competency D5.S1	Demonstrate application of comprehensive knowledge of OMT in the examination and management of patients with NMS dysfunction.
Competency D5.S2	Demonstrate accurate physical diagnosis of NMS dysfunctions.
Competency D5.S3	Demonstrate critical evaluation of the contribution of OMT knowledge to the examination and management of the patient with NMS dysfunction.
Competency D5.S4	Demonstrate integration of principles of mobilisation and manipulation as a component of multimodal OMT Physical Therapy management.
Competency D5.S5	Demonstrate integration of principles of exercise physiology as it applies to therapeutic rehabilitation exercise programmes as a component of multimodal OMT Physical Therapy intervention for management of NMS dysfunction.
Competency D5.S6	Demonstrate integration of principles of motor learning as a component of multimodal OMT Physical Therapy intervention for management of NMS dysfunction.
Competency D5.S7	Demonstrate integration of principles of patient education as a component of multimodal OMT Physical Therapy intervention for management of NMS dysfunction.
Competency D5.S8	Demonstrate integration of principles of other modalities (such as taping, bracing, electrophysical modalities, acupuncture/ needling) as a component of multimodal OMT Physical Therapy intervention for management of NMS dysfunction.
Competency D5.S9	Demonstrate advanced use of interpersonal and communication skills in effective application of OMT during the patient history, physical examination, reassessment of patients, patient management, and in all documentation.
Competencies relating to attributes	
Competency D5.A1	Demonstrate adaptability of knowledge of OMT in the context of patient-centred practice.

Competency D5.A2	Demonstrate criticality of evidence-informed practice in the application of knowledge of OMT.
Competency D5.A3	Demonstrate creativity and innovation in the application of knowledge of OMT.
Dimension 6	**Demonstration of critical advanced-level clinical reasoning skills enabling effective assessment and management of patients with NMS dysfunctions.**
Competencies relating to knowledge	
Competency D6.K1	Demonstrate critical understanding of the process of hypothetico-deductive clinical reasoning, including hypothesis generation and testing.
Competency D6.K2	Demonstrate effective use of the process of pattern recognition, including the importance of organising clinical knowledge in patterns.
Competency D6.K3	Demonstrate critical application of the various categories of hypotheses used in OMT, including those related to diagnosis, treatment, and prognosis.
Competency D6.K4	Demonstrate effective recognition of dysfunction requiring further investigation and/or referral to another healthcare professional.
Competency D6.K5	Demonstrate critical evaluation of common clinical reasoning errors.
Competencies relating to skills	
Competency D6.S1	Demonstrate accurate and efficient selection of inquiry strategies based on early recognition and correct interpretation of relevant clinical cues.
Competency D6.S2	Demonstrate critical and evaluative collection of clinical data to ensure reliability and validity of data.
Competency D6.S3	Demonstrate advanced use of clinical reasoning to integrate scientific evidence, clinical data, the patient's perceptions and goals, and factors related to the clinical context and the patient's individual circumstances.
Competency D6.S4	Demonstrate integration of evidence-informed practice and reflective practice in clinical decision-making.

Competency D6.S5	Demonstrate application of collaborative clinical reasoning with the patient, carers/care-givers and other health professionals in determining management goals, interventions, and measurable outcomes.
Competency D6.S6	Demonstrate effective prioritisation in the examination and management of patients with NMS dysfunction.
Competency D6.S7	Demonstrate effective use of metacognition in the monitoring and development of clinical reasoning skills.
Competencies relating to attributes	
Competency D6.A1	Demonstrate patient-centred clinical reasoning in all aspects of clinical practice.
Competency D6.A2	Demonstrate critical understanding of the key role of clinical reasoning skills in the development of clinical expertise.
Competency D6.A3	Demonstrate effective collaborative and communication skills in requesting further investigation or referral to another healthcare professional.
Competency D6.A4	Demonstrate learning through critical reflection during and after the clinical encounter.
Competency D6.A5	Demonstrate learning through precise and timely reassessment.
Dimension 7	**Demonstration of an advanced level of communication skills enabling effective assessment and management of patients with NMS dysfunctions.**
Competencies relating to knowledge	
Competency D7.K1	Demonstrate critical understanding of the processes of verbal communication.
Competency D7.K2	Demonstrate critical understanding of the processes of non-verbal communication.
Competency D7.K3	Demonstrate critical understanding of the processes of written communication and record keeping.
Competency D7.K4	Demonstrate critical awareness of common errors of communication e.g. use of inappropriate closed questions.
Competencies relating to skills	
Competency D7.S1	Demonstrate efficient and effective questioning strategies to obtain reliable and valid data from the patient.
Competency D7.S2	Demonstrate efficient and effective use of active listening skills throughout the patient encounter.

Competency D7.S3	Demonstrate effective explanation to the patient of their individual presentation and their management options.
Competency D7.S4	Demonstrate effective collaboration with the patient to inform management decisions.
Competency D7.S5	Demonstrate a high level of skill in implementing and educating patients in appropriate rehabilitation exercise programmes.
Competency D7.S6	Demonstrate effective documentation of informed consent from the patient for assessment and management procedures as appropriate.
Competency D7.S7	Demonstrate maintenance of clear, accurate, and effective records of patient assessment and management to meet medical and legal requirements.
Competencies relating to attributes	
Competency D7.A1	Demonstrate critical awareness of patient-centred communication as being central to effective clinical practice.
Competency D7.A2	Demonstrate critical awareness of the central role of communication skills in the development of clinical expertise.
Competency D7.A3	Demonstrate critical awareness of the promotion of wellness and prevention through the education of patients, carers/care-givers, the public, and healthcare professionals.
Competency D7.A4	Demonstrate empathy in the application of communication skills.
Dimension 8	**Demonstration of an advanced level of practical skills with sensitivity and specificity of handling, enabling effective assessment and management of patients with NMS dysfunctions.**
Competencies relating to knowledge	
Competency D8.K1	Demonstrate application of knowledge of indications for practical skills.
Competency D8.K2	Demonstrate application of knowledge of contraindications for practical skills.
Competency D8.K3	Demonstrate integration of knowledge and clinical reasoning in the decision to perform practical skills.
Competency D8.K4	Demonstrate integration of knowledge and clinical reasoning in the evaluation of clinical data obtained.
Competency D8.K5	Demonstrate integration of knowledge and clinical reasoning in the progression of OMT techniques and management.

Competency D8.K6	Demonstrate critical understanding of other interventions and modalities, for example taping, needling, and electrophysical modalities, to enhance rehabilitation of NMS dysfunction.
Competencies relating to skills	
Competency D8.S1	Demonstrate sensitivity and specificity of handling in the analysis of static and dynamic posture.
Competency D8.S2	Demonstrate sensitivity and specificity of handling in the clinical examination of the articular system.
Competency D8.S3	Demonstrate sensitivity and specificity of handling in the clinical examination of the nervous system.
Competency D8.S4	Demonstrate sensitivity and specificity of handling in the clinical examination of the muscular and fascial systems.
Competency D8.S5	Demonstrate sensitivity and specificity of handling in the application of any special tests for the safe practice of OMT, for example cervical artery screening.
Competency D8.S6	Demonstrate sensitivity and specificity of handling in the application of a broad range of OMT techniques.
Competency D8.S7	Demonstrate sensitivity and specificity of handling in the performance of low -velocity, rhythmical, passive movements (mobilisation), and high-velocity, low-amplitude passive movements with impulse (manipulation).
Competency D8.S8	Demonstrate sensitivity and specificity of handling in the performance of manual and other Physical Therapy techniques to treat the articular, muscular, neural, and fascial systems.
Competency D8.S9	Demonstrate sensitivity and specificity of handling in the implementation and instruction of patients in appropriate therapeutic rehabilitation exercise programmes.
Competency D8.S10	Demonstrate advanced use of interpersonal and communication skills in the effective application of practical skills.
Competencies relating to attributes	
Competency D8.A1	Demonstrate adaptability of practical skills in the context of patient-centred practice.
Competency D8.A2	Demonstrate criticality of practice in the application of practical skills.
Competency D8.A3	Demonstrate creativity and innovation in the application of practical skills.

Dimension 9	**Demonstration of a critical understanding and application of the process of research.**
Competencies relating to knowledge	
Competency D9.K1	Demonstrate critical understanding of common quantitative research designs, including strengths and weaknesses.
Competency D9.K2	Demonstrate critical understanding of common qualitative research designs, including strengths and weaknesses.
Competency D9.K3	Demonstrate critical evaluation of ethical considerations relating to human research.
Competencies relating to skills	
Competency D9.S1	Demonstrate effective critical appraisal of research relevant to OMT Physical Therapy practice as it relates to NMS dysfunction.
Competency D9.S2	Demonstrate generation of a research question based on a critical evaluation of the current literature relevant to OMT Physical Therapy practice and relating to NMS dysfunction.
Competency D9.S3	Demonstrate development of a research proposal that meets the requirements of a human ethics committee as appropriate.
Competency D9.S4	Demonstrate selection and application of appropriate data analysis procedures.
Competency D9.S5	Demonstrate effective execution of a research project and dissemination of its conclusions*.
Competencies relating to attributes	
Competency D9.A1	Demonstrate appreciation of the need for the development of further evidence in OMT Physical Therapy practice through research.
Competency D9.A2	Demonstrate critical awareness of the role of research in advancing the body of knowledge in OMT Physical Therapy.
Dimension 10	**Demonstration of clinical expertise and continued professional commitment to the development of OMT practice.**
Competencies relating to knowledge	
Competency D10.K1	Demonstrate effective integration of comprehensive knowledge, and cognitive and metacognitive proficiency.
Competency D10.K2	Demonstrate advanced knowledge of current best evidence in OMT theories, as well as diagnostic, prognostic, and intervention techniques.

Competency D10.K3	Demonstrate understanding of advanced knowledge of OMT based on current and classic literature.
Competency D10.K4	Demonstrate scholarly contribution to body of OMT knowledge, skills, and measurement of outcomes.
Competency D10.K5	Demonstrate efficiency in utilising cues and recognising patterns of NMS dysfunction.
Competencies relating to skills	
Competency D10.S1	Demonstrate ability to combine the evidence, knowledge, skills, other clinical applications, patient preferences, circumstances, and environmental situations in determining an OMT intervention.
Competency D10.S2	Demonstrate effective continued direct patient care.
Competency D10.S3	Demonstrate effective and efficient communication and interpersonal skills involving the patient and others in decision-making.
Competency D10.S4	Demonstrate ability to solve problems with accuracy and precision.
Competency D10.S5	Demonstrate ability to employ lateral thinking to generate new hypotheses or techniques to produce a positive outcome or plan of care.
Competency D10.S6	Demonstrate sound professional judgements when selecting assessment and treatment techniques, evaluating benefit and risk.
Competency D10.S7	Demonstrate ability to simultaneously monitor multiple dimensions of data during patient contact while maintaining a professional but relaxed communication style.
Competency D10.S8	Demonstrate efficient and effective use of a variety of techniques that encompass the breadth of OMT.
Competency D10.S9	Demonstrate efficiency and effectiveness in the practice of OMT in the clinical setting.
Competency D10.S10	Demonstrate a patient-centred approach to practice, responding and rapidly adapting the assessment and intervention to the emerging data and the patient's perspective.
Competency D10.S11	Demonstrate efficient and effective use of OMT within one episode of care with patients with multiple inter-related or separate dysfunctions and/or co-morbidities.

Competency D10.S12	Demonstrate ability to skilfully consult with peers, other professionals, and legislative and regulatory organisations as appropriate.
Competencies relating to attributes	
Competency D10.A1	Demonstrate professional, ethical, and autonomous practice
Competency D10.A2	Demonstrate a commitment to life-long learning with continuous educational development.
Competency D10.A3	Demonstrate a commitment to contributing to the professional development of OMTs through teaching and mentoring.
Competency D10.A4	Demonstrate a commitment to professional service to the profession and community to assist in the advancement of the OMT profession and to the benefit of the public.
Competency D10.A5	Demonstrate sound professional judgement, empathy, and cultural competence in all patient interactions.

13.0 References

Boud D, Keogh R, Walker D (1985). Reflection: Turning Experience into Learning, Kogan Page, London.

Brown RA (1992). Portfolio Development and Profiling for Nurses, Quay Publishing Ltd, Lancaster.

Girot, E.A., (2001) Reflective skills. In Maslin-Prothero, S. (ed). Baliere's study skills for nurses. Second edition. Balliere Tindall/RCN. London.

HEE, NHS-England. Musculoskeletal core capabilities framework for first point of contact practitioners: Health Education England and NHS England, 2018.

Honey P, Mumford A (1992). The Manual of Learning Styles, Peter Honey, Ardingly House, 10 Linden Avenue, Maidenhead, Berkshire.

Jasper, M. A., (1999) Nurses' perceptions of the value of written reflection. Nurse Education Today. Vol. 19(6) p452-63.

Jasper, M. (2003) *Beginning Reflective Practice – Foundations in Nursing and Health Care* Nelson Thornes. Cheltenham

Kolb D (1984). Experiential Learning: Experience as a Source of Learning and Development, Prentice Hall, New Jersey.

NHS England. Multi-professional framework for ACP in England: NHS England, 2017.

Rushton A, Beeton K, Jordaan R, et al. IFOMPT Educational Standards: International Federation of Orthopaedic Manipulative Physical Therapists, 2016.

Schon D (1983). The Reflective Practitioner, Basic Books Inc, New York.

Snell F, Sherbino JC. Physician competency framework. Ottawa: *Royal College of Physicians and Surgeons of Canada* 2015.