NHS
Health Education England

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

A Roadmap to Practice

Developing people
for health and
healthcare

www.hee.nhs.uk

January 2021

Acknowledgements

This Primary Care Educational Roadmap was developed by Health Education England, with support from and in collaboration with multi-organisational, multi-professional, and patient group stakeholders. It builds upon work previously undertaken by the national programme delivered by the Arthritis and Musculoskeletal Alliance (ARMA) and its member organisations, as well as the subsequent work that delivered the Musculoskeletal core capabilities framework for first point of contact practitioners.

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 development of the paramedic knowledege skills and attributes document was led by Jessica Willetts, advanced paramedic lead (Park Surgery, Herne Bay). Supervision content was led by Julia Taylor (Lister House Surgery and Health Education England). Andy Collen, Will Broughton and Helen Beaumont-Waters (College of Paramedics) provided expert support in the building of this roadmap.

We are extremely grateful to the many stakeholders who have been instrumental in shaping this piece of work, in particular to our patient representatives who sit in the heart of the roadmap. We would also like to thank:

Dr Richard Collier (Centre for Advancing Practice, Health Education England), Primary Care Deans, National Health Service England Improvement, Care Quality Commission, Arthritis and Musculoskeletal Alliance, Health Care, Royal College of General Practitioners, Chartered Society of Physiotherapy, Royal Collage of Occupational Therapy, College of Podiatry, Institute of Osteopathy, MSK Partnership group, Musculoskeletal Association of Chartered Physiotherapists, Society of Musculoskeletal Medicine, Advanced Practice Physiotherapy Association, The British Dietetic Association, National First Contact working group, Primary Care Network representatives, Nursing and Midwifery Council, Public Health England, Primary Care Rheumatology and Musculoskeletal Medicine Society, Skills for Health, Connect Health, MSK Reform, Higher Education Institutions, and all the multi-professional clinicians who have taken time to contribute.

Table of Contents

Glossary

Abbreviation	Full text
AP	Advanced Practice Advanced Practitioner
FCP	First Contact Practitioner
GP	General Practitioner
NHSE	NHS England
HEE	Health Education England
KSA	Knowledge Skills and Attributes
The Centre	Centre for Advancing Practice
QAA	Quality Assurance Agency
ICS	Integrated Care System
CCG	Clinical Commissioning Group
PCN	Primary Care Network
CPD	Continuing Professional Development
PDP	Personal Development Plan
SMART	Specific, Measurable, Attainable, Relevant, Timebound
Band 7 Band 8a	Agenda for Change pay bands 7 = FCP 8a =Advanced Practitioner
RCGP	Royal College of General Practitioners
WPBA	Workplace-Based Assessment
COT	Consultation Observation Tool
CBD	Case Based Discussion
FTE	Full time Equivalent
CEPS	Clinical Examination Procedure Skills
PSQ	Patient Satisfaction Questionnaire
MSF	Multi-Source Feedback
MSc	Master of Science
CCF	Core Capability Framework

Abbreviation	Full text
HEI	Higher Education Institution
QIP	Quality Improvement Project
Level 7 Level 8	Academic level of practice. 7 = Master's 8 = Doctorate

Introduction

i Purpose

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

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

This is the Paramedic version of the educational pathway to FCP and AP in Primary Care. 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. Visit the getting it right first time website for more information.
- As the FCP role evolved (see historial perspectIve), it created a template for other professions to use and develop FCP roles in Primary Care. This created an assurance that there was a standardisation of quality provided across multiple professions at this level of practice. This standardisation assures governance and ultimately patient safety, ensuring capability to see and manage undifferentiated and undiagnosed presentations within an agreed scope of practice.

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

- HEE Primary Care training begins typically 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.

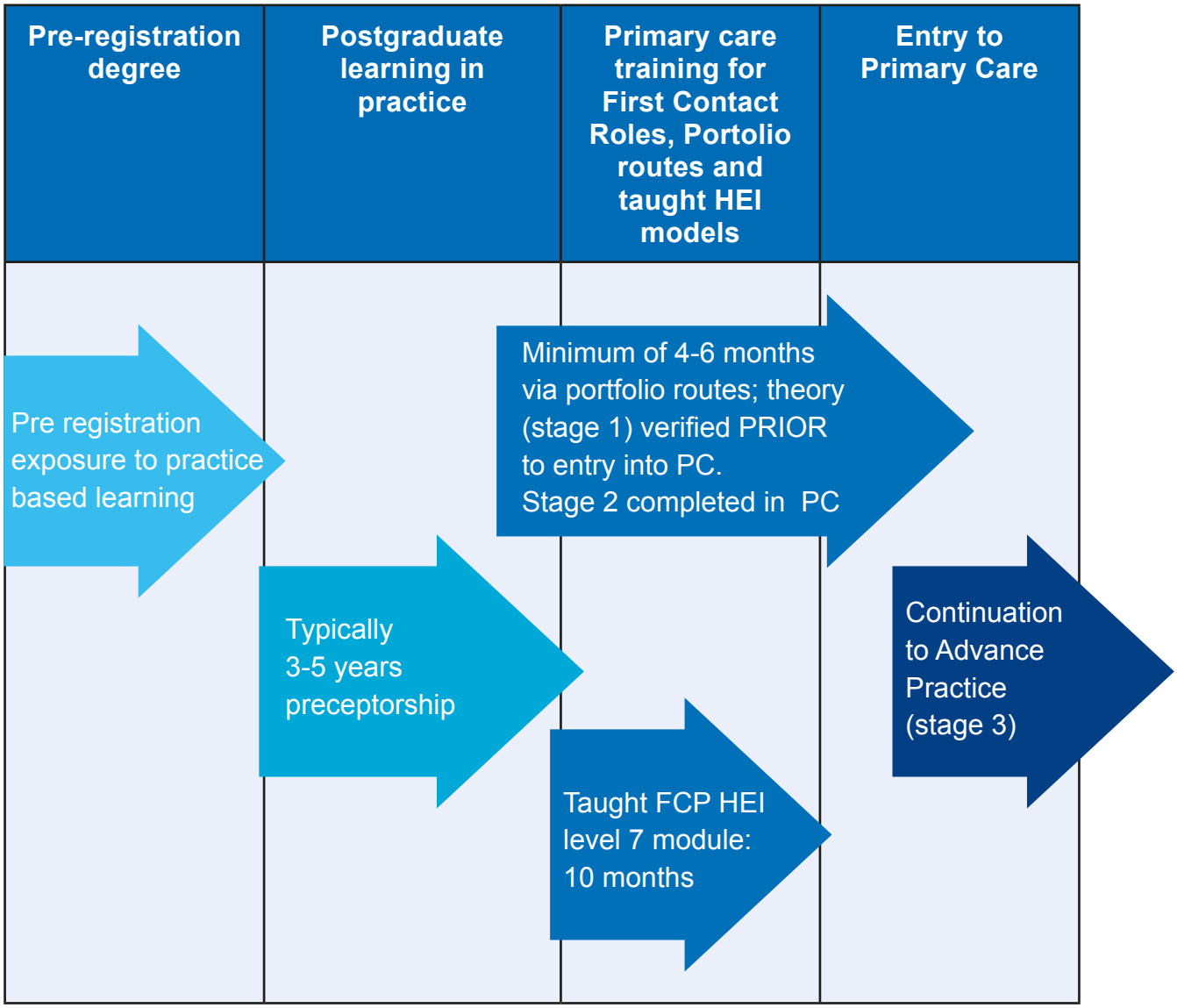


Diagram to illustrate career progression of Primary Care roles.

- Clinicians will need to be supported by a verified FCP AP 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;

- An FCP Directory will be held for verified FCPs.
- There will be portfolio routes and taught routes to recognition as an FCP in the FCP directory.
- A retrospective route for existing FCPs will be available via the portfolio route to gain recognition.
    - *This route will only be available for existing FCPs that meet the criteria and have undertaken the mapping required to achieve recognition.*
    - *This route will only be available for a limited period of time - 12 months maximum (this is based on the minimum employment model of one session a week): the start date TBC.*

- FCP recognition is not a 'short cut' to full AP status. 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 FCP roles within Primary Care (appendix 12.14). 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).

- The Centre will also hold a directory of Advanced Practice Roadmap supervisors. Roadmap 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 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 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 patient presentations and pharmacology outside their agreed scope of practice

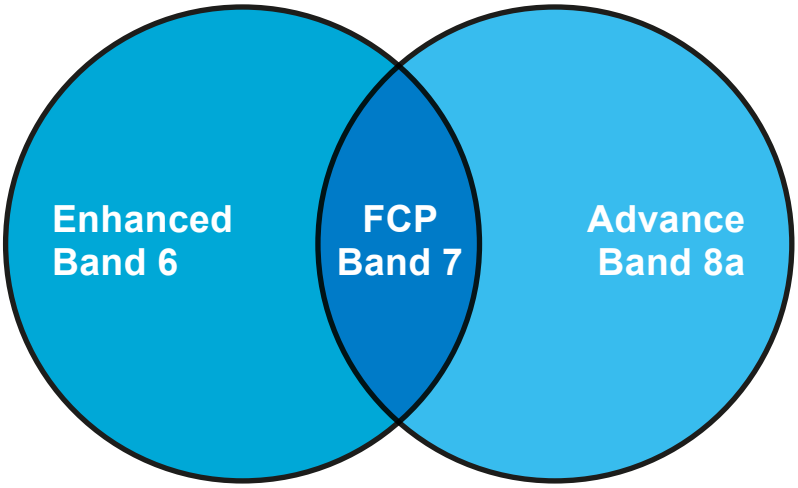


Diagram illustrating the relationship between Bands 6, 7, 8a (AfC), and Enhanced, FCP, and AP.

✔ 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 typically have 3-5 years post preceptorship experience 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.

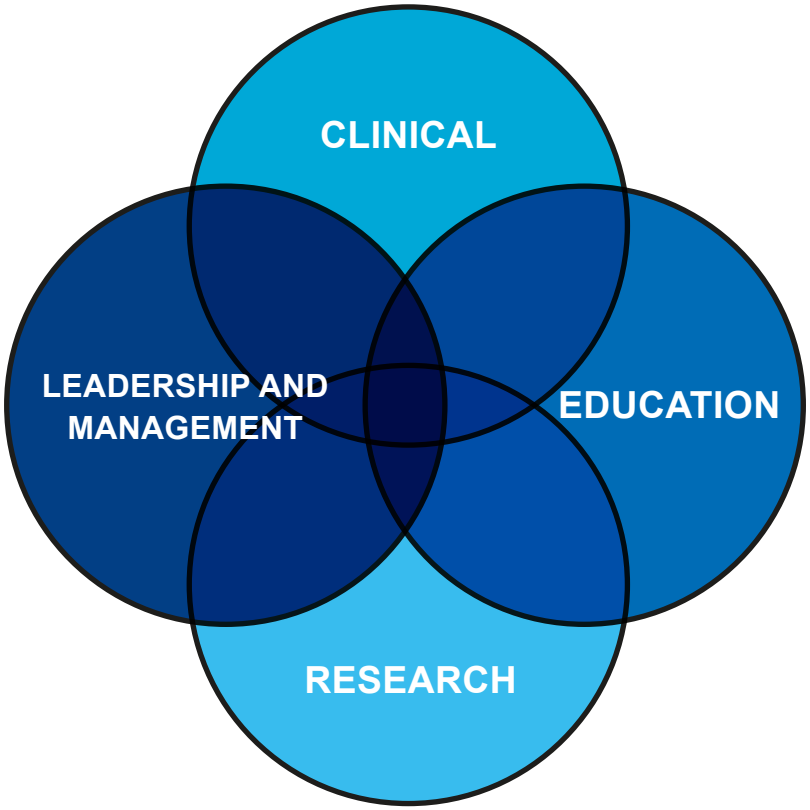


Diagram that illustrates interlinkage of the four pillars of advanced practice.

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

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

- 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.

- 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 toward Advanced Clinical 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.

NB: Trainee FCPs can be employed at a band 6. It is preferable that a trainee FCP is employed in a rotational model. If Employed directly, there will need to be a paramedic infrastructure in place in the PCN to support the Trainee.Trainee FCPs CANNOT refer for investigations or onward care without agreement from a recognised Advanced Practitioner or GP. Trainee FCPs CANNOT prescribe or work under a PGD.

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 (click to view)
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.

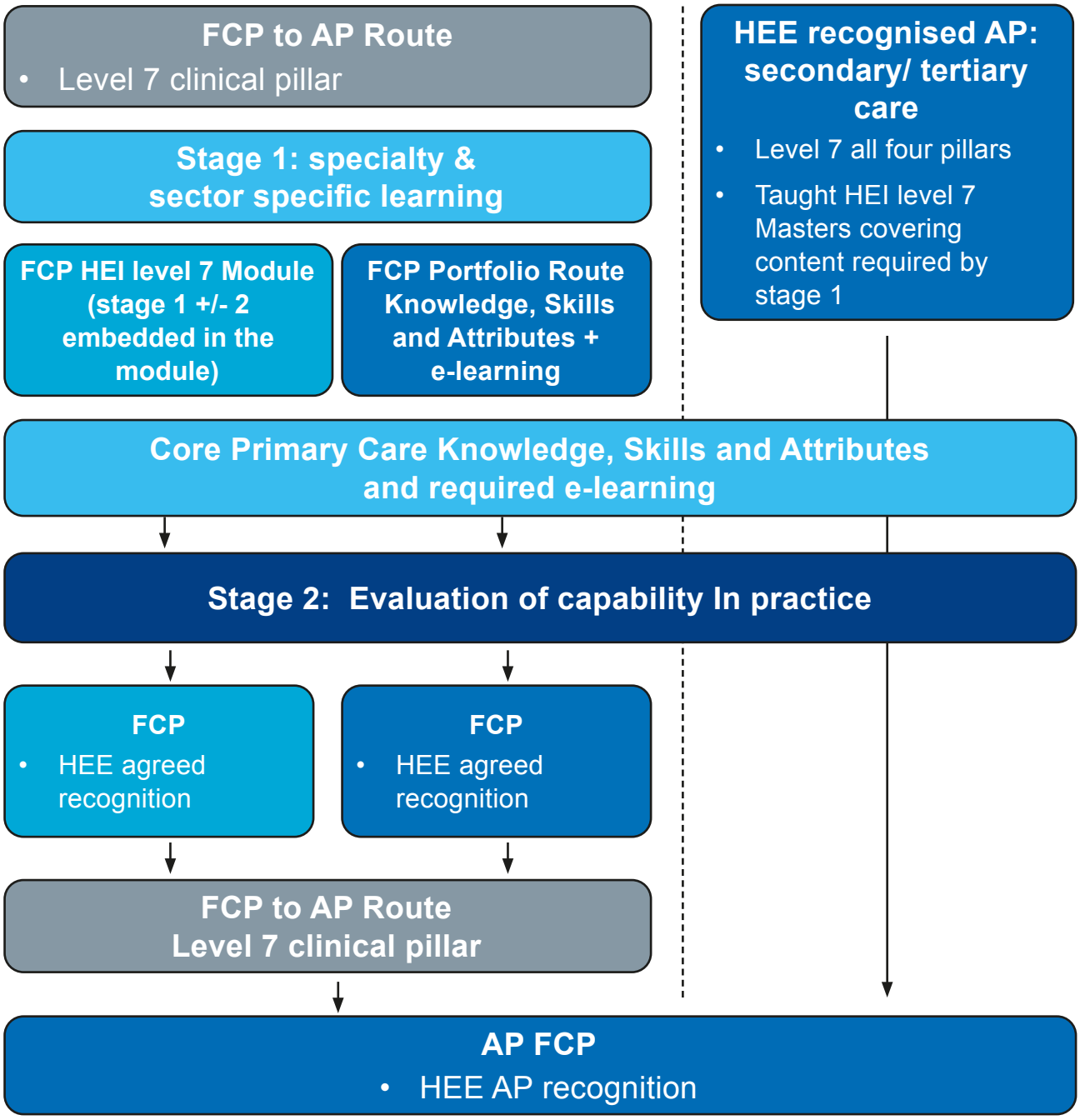


Diagram to illustrate pathways to FCP and AP in Primary Care

3.0 National standards and frameworks for Paramedics

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

- The capabilities are crossed referenced to the Paramedic Specialist in Primary and Urgent Care Core Capabilities Framework and uplift it to Level 7 of clinical practice.

- The document is also cross-referenced to the Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice / Primary Care in England to ensure capability alignment of the core generalist skills that both paramedics and nursing share where relevant to paramedic practice.

- It is important to note that paramedics are a distinct profession, hence capabilities have been changed, added or removed to fit with the unique skills and attributes paramedics bring to the primary care setting.

- FCP Paramedics work with urgent and unscheduled care and acute presentations that have had an acute or chronic onset. Appendix 12.12 at the bottom of the KSA domains outlines a number of key clinical presentations that FCP (Paramedics) need to manage in general practice/primary care, according to the scope of their role. It details assessment and management skills that FCP (Paramedics) must be able to apply appropriately within the context of the capabilities and are applicable across the diversity of people presenting across the age range.

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

  It should be noted that some key clinical presentations can be related to more than one system and systems interlink; therefore, whilst it is important for the FCP (Paramedic) to have the appropriate knowledge and skills of each system they must also and importantly understand the complex inter and co dependencies of systems when providing care to people.

  For each of the clinical skills outlined, the FCP (Paramedic) will also need to have sufficiency in the theoretical and practical underpinning knowledge and understanding of each system in order to demonstrate capability in the provision of care for each of the core clinical skills.

  The knowledge statements therefore apply to clinical skills that are within this appendix.

  It will be for the FCP (Paramedic) and their Clinical Supervisor to contextualise the knowledge statements appropriate to the clinical environment.

  In addition to the generic capabilities outlined in the KSA framework (appendix 12.12) the FCP (Paramedic) will need to know and understand:

  - *When a more focussed history is required relating to a specific presenting problem.*
  - *That conditions can present differently in people, and that many presentations can be attributed to more than one system.*
  - *How to assess and recognise `red flags' for the variety of presenting problems and an awareness of `masquerading red flags'.*

- *How individuals' current medication and existing conditions may affect their presenting symptoms.*

- *The anatomy and physiology of the human body as it applies to the clinical condition/presentation to be assessed.*

- *The different stages of specific health conditions including the short, medium and long-term effects of specific health conditions on the individual's physiological, psychological, mental and biological states and function.*

- *The range of relevant baseline observations and tests across the life span, and appropriate methods for performing them.*

- *Where further investigations can be carried out, who undertakes them, and the timescales involved.*

- *The importance of supporting people to develop their knowledge, confidence and skills in managing their own health and improving their levels of empowerment.*

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

3.1 Building the evidence

In order to develop a coherent professional career infrastructure, the 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 roadmap 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 AP 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.** Frameworks 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 QAA level 7 criteria.

- 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 embarking in Primary Care to assure patient safety.

- **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. This should be completed within a maximum of one year following employment (based on the minimum employment of one session a week).

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

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

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

- There are currently two surveys that form an interim process to collect a list of practitioners who have completed FCP recognition to be credentialed, and who will be transferred to the Centre for Advancing Practice. Once the Centre for Advancing Practice is fully operational, the surveys will be transferred into an FCP 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.

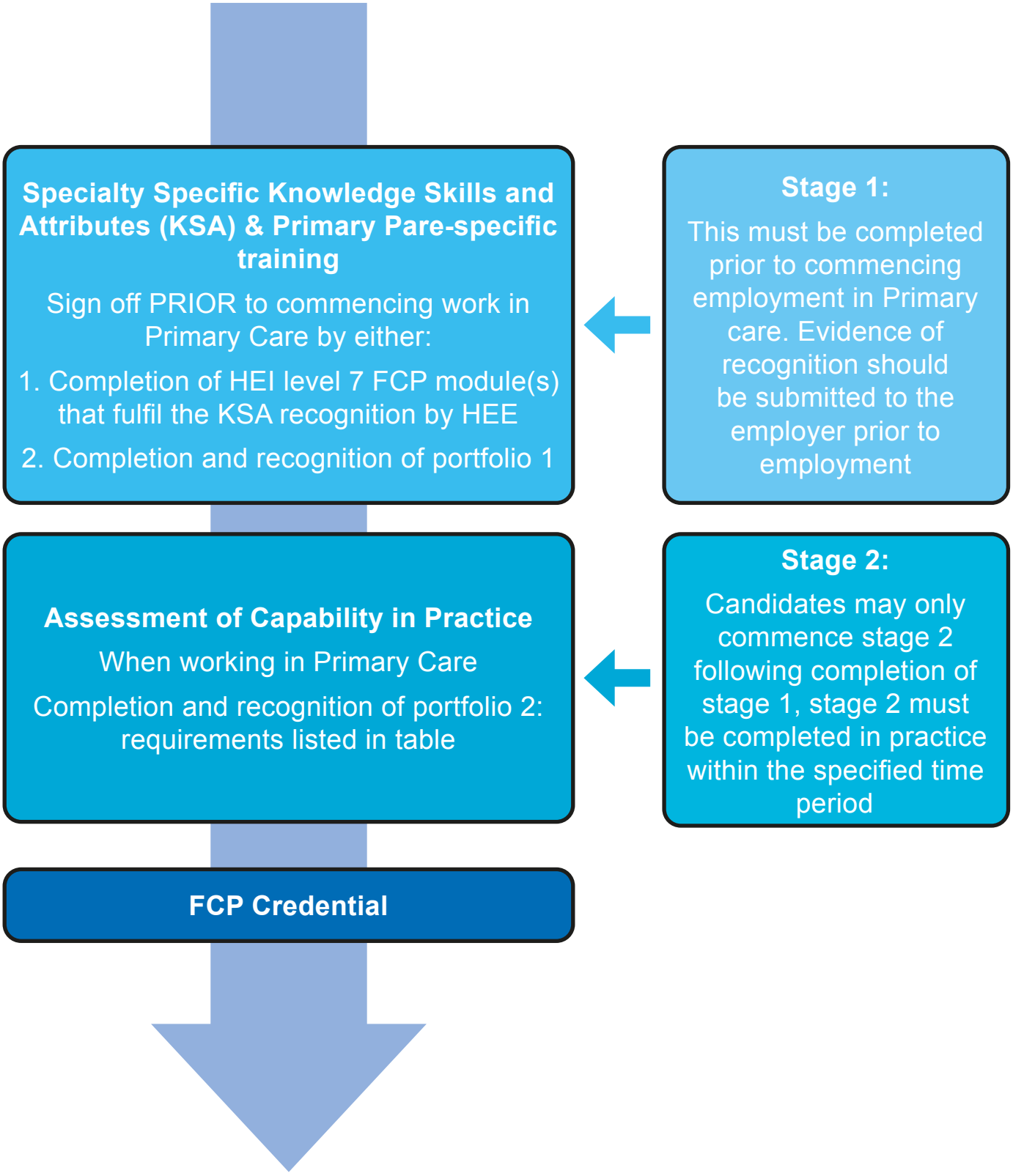


Diagram to illustrate the process of FCP recognition.

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. Although labeled as MSK these are generic modules relevant to all professions. Complimenting these modules are three personalised care modules. Clinicians are required to complete all modules associated with both programmes. For external partners, eIntegrity Registration 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 12.14).

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. 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 paramedics. 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 HEE AP 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 12.14** 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 Paramedic specialist in primary and urgent care core capabilities framework and to the right of each capability there is a cross reference to the core capabilities framework for advanced clinical practice (nurses) working in general practice/primary care in England. 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 12.14 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, Roadmap 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 capability 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 capability 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

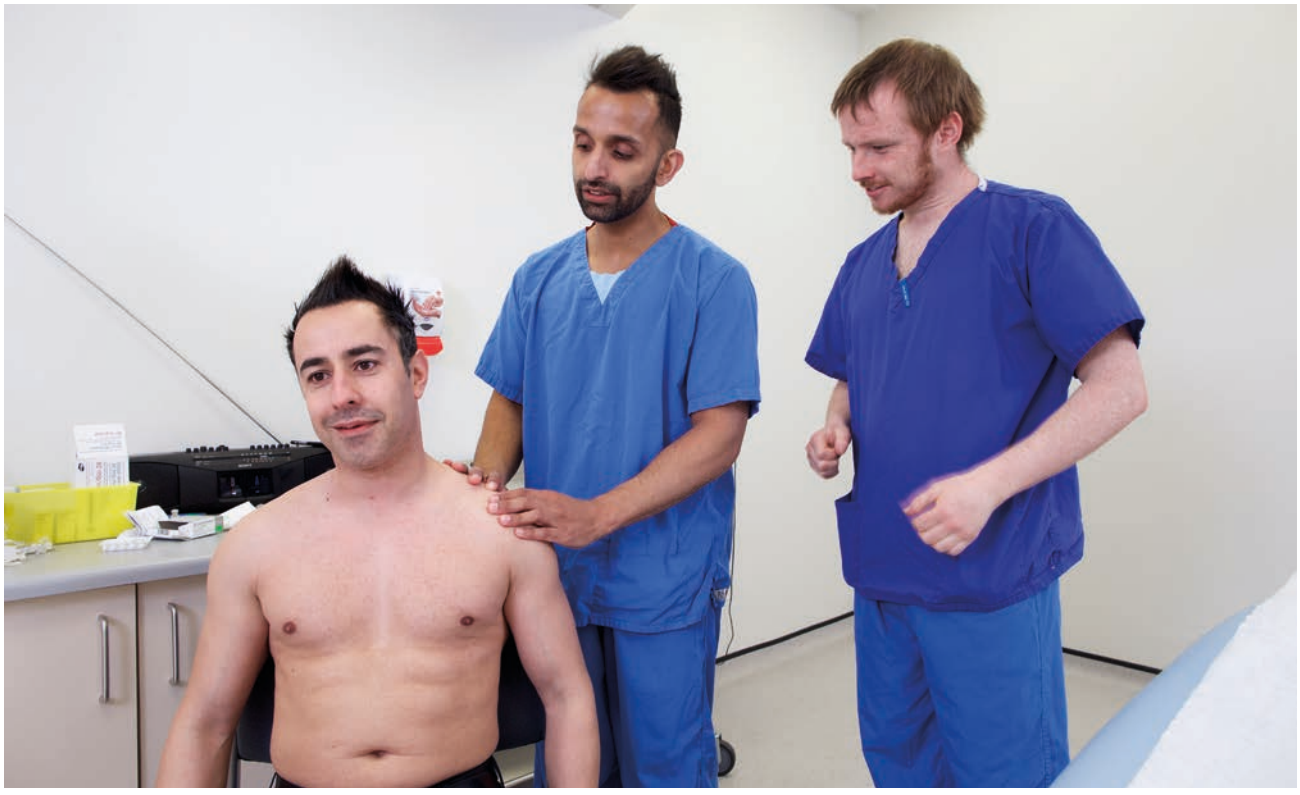
A portfolio is an individual's collection of evidence that illustrates development and learning to date, and provides an overview of plans for future development. In addition, it facilitates analysis of current skills and knowledge through critical reflection and evaluation of learning and development. 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.'

Step 1: gather key documents as referenced in the appendicies to include in your portfolio

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, 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 roadmap 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 Supervision

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.

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.

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 Roadmap 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 FCP or AP roles
- Supporting trainees in/with difficulties
- How to use WPBA
- Supporting FCP/AP with their portfolio of evidence
- The verification process

The HEE Centre for Advancing Practice will hold a directory of practitioners who have completed the HEE Multi-professional Primary Care Supervision Course.

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:**12.14 (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		
Complete FCP Verification Form		
RECOGNITION SURVEYS TO BE COMPLETED Primary Care Clinical Level 7 - FCP Survey Primary Care Clinical Level 7 - FCP Supervisor Survey		

Verification Process for First Contact Practitioners

- Ensure that the stage one and stage two checklists have been completed and signed by both the trainee FCP and the Roadmap Supervisor.

- The trainee FCP should have a discussion with their Roadmap Supervisor to decide if they agree readiness to seek verification.

- The verification form is a summary of the evidence in the portfolio – objective in nature.

- The trainee FCP will need to complete the FCP Verification Form. They should use the form to undertake a self-rating by linking a range of evidence to each capability heading (and example form is included in the appendices)

- If they have enough evidence to demonstrate capability across all the headings, they can pass their portfolio to their Roadmap Supervisor for review, along with their self-ratings on the verification form.

- The Roadmap Supervisor must review the trainee FCP self-ratings and make their own rating either agreeing or disagreeing whether there is evidence of capability across all the headings. Further evidence should be linked by the Roadmap Supervisor.

- If the Roadmap Supervisor supports a rating of capable or excellent then the final page with declarations can be completed and process for recognition with the HEE Centre completed.

- The HEE Centre will audit a percentage of FCP applications for recognition, liaising with both the FCP & the Roadmap Supervisor.

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	
Complete the Advanced Practice Verification Form (in addition to the FCP Verification Form if not already recognised as an FCP by the HEE Centre)		
Advanced practice portfolios will require external verification - process currently under development		

Verification Process for Advanced Practice

- The process for Advanced Practice recognition starts as for FCP (stage 1 and stage 2)

- If the FCP is already recognised by the HEE Centre they will need to 'top up' and evidence the additional capabilities identified in stage 3 of the roadmap and on the Advanced Practice Verification Form

- If the practitioner is not a recognised FCP they will have to complete both the FCP and Advanced Practice roadmap requirements and complete both verification forms with a self-rating

- The Roadmap Supervisor must review the self-ratings and make their own rating either agreeing or disagreeing whether there is evidence of capability across all the headings. Further evidence should be linked by the Roadmap Supervisor

- If the Roadmap supervisor supports a rating of capable or excellent then the final page with declarations can be completed.

- Advanced Practice verification will include an external review of the portfolio of evidence (This process is currently under development)

- Once the external portfolio review is complete the HEE Centre will recognise those who have successfully completed the process (again this process is currently under development).

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

- The document **'Linking KSA/Primary Care Recognition to AP Capabilities'** 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 Paramedics framework becomes important and this document supports the process.

- Each FCP prerequisite KSA is mapped to the relevant dimension (learning outcome and/or competency), fulfilling a subset of the clinical standards required by Paramedic 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 Paramedic 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 Paramedic Advanced Practitioner in Primary Care on completion of the AP level of practice.

When an FCP has completed their FCP portfolio, they would then need to build the evidence against the capabilities 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 resources 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

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.

11.3 Charity & third sector resources

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

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

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

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

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

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.

Childhood Cancer Trust

The British Menopause Society

The Family Planning Association

Parkinsons UK

Prostate Cancern UK

Promoting conversations about death and dying with **dying matters**.

Asthma UK

Heart Failure resources on the **pumping marvellous website**.

11.4 Primary Care

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

Cost: varies, audio book approximately £49.

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

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

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

Cost: approximately £225.

Some resources require a subscription

NB Medical education

RCGP Learning

GP notebook

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

Clinical Knowledge Summaries

e-learning modules supporting paramedic prescribing

British National Formulary

Primary Care Womens Health Forum

Bladder Matters

Live well with pain

Resources to support physical activity conversations on the **moving medicine website**.

'When Should I Worry?' provides information for parents about the management of respiratory tract infections in children, and has been designed to be used in primary care consultations.

Resources supporting CPD in Primary Care

The Children's Bowel and Bladder Charity

Social prescribing in Mendip, Surrey (other areas have similar resources).

12.0 APPENDICES

12.1 Roadmap supervision flow chart

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

Clinical supervision

Must be provided in the clinical setting

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

WHAT?

CPD supervision

Must be provided by the employer

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

Wellbeing and Practitioner Development

Patient Safety and Practitioner Safety

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

Self, Teams & Service Delivery

Is the practitioner & employer:

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

WHY?

WHO?

Clinical Supervisor (CS)

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

CPD Supervisor (CPDS)

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

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

HOW?

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

Educational Supervision

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

12.2 Case-Based Discussion FCP to Advanced Practice

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

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

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

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Working with colleagues and in teams FCP 3			
Maintaining an ethical approach & fitness t practice FCP 4			
Information gathering & interpretation FCP 5			

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Clinical examination FCP 6			
Making a diagnosis FCP 7			
Clinical management FCP 8			

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Managing medical & clinical complexity (For Advanced Practice only) **ACP 13**			
Independent prescribing, pharmacotherapy & treatment **FCP 9** **ACP 14**			
Leadership, management, and organisation **FCP 10** **ACP 10**			
Education and development **FCP 11** **ACP 11**			

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Research and evidence-based practice **FCP 12** **ACP 12**			

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.

Good practice would be for the Practioner 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 Practioner to 'present' the chosen case to them.

The CS can then ask questions and a discussion can follow.

What should be covered in the discussion

- The discussion is framed around the actual case rather than hypothetical events. Questions should be designed to elicit evidence of competence/capability. The Clinical Supervisor should aim to cover up to four capabilities in a single CBD, but if there are too few you 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 (CEPS) Skills Assessment FCP to Advanced Practice Roadmap

Practitioner:	
Clinical Supervisor Name:	
Date:	

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

Guidance when assessing clinical examination procedural skills (CEPS) for FCP to Advanced practice Roadmap

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 Practitioner maintain an empathetic approach throughout?
- Does the Practitioner explain what is going on throughout the procedure?
- Are their findings accurate? Findings should be checked by the Clinical Supervisor.
- Does the Practitioner provide an appropriate explanation of their findings and the implications to the person?
- Is there an appropriate management/personalised care and support plan made with the person?

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

Please ensure that your Clinical Supervisor signs off your CEPS.

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

12.4 Clinical Supervisor's Report

Practitioner's Name:	
Clinical Supervisor Name:	
Date:	

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

RELATIONSHIP	
Explores person's agenda (their Ideas, Concerns and Expectations) (FCP Capability 1)	Grade
Works in partnership to negotiate a plan (FCP Capability 2, ACP 2a)	Grade
Recognises the impact of the problem on the person's life (FCP Capabilities 1, 2, 8, ACP2a)	Grade
Works co-operatively with team members, using their skills appropriately (FCP Capabilities 3, 10)	Grade
DIAGNOSTICS	
Takes a history and investigates systematically and appropriately (FCP Capability 5)	Grade

Examines appropriately and correctly identifies any abnormal findings (please comment on specific examinations observed) (FCP Capability 6, ACP 13)	Grade
Elicits important clinical signs & interprets information appropriately (FCP Capabilities 5, 6, ACP 13)	Grade
Suggests an appropriate differential diagnosis (FCP Capability 7, ACP 13)	Grade
Refers appropriately and co-ordinates care with other professionals (FCP Capabilities 3, 4 8, ACP 2b)	Grade
MANAGEMENT	
Keeps good medical records (FCP Capabilities 8, 10)	Grade
Uses resources cost-effectively (FCP Capabilities 3, 9, 12 ACP 14)	Grade
Keeps up-to-date and shows commitment to addressing learning needs (FCP Capabilities 11. 12)	Grade

PROFESSIONALISM	
Identifies and discusses ethical conflicts (FCP Capability 4)	Grade
Shows respect for others (FCP Capabilities 3, 4, ACP 10)	Grade
Is organised, efficient, and takes appropriate responsibility (FCP Capability 10, ACP 10)	Grade
Deals appropriately with stress (FCP Capabilities 3, 10)	Grade

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

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

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

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

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

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

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

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

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

Feedback & recommendations for further development:
Agreed action plan:

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

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

Consultation Observation Tool (COT) – guidance & consent form

Clinical Supervisors use the Consultation Observation Tool (COT) to support holistic judgements about the practitioner level of practice in primary care. COT is one of the tools used to collect evidence for the FCP portfolio of evidence of capability, as a Workplace-Based Assessment.

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 Practitioner role, e.g. MSK, children, older adults, mental health, etc. The Practitioner can include consultations in different contexts – for example, a home visit.

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

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

Collecting evidence from the consultation

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

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

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

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

TO BE COMPLETED BY PATIENT

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

Signature of patient BEFORE CONSULTATION:

.....Date.....

Signature of person accompanying patient to the consultation:

.....Date.....

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

Signature of patient AFTER CONSULTATION:

.....Date.....

Signature of person accompanying patient to the consultation

.....Date.....

12.6 Multi-Source Feedback (MSF)

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

Part 1

This part should be completed by all respondents

Please state your job title

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

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

Notes: You may wish to consider the following:

The Practitioner:

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

Comments (where possible please justify comments with examples)

Highlights in performance areas (areas to be commented)

Suggested areas for development in performance

Part 2

To be completed by clinical staff only

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

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

You may wish to consider the following about the Practitioner:

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

Comments (where possible please justify comments with examples)

Highlights in performance areas (areas to be commented)

Suggested areas for development in performance

Multi-Source Feedback (MSF) Guidance

Multi-Source Feedback is collected from colleagues.

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

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

12.7 Personal development plan (PDP)

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

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

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

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

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

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

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

FCP - Advanced Practice Roadmap

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

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

Practitioner: .....

Supervisor: .....

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

Hello,

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

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

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

Thank you.

Please rate the Practitioner at:

Please tick your response

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Overall, how would you rate your consultation today?

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

Many thanks for your assistance

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

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 Practitioner, 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 Practitioner.

The Practitioner should reflect on the feedback in a learning log.

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

12.9 Tutorial record

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

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

12.10 Tutorial evaluation

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

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

Signed:	

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

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

Once you have completed both sessions of training, you will be put on a list of verified Advanced Practice roadmap supervisors regionally that will be transferred to and held on a directory by the Centre of Advancing Practice, once it has been fully established.

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 FCP Verification of Evidence Form Example form

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRACTITIONER

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

FCP SIGNATURE ……

FCP HCPC REGISTRATION NUMBER……DATE……..

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

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

I HAVE REVIEWED THE EVIDENCE OF CAPABILITYIN THIS PORTFOLIO YES ☐ NO ☐

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

OVERALL RATING OF CAPABILITY FOR STAGE TWO (PLEASE TICK)

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

SUPERVISOR SIGNATURE……DATE……..

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

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

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

12.13 Advanced Practice Verification of Evidence Form

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

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

CAPABILITY	ACP LINKS
WORKING WITH COLLEAGUES & IN TEAMS	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 3a
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
WORKING WITH COLLEAGUES & IN TEAMS	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 3a
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
MANAGING MEDICAL & CLINICAL COMPLEXITY	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 13 a - f
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
MANAGING MEDICAL & CLINICAL COMPLEXITY	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 13 a - f
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
INDEPENDENT PRESCRIBING, MEDICINES SUPPLY & PHARMACOTHERAPY	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 14 a - p
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
INDEPENDENT PRESCRIBING, MEDICINES SUPPLY & PHARMACOTHERAPY	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 14 a - p
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
LEADERSHIP, MANAGEMENT & ORGANISTAION	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 10 a - h
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
LEADERSHIP, MANAGEMENT & ORGANISTAION	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 10 a - h
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
EDUCATION & DEVELOPMENT	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 11 a – h
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
EDUCATION & DEVELOPMENT	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 11 a – h
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 12 a - h
EVIDENCE TYPE & DATE(S)	

CAPABILITY	ACP LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 12 a - h
EVIDENCE TYPE & DATE(S)	

PRACTITIONER

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

PRACTITIONER SIGNATURE …… ……

PRACTITIONER HCPC REGISTRATION NUMBER……DATE……..

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

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

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

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

OVERALL RATING OF CAPABILITY FOR STAGE TWO (PLEASE TICK)

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

SUPERVISOR SIGNATURE……DATE……..

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

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

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

12.14 Knowledge, Skills and Attributes document

Domain A: Person-centred Collaborative Working

Capability 1. Communication and consultation skills			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) Capabilities	FCP Capabilities
	Critically appraise communication strategies and be able to optimise communication approaches appropriately using skills such as active listening e.g. frequent clarifying, paraphrasing and picking up verbal cues such as pace, pauses and voice intonation.	A1(a)	1a
Critical skills			
A1(a)	Convey information and address issues in ways that avoid jargon and assumptions; respond appropriately to questions and concerns to promote understanding, including use of verbal, written and digital information.	A1(k)	1b
A1(b)	Adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to people's communication and language needs and preferences, including levels of spoken English and health literacy.	A1(c)	1c
A1(c)	Communicate effectively with individuals who require additional assistance to ensure an effective interface with a practitioner, including the use of accessible information.	A1(d)	1d
A1(d)	Evaluate situations, circumstances or places which make it difficult to communicate effectively (e.g. noisy, distressing or emergency environments), and have strategies in place to overcome these barriers. Adapt communication styles to meet the needs of people who have learning disabilities, are neuro-diverse or other disabilities that impair communication.	A1(e)	1e

A1(e)	Enable effective communication approaches to non-face to face situational environments e.g. phone, video, email or remote consultation.	A1(i)	1f
	Consult in a highly organised and structured way, with professional curiosity as required, whilst understanding the constraints of the time limited nature of primary/urgent care consultations and ensure communication is safe and effective.	A1(g)	1g
	Elicit psychosocial history to provide context for peoples' problems or presentations.	A1(h)	1h
A1(f)	Manage people effectively, respectfully and professionally (including where applicable, carers and families) especially at times of conflicting priorities and opinions.	A1(l)	1i
A1(j)	Communicate in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate people's care.	A1(m)	1j
A1(k)	Recognise that effective consultation skills are a subset of advanced communication skills highlighted in the capability for history taking and consultation skills.	A1(n)	1k

Capability 2. Practicing holistically to personalise care and promote public and person health			
Cross-referenced SPUC capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) capabilities	FCP Capabilities
	Critically appraise the impact that a range of social, economic, and environmental factors can have on health outcomes for people, and where applicable their family and carers.	A2(a)	2a
A2(b)	Evaluate how a person's preferences and experience, including their individual cultural and religious background, can offer insight into their priorities and wellbeing.	A2(d)	2b
A2(f)	Evaluate the implications of, and apply in practice, the relevant legislation for informed consent and shared decision making (e.g. mental capacity legislation, Fraser Guidelines).	A2(m)	2c
Critical skills			
	Explore and act upon day to day interactions with people to encourage and facilitate changes in behaviour such as smoking cessation, reducing alcohol intake and increasing exercise that will have a positive impact on the health and wellbeing of people, communities and populations i.e. 'Making Every Contact Count' and signpost additional resources.	A2(e)	2d
	Effectively employ the Public Health England "All Our Health" framework in own and wider community of practice.	A2(b)	2e

A2(d)	Engage people in shared decision making about their care by: • supporting them to express their own ideas, concerns and expectations and encouraging them in asking questions • explaining in non-technical language all available options (including watch and wait approaches or doing nothing) • exploring with them the risks and benefits of each available option and discussing any implications • supporting them to make decisions on their preferred way forward.	A2(h)	2f
	Recognise and respond appropriately to the impact of psychosocial factors on the presenting problem, condition or general health such as housing issues, work issues, family/carer issues, lack of support, social isolation and loneliness.	A2(g)	2g
A2(e)	Evaluate how the vulnerabilities in some areas of a person's life might be overcome by promoting resilience in other areas.	A2(j)	2h
	Advise on and refer people appropriately to psychological therapies and counselling services, in line with their needs and wishes, taking account of local service provision.		2i
	Advise on sources of relevant local or national self-help guidance, information and support including coaching and social prescrbing.	A2(o)	2j

Capability 3. Working with colleagues and in teams			
Cross-referenced SPUC capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) capabilities	FCP Capabilities
	Have a deep and systematic knowledge and understanding of wider primary, community care and secondary care, voluntary sector services and teams and refer independently using professional judgement.	A3(c)	3a
Critical skills			
A4(a)	Ensure own work is within professional and personal scope of practice and access advice when appropriate.	A3(a)	3b
A4(b)	Advocate and utilise the expertise and contribution to peoples' care of other health and social care professionals, and work collaboratively within the multi-professional team to optimise assessment, diagnosis and integrated management and care for people.	A3(b)	3c
A1(h)	Communicate effectively with colleagues using a variety of media (e.g. verbal, written and digital) to serve peoples' best interests.	A3(e)	3d
A4(c)	Engage in effective inter-professional communication and collaboration (with clear documentation) to optimise integrated management and care for people.		3e
	Make direct referrals in a timely manner as indicated by peoples' needs with regard to referral criteria and organisational policies e.g. 2-week wait cancer pathway, urgent or routine referrals.	A3(f)	3f

A4(d, e)	Participate in effective multi-disciplinary team activity and understand the importance of effective team dynamics. This may include but is not limited to the following; service delivery processes, research such as audit/ quality improvement, significant event review, shared learning and development.	A3(g)	3g
	Take responsibility for one's own well-being and promote the well-being of the team escalating any causes for concern appropriately.	A3(i)	3h

Capability 4. Maintaining an ethical approach and fitness to practice			
Cross-referenced SPUC capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) capabilities	FCP Capabilities
	Critically reflect on how own values, attitudes and beliefs might influence one's professional behaviour.	A4(b)	4a
Critical skills			
	Demonstrate the application of professional practice in one's own day to day first contact clinical practice.	A4(a)	4b
A5(d)	Identify and act appropriately to promote positive behaviour around equality, diversity and human rights.	A4(c)	4c
	Reflect on and address and engage appropriately ethical/moral dilemmas encountered during one's own work which may impact on care. Advocate equality, fairness and respect for people and colleagues in one's day to day practice	A4(d)	4d
	Keep up to date with mandatory training and CPD requirements, encompassing those requiring evidence for a first contact role.	A4(e)	4e
	Recognise and ensure a balance between professional and personal life that meets work commitments, maintains one's own health, promotes well-being and builds resilience.	A4(f)	4f
	Demonstrate insight into the health issues primary care can place on personal health and wellbeing (e.g. workload pressures, lone working etc.) when working as an FCP.	A4(g)	4g
	Promote mechanisms such as complaints, significant events and performance management processes in order to improve people's care.	A4(i)	4h
	Promote mechanisms such as compliments and letters of thanks to acknowledge and promote good practice.	A4(j)	4i

Domain B: Assessment, investigations and diagnosis

Capability 5: Information gathering and interpretation			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) Capabilities	FCP Capabilities
	Understand and apply a range of consultation models appropriate to the clinical situation and appropriately across physical and mental health presentations.	B5(d)	5a
(new)	Understand the limits of own clinical knowledge and recognise when presentations are outside own scope of practice. Ensure history taking is detailed to enable advice referral as appropriate.	(new)	5b
Critical skills			
(new)	Be able to take a succinct, pertinent history when managing the acutely unwell or time-critical patient, balancing the benefits of a detailed history against the need for immediate treatment to preserve life or prevent deterioration.	(new)	5c
B6(a)	Structure consultations to encourage the patient and/or their carer to express their ideas, concerns, expectations and understanding, using active listening skills and open questions to effectively engage with people and carers.	B5(a)	5d
	Be able to undertake general history-taking, and focused history-taking to elicit and assess “red flags”. Be aware that “red flags” may differ in a primary/urgent care setting compared to an emergency setting (e.g. symptoms suggestive of cancer).	B5(e)	5e

B6(c)	Synthesise information, considering of factors which may include the presenting complaint, existing complaints, past medical history, genetic predisposition, medications, allergies, risk factors and other determinants of health to establish differential diagnoses.	B5(f)	5f
B6(d)	Incorporate information on the nature of the person's needs preferences and priorities from various other appropriate sources e.g. third parties, previous histories and investigations.	B5(g)	5g
B6(e)	Explore and appraise peoples' ideas, concerns and expectations regarding their symptoms and condition, and whether these may act as a driver or form a barrier.	B5(c)	5h
B6(f)	Critically appraise complex, incomplete, ambiguous and conflicting information gathered from history-taking and/or examination, distilling and synthesising key factors from the appraisal, and identifying those elements that may need to be pursued further.	B5(h)	5i
B6(g)	Deliver diagnosis and test/investigation results, (including bad news) sensitively and appropriately in line with local or national guidance, using a range of mediums including spoken word and diagrams for example to ensure the person has understands what has been communicated.	B5(i)	5j
B6(h)	Record all pertinent information gathered concisely and accurately complying with local guidance, legal and professional requirements for confidentiality, data protection and information governance.	B5(j)	5k

Capability 6 Clinical examination and procedural skills			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) Capabilities	FCP Capabilities
B7(c)	Demonstrate the ability to apply a range of physical assessment techniques, being informed by an understanding of such techniques' respective validity, reliability, specificity and sensitivity, and the implications of any limitations within such assessments, to enable an appropriate examination.		6a
(new)	Understand and have insight into the limits of own knowledge, skills, scope of practice and competence, and practice within these boundaries, recognising when referral to another professional for examination may be more appropriate.	(new)	6b
Critical skills			
	Ensure the person understands the purpose of any physical examination (including intimate examinations), and/or mental health assessment, describe what will happen and the role of the chaperone where applicable.	B6(a)	6c
B7(a)	Obtain appropriate consent and ensure where examinations take place, the person is afforded privacy and their dignity is respected (addressing comfort where practicable and reasonable adjustments being made as needed). Ensure examination is appropriate and clinically effective.	B6(b)	6d
B7(b)	Adapt practice to meet the needs of different groups and individuals, including adults, children and those with particular needs (such as cognitive impairment, sensory impairment or learning disability), working with chaperones, where appropriate.	B6(c)	6d

B7(c)	Apply a range of physical assessment and clinical examination techniques appropriately, systematically and effectively.	B6(d)	6e
B7(d)	Perform a mental health assessment appropriate to the needs of the person, their presenting problem and manage any risk factors such as suicidal ideation promptly and appropriately.	B6(d)	6f
	Use nationally recognised tools where appropriate during assessment.	B6(f)	6g
B7(e)	Using a systematic approach, identify, analyse and interpret potentially significant information from the physical and mental health assessment (including any ambiguities).		6h
B7(f)	Demonstrate accurate and concise documentation of examinations or procedures undertaken to support a clinical management plan, and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance.	B6(h)	6i

Capability 7: Making a Diagnosis Paramedics have extensive experience of assessing patients, reaching working diagnoses and providing appropriate treatment. The FC Paramedic can adapt these skills to a primary care setting, where most presentations will not be life threatening, whilst maintaining the ability to recognise serious underlying pathology.			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) Capabilities	FCP Capabilities
B8(g)	Understand how to make a diagnosis in a structured way using a problem-solving method informed by an understanding of probability based on prevalence, incidence and natural history of illness to aid decision making.	B7(a)	7a
B7(g)	Understand key diagnostic biases and common errors and the issues relating to diagnosis in the face of ambiguity and incomplete data.		7b
(new)	Critically appraise own decision-making processes by applying underpinning models of complex clinical decision making into practice.	(new)	7c
(new)	Understand diagnostic uncertainty, sharing uncertainty with patients. Recognise the urgency and necessity of further assessment or investigations required to reach a diagnosis by assessing the relative risks as being immediately life threatening, serious or minor.	(new)	7d
Critical skills			
	Target further investigations appropriately and efficiently following due process with an understanding of respective validity, reliability, specificity and sensitivity and the implications of these limitations.	B7(b)	7e

B8(b)	Understand the importance, and implications, of findings and results and take appropriate action. This may be urgent referral/escalation as in life threatening situations, or further investigation, treatment or referral.	B7(c)	7f
	Synthesise the expertise of multi-professional teams to aid in diagnosis where needed.	B7(d)	7g
B8(f)	Focus the objective data gathering and prioritise investigations in the context of the patient presentation and the clinical environment.		7h
B8(c)	Formulate a differential diagnoses based on subjective and where available objective data, identifying where necessary the need for investigations to aid diagnoses.	B7(e)	7i
B8(a)	Interpret the subjective and objective findings from the consultation. Exercising clinical judgement, determine differential diagnoses and a working diagnosis in relation to all information obtained. This may include the use of time as a diagnostic tool where appropriate.	B7(f)	7j
	Revise hypotheses in the light of additional information and think flexibly around problems, generating functional and safe solutions.	B7(g)	7k
B8(f)	Recognise when information/data may be incomplete (e.g. patient personally unable to provide a comprehensive history) and take mitigating actions to manage risk appropriately. Recognise the limitations of collateral information from others.	B7(h)	7l
B8(h)	Be confident in and take responsibility for own decisions whilst being able to recognise when a clinical situation is beyond own capability or competence and escalate appropriately.	B7(i)	7m

Domain C: Condition management, treatment and prevention

Capability 8: Clinical Management			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) Capabilities	FCP Capabilities
(new)	Critically reflect on limits of own knowledge, and seek advice, when uncertain about correct clinical management.	(new)	8a
Critical skills			
C9(a)	Vary the management options responsively according to the circumstances, priorities, needs, preferences, risks and benefits for those involved with an understanding of local service availability and relevant guidelines and resources.	C8(a)	8b
	Consider a “watch and wait” approach where appropriate.	C8(b)	8c
	Safely prioritise problems in settings where the person presents with multiple issues. Manage any conflict between patient priorities and clinically urgent problems.	C8(c)	8d
C9(c)	Implement shared management/ personalised care/support plans in collaboration with people (and where appropriate carers), families and other healthcare professionals.	C8(d)	8e
C9(b)	Ensure the management plan considers all options that are appropriate for the care pathway.		8f
C9(d)	Arrange appropriate follow up that is safe and timely to monitor changes in the person’s condition in response to treatment and advice, recognising the indications for a changing clinical picture and the need for escalation or alternative treatment as appropriate.	C8(e)	8g

	Evaluate outcomes of care against existing standards and patient outcomes, managing/ adjusting plans appropriately in line with best available evidence.	C8(f)	8h
C9(e)	Identify when interventions have been successful and complete episodes of care with the person, offering appropriate follow-on advice to ensure people understand what to do if situations/circumstances change.	C8(g)	8i
	Promote continuity of care as appropriate to the person and practice setting.	C8(h)	8j
	Suggest a variety of follow-up arrangements that are safe and appropriate, whilst also upholding the person's autonomy.	C8(i)	8k
	Ensure safety netting advice is appropriate and the person understands when to seek urgent or routine review.	C8(j)	8l
	Support people who might be classed as frail and work with them utilising best practice.	C8(k)	8m
	Recognise, support and proactively manage people who require palliative care and those in their last year of life, extending the support to carers and families as appropriate.	C8(l)	8n

Capability 9: Prescribing treatment, administering drugs/medication, pharmacology.			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) Capabilities	FCP Capabilities
C10(d)	Demonstrate knowledge of drug legislation including medicines management adhering to legal frameworks and use appropriate source literature where required (e.g. British National Formulary).		9a
(new)	Understand the legal mechanisms by which drugs may be supplied or administered by paramedics ie. exemptions under the Human Medicine Regulations (2012), Patient Group Directions, Patient Specific Directions and Independent and Supplementary Prescribing, and the advantages and limitations of each. Understand the basis on which you may be supplying and administering medicines in your setting, always adhering to the legal mechanism and frameworks.	(new)	9b
Critical skills			
	Promote personalised, patient-shared decision-making to support adherence leading to concordance.	C10(b)	9c
C10(c)	When using PGD's practice in line with the principles of antimicrobial stewardship and antibiotic resistance using available local or national resources.	C10(e)	9d
	Be able to confidently explain and discuss the risks and benefits of medication with people, using appropriate tools to assist as necessary.	C10(g)	9e
C10(f)	Recognise adverse drug reactions and manage appropriately, including reporting as required through the correct route.		9f

C10(g)	Advise people on medicines management, including compliance, the expected benefits and limitations, and inform them impartially on the advantages and disadvantages in the context of other management options.	C10(h)	9g
C10(h)	Identify sources of further information (e.g. websites or leaflets) and advice (e.g. pharmacists) and signpost appropriately to complement the advice given.		9h
	Understand a range of options available other than supplying, administering or prescribing (e.g. not prescribing, promoting self-care, advice on over-the-counter medicines).	C10(i)	9i
	Facilitate and or prescribe non-medicinal therapies such as psychotherapy, lifestyle changes and social prescribing.	C10(j)	9j
C10(i)	Maintain accurate, legible and contemporaneous records of medication prescribed and/or administered and advice given in relation to medicine.	C10(l)	9k

Domain D: Leadership and management, education and research

Capability 10: Leadership, management and organisation			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) Capabilities	FCP Capabilities
	Show consideration for people and colleagues, carrying out both clinical and non-clinical aspects of work in a timely manner, demonstrating effective time management within the constraints of the time limited nature of general practice/ primary care.	D11(a)	10a
Critical skills			
	Respond positively when services are under pressure, acting in a responsible and considered way to ensure safe practice.	D11(b)	10b
	Role model the values of being an FCP(Paramedic) and their place of work, demonstrating a person-centred approach to service delivery and development.	D11(d)	10c
	Actively engage in peer review to inform own and other's practice, formulating and implementing strategies to act on learning and make improvements.	D11(g)	10d
	Actively seek and be positively responsive to feedback and involvement from people, families, carers, communities and colleagues in the co-production of service improvements.	D11(h)	10e
	Demonstrate receptiveness to challenge and preparedness to constructively challenge others, escalating concerns that affect people, families, carers, communities and colleagues' safety and well-being when necessary.	D11(m)	10f

For further details on leadership and management, see the NHS Leadership Academy.

	Negotiate an individual scope of practice within legal, ethical, professional and organisational policies, governance and procedures, with a focus on managing risk and upholding safety.	D11(n)	10g
	Deal with compliments and complaints appropriately, following professional standards and applicable local policy.	D11(o)	10h
	Actively participate in Significant Event Review and share the learning.	D11(p)	10i

Capability 11: Education and development			
Cross-referenced SPUC capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) capabilities	FCP Capabilities
13(a)	Critically assess and address own learning needs, negotiating a personal development plan that reflects a breadth of ongoing professional development.	D12(a)	11a
Critical skills			
13(b)	Engage in self-directed learning, critically reflecting on practice to maximise skills and knowledge.	D12(b)	11b
	Actively seek and be open to feedback on own practice by colleagues to promote ongoing development.	D12(c)	11c

Capability 12: Research and evidence based practice			
Cross-referenced SPUC capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) capabilities	FCP Capabilities
Critical skills			
	Understand and utilise the evidence of best practice to inform own practice.	D12(c)	12a
	Support quality improvement initiatives/ projects – sharing outcomes and promoting change.	D12 (e)	12b

For further details on research, see the NHS National Institute for Health Research

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

Cardiovascular System

Demonstrate knowledge of the cardiovascular system, analysing potential severity and the impact on related systems.

Demonstrate knowledge of the influencing factors such as psycho-social & family history, risk factors, age, symptomatic and clinical signs.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for and initiate immediate treatment of person with chest pain. • Understand the implications of an existing cardiovascular condition. • Take a structured and appropriate history of a person presenting with a cardiovascular condition. • Perform appropriate cardiovascular assessment. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Instruct and support service users in the use of medicines and devices. • Identify and rationalise need for additional tests such as ECG, X-ray, blood tests, echo etc.	• Chest pain • Chest discomfort • Orthopnoea • Palpitations • Irregular pulse • Oedema • Blood pressure issues • Shortness of breath on exertion	• Temperature • Pulse rates, rhythm, volume and character • Blood pressure • Respiratory rate • Oxygen saturations • Jugular venous pressure • Cardiovascular examination – including inspection, auscultation & palpation • Chest X-ray • Bloods – FBC, U&E, haematinics, TFT, ESR/CRP, lipid profile, HbA1c, BNP/NT-proBNP

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Accurately interpret ECGs for common presentations of cardiac problems (e.g. tachyarrhythmias, bradyarrhythmia, conduction and bundle branch blocks. ST elevation, atrial fibrillation, flutter etc) • Identify the need for additional clinical and professional support such as referral, second opinion etc. • Be able to write a comprehensive and appropriate referral letter. • Recognise the effect that the environment, lifestyle and genetics can have on the cardiovascular system and provide lifestyle and health promotion advice or referral, such as weight loss, exercise and smoking cessation etc. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them.		• Electrocardiograph (ECG) • Echocardiogram (Echo) • 24-hour BP monitoring • 24-hour ECG Monitoring • Use of risk factor calculators • Routine, urgent and 2 week wait referral criteria

Dermatology

Demonstrate knowledge of the dermatological system including the gross and surface anatomy of skin.

Demonstrate knowledge of how to recognise the influence of mechanism of any injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Take a structured and appropriate history of a person presenting with a skin problem. • Understand the implications of an existing skin condition. • Perform an appropriate skin and/or wound examination. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Use of appropriate descriptors such as ABCDE • Identify the need for and initiate immediate treatment of a person with obvious skin emergencies. • Identify and initiate appropriate treatment for people presenting with minor wounds. • Follow local or national guidance and utilise navigation pathways to identify and rationalise need for additional tests such as biopsy, swab, doppler etc. • Supply, and/or administer or prescribe appropriate therapies when indicated in agreement with the patient.	• Rash – localised • Rash – systemic • Itching • Infestation • Spots • Skin lesions, moles • Nail issues/changes • Changes in pigmentation	• Temperature • Pulse rate • Inspection, palpation • Skin and/or nail scrapings/samples • Blood tests FBC, calcium, U&Es, LFT, ESR, CRP, TFT, haematinics. • Routine, urgent and 2 week wait referral criteria

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for additional clinical and professional support such as referral, second opinion etc. • Be able to write a comprehensive and appropriate referral letter. • Recognise the effect that the environment, lifestyle and genetics can have on the skin and provide information, lifestyle and health promotion advice or referral. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them.		

Ears Nose and Throat

Demonstrate knowledge of the ear, nose and throat systems.

Demonstrate knowledge of how to recognise the influence of mechanism of any injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Take a structured and appropriate history of a person presenting with a person presenting with an ears, nose and/or throat condition. • Understand the implications of an existing ENT condition. • Perform an appropriate ENT examination/assessment; including ear, nose/nasal, oral cavity and cervical lymph nodes. • Identify the need for and initiate immediate treatment of a person with obvious ENT emergencies. • Supply, and/or administer or prescribe appropriate therapies when indicated in agreement with the patient. • Identify and rationalise need for additional tests such as swabs, blood tests etc. • Identify the need for additional clinical and professional support such as referral, second opinion etc.	• Dizziness • Vertigo • Otalgia • Otorrhoea • Sinus pain • Nasal pain, obstruction • Mouth pain • Neck swelling • Sore throat • Throat swellings • Tinnitus • Hearing loss • Voice changes	• Temperature • Pulse rate • Respiratory rate • Assessment for lymphadenopathy • Blood tests – FBC, glandular fever screen. TFT • Otoscopy • Throat examination • Routine, urgent and 2 week wait referral criteria • Swabs

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Be able to write a comprehensive and appropriate referral letter. • Recognise the effect that the environment, lifestyle and genetics can have on the ENT system and provide information, lifestyle and health promotion advice or referral. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them		

Emergency Presentations

Demonstrate knowledge of the range of emergency person presentations, understanding the complex interrelations of body systems and their inter-dependencies on life.

Demonstrate knowledge of what appropriate actions to take in a range of emergency situations.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Act as clinical lead for emergencies where appropriate • Initial ABCDE assessment and action needed. • Take a structured and appropriate history of a person presenting. • Perform an appropriate examination/assessment. • Provide well evidenced differential diagnosis and suggested management plan. • Identify the need for and initiate immediate treatment • Supply, administer or prescribe appropriate therapies when indicated, where possible in agreement with the patient. • Make suitable and appropriate referrals. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them.	• Cardiac arrest • Catastrophic haemorrhage • Shock • Respiratory distress • Cardiovascular adverse signs • Anaphylaxis • Angioedema • Allergic reaction • Collapse • Seizure • Sepsis • Non blanching rash • Overdose/poisoning • Suspected diabetic ketoacidosis • Meningism • Limp Child	• Emergency procedures for seeking assistance and calling ambulance • Provide basic life support (CPR, defibrillator) • Administration of nebulised therapies (if available in practice setting) • Management of anaphylaxis (administration of adrenaline, hydrocortisone, chlorphenamine) • Management of suspected meningitis (including administration of benzylpenicillin or alternative) • Administration of oxygen • Initiation of the sepsis 6 guidelines

Eyes

Demonstrate knowledge of the ophthalmic system and any impact on related systems.

Demonstrate knowledge of how to recognise the influence of mechanism of injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Take a structured and appropriate history of a person presenting with an eye problem. • Understand the implications of an existing eye condition. • Perform appropriate ocular, fundoscopy and visual examination / assessment. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Identify the need for and initiate immediate treatment of a person with obvious eye emergencies. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient. • Identify and rationalise need for additional tests such as fluorescein staining, slit lamp or conjunctival swabs and referral for such if required. • Identify the need for additional clinical and professional support such as referral, second opinion etc.	• Red eye • Painful eye – including eye & or lids • Visual disturbance – blurred vision, diplopia, flashing lights, floaters • Acute loss of vison • Eye discharge • Eye injury • Foreign Body • Swollen eye/lid	• Temperature • Pulse rate • Blood pressure • Eye examination including inspection and palpitation • Visual acuity • Fundoscopy • Pupils • Routine, urgent, emergency and 2 week wait referral criteria

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Be able to write a comprehensive and appropriate referral letter. • Recognise the effect that the environment, lifestyle and genetics can have on the eye and provide information, lifestyle and health promotion advice or referral. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them..		• Temperature • Pulse rate • Blood pressure • Eye examination including inspection and palpitation • Visual acuity • Fundoscopy • Pupils • Routine, urgent, emergency and 2 week wait referral criteria

Gastrointestinal & Hepatic System

Demonstrate knowledge of the gastrointestinal system.

Demonstrate knowledge of the hepatic system, analysing severity and its impact on related systems.

Understand how to recognise the influence of psychosocial & family history, age, risk factors, symptomatic and clinical signs, relevant to the normal and abnormal anatomy and physiology of the person.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Take a structured and appropriate history of a person presenting with an abdominal or associated condition. • Understand the implications of an existing GI/hepatic condition. • Perform appropriate abdominal examination/assessment including digital rectal examination. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Identify the need for and initiate immediate treatment of person with obvious GI & hepatic emergencies. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient. • Identify and rationalise need for additional tests such as urinalysis, stool and blood tests etc.	• Difficulty Swallowing • Poor appetite • Excessive thirst • Abdominal pain • Abdominal distension • Abdominal mass/swelling • Constipation • Diarrhoea • Change in bowel habit – blood in stools, mucus in stools • Nausea/Vomiting • Hematemesis • Indigestion	• Temperature, • Pulse rate • Blood pressure • Respiratory rate • Blood tests – FBC, LFT, U&Es ESR, CRP, coeliac screen, haematinics, amylase, hepatitis, HIV • Stool sample – culture and sensitivity, faecal calprotectin, helicobacter-pylori testing, FIT testing or FOB depending on local availability • Abdominal examination – including inspection, auscultation, percussion & palpation • Assessment for lymphadenopathy

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for additional clinical and professional support such as referral, second opinion, notification of infectious diseases for public health management etc. • Be able to write a comprehensive and appropriate referral letter. • Recognise the effect lifestyle that the environment, lifestyle and genetics can have the GI and hepatic systems and provide preventative advice regarding high risk behaviours, importance of screening and immunisations along with, information, lifestyle and health promotion advice or referral, such as substance misuse or weight loss etc. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them. • Provide advice to prevent secondary transmission e.g. hygiene advice and refer to appropriate services where patient contact management required.	• Rectal pain • Rectal bleeding • Abnormal blood results – deranged Liver function tests (LFTs), anaemia • High risk behaviours & concerns – intravenous (IV) drug use, sexual history, contact with suffers of hepatitis • Stoma issues	• Digital rectal examination • Abdominal Ultrasound • Direct referral for gastroscopy, endoscopy, routine, urgent and 2 week wait referral criteria

Learning Disability

(Health Education England and Skills for Health (2019), Advanced Clinical Practice: Capabilities framework when working with people who have a learning disability and/or autism)

Learning Disability

Have knowledge on how to access additional specialist advice and help support people and their relatives/carers.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Demonstrate the ability to engage with people with a Learning Disability. • Demonstrate sensitivity to the impact of any change, such as hospital appointments, admission or any transition which people may find particularly distressing, as they are unfamiliar. • Support people to be fully informed and involved in their care decisions thereby empowering them to be autonomous. • Support people in accessing regular health checks and other universal services they are entitled to benefit from. (Including immunisations). • Ensure that where people with a Learning Disability also have another condition that appropriate attention is made to their specific needs and their care is tailored to these. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them.	• Any of the presentations included in this table	• Specialist Learning Disability Services • Advocacy Groups • Peer Networks

Male & Female Anatomical Health

Demonstrate knowledge of the anatomy and physiology of the male & female genitalia and related systems, including prostate and breasts.

Demonstrate knowledge of how to recognise the influence of mechanism of any injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people.

Have knowledge and understanding of issues related to male & female anatomical health.

Be aware of a variety of potential of issues that may present differently in males and females including but not limited to domestic abuse, female genital mutilation, sexual abuse, menopausal symptoms, erectile disjunction & depression.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand the implications of an existing relevant condition. • Take a structured and appropriate history including sexual health history when appropriate. • Assess disease risk factors specific to male or female anatomy. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient. • Identify emergencies and refer accordingly (e.g. suspected ectopic pregnancy, ovarian or testicular torsion). • Understand how to refer, in a timely manner, using national and local guidelines.	• Testicular pain and/or swelling • Inability to pass urine • Profuse vaginal bleeding • Genital rashes/irritation • Urinary symptoms including nocturia, changes in urinary stream • Penile pain • Penile discharge • Acute groin swelling/pain	• Temperature • Pulse rate • Abdominal examination • Assessment for lymphadenopathy • Ultrasound; pelvic transvaginal and testicular • Blood tests FBC, U&Es, HbA1c, lipids, testosterone, SHBG, free androgen index, FSH/LH +/- prolactin, CA125, PSA • Routine, urgent and 2 week wait referral criteria

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Be able to write a comprehensive and appropriate referral letter. • Have a clear understanding of adult safeguarding issues. • Be able to carry out male or female genital examination, prostate examination or breast examination when appropriate and with consent. • Request further investigations appropriately. • Advocate public screening and immunisations in line with local and national programmes. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them.	• Breast symptoms including pain, lump, nipple discharge, skin changes • Pelvic pain/mass	

Medication Review & Medication Issues (Independent Prescribers Only)

Understand the necessary monitoring requirements of medicines and how to act on the results.

Understand how to document the details of a medication review on the clinical system.

Have a sound understand how repeat prescribing works within the general practice/primary care and wider team – e.g. community pharmacy.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Be able to review medication in terms of efficacy, need, side effects, safety, clinical cost and in line with prescribing guidelines. and AMR standards. • Assess for concordance and compliance issues considering the people individual circumstances and requirements. • Help people to understand what medication they have been prescribed (or not prescribed) and why. • Act appropriately on alerts issued by the MHRA. • Understand the traffic light system for local formulary and medications issued only under shared care agreements. • Consider de-prescribing where appropriate.	• Adverse side effects • Ineffective medication • Poor compliance • Overuse of medication • Misuse of medication • Issues with polypharmacy • Abnormal blood test monitoring results • Higher risk groups – requiring risk reduction medicines	• Blood monitoring – U&E, LFT, FBC, drug levels, CRP, TFT, haematinics • Referral back to secondary care when required

Mental Health

(Skills for Health, Health Education England and Skill for Care (2016), Mental Health Core Skills Education and Training Framework)

Demonstrate knowledge of the range of different mental health needs and their impact on physical, behavioural, emotional and psychological wellbeing.

Demonstrate knowledge of how to recognise any trigger & the importance of psycho-social, family & occupational history, age, symptomatic and clinical signs.

Understand mental health and related services, and the policies and procedures for referring individuals to them.

Demonstrate knowledge of the range of actions you can take when people may have mental health needs and/or related issues, and how to decide what action is appropriate.

Understand the services which can be accessed by people in your locality who have specific mental health requirements including the eligibility criteria.

Demonstrate knowledge of how to assess the required degree of urgency when referring people to services and how to assess risk.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand the implications of a relevant existing mental health condition. • Take a structured and appropriate history. • Risk assess the possibility of harm to self or others and refer appropriately. • Assess the impact of the person's complaint on their daily life, including work life, home life, social life, dietary intake, sleep, illicit drug use, prescription drug misuse, thought of deliberate self-harm, suicidal ideation and seek/identify ways to positively support them.	• Suicidal ideation, self-harm • Acute anxiety • Stress • Panic • Post-natal mental health issues • Visual/auditory hallucinations • Paranoia	• Person Health Questionnaire (PHQ9) • Generalised Anxiety Disorder Questionnaire (GAD7) • Edinburgh Post Natal Depression Questionnaire • Referral to the crisis team • Urgent and routine referral to secondary care

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient. • Develop, maintain & utilise links with other agencies in support of people with mental health issues. • Be aware of local guidelines & pathways for referral to other agencies to support this client group including psychiatry, counselling, support groups. • Be able to write a comprehensive and appropriate referral letter. • Understand the need for multi-agency working for adult safeguarding and know how to make a referral when there are concerns. • Understand how to make a referral to the crisis team. • Understand the procedures & protocols in place both within & outside of the practice in relation to adult safeguarding, care of vulnerable adults. • Understand the effect of long-term conditions and other diagnoses on mental and psychological health. • Recognise the effect that the environment, lifestyle and genetics can have on mental health and provide information, lifestyle and health promotion advice or referral.	• Bereavement • Substance misuse	• Referral for counselling/ psychotherapy • Referral to other agencies

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them. • Understand ways to promote recovery.		

Musculoskeletal System

(Health Education England, NHS England & Skills for Health (2018), Musculoskeletal Core Capabilities Framework)

Demonstrate knowledge of the musculoskeletal system and its impact on related systems.

Demonstrate knowledge of how to recognise the influence of mechanism of any injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people.

Demonstrates knowledge of the gross and surface anatomy of the musculoskeletal system relevant to joint/area being assessed and presenting pathology.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Take a structured and appropriate history of a person presenting with a musculoskeletal issue. • Understand the implications of an existing musculoskeletal condition. • Perform an appropriate musculoskeletal examination/ assessment. Including examination of the spine, shoulder, elbow, wrist, hand & fingers: the pelvis, hip, knee, ankle, foot & toes. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Identify the need for and initiate immediate treatment of patients with obvious musculoskeletal emergencies.	• Pain • Swelling • Redness • Stiffness • Difficulty with movement – spasticity • Minor injury	• Temperature • Pulse rate • Examination using Look/Feel/Move principles • Examination of spine, including neck. Shoulders, elbows, wrists, hands & fingers. Hips, pelvis, knee, ankle, feet and toes. • Blood tests – FBC, calcium, ESR, CRP, vitamin D, rheumatoid factor, anti CCP, urate, autoimmune antibodies • X-ray if fracture suspected

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient. • Identify and rationalise need for additional tests such as X-ray, ultrasound, MRI, CT, blood tests etc. • Identify the need for additional clinical and professional support such as referral, second opinion etc (such as but not limited to physiotherapy, occupational therapy, podiatry, orthotist, orthopaedics). • Recognise the effect that the environment, lifestyle and genetics can have on the musculoskeletal system and provide information, lifestyle and health promotion advice or referral. • Be able to write a comprehensive and appropriate referral letter. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them.		• Magnetic Resonance Imaging (MRI Scan) if underlying serious pathology suspected • Physiotherapy • Routine, urgent and 2 week wait referral criteria

Neurological System

Demonstrate knowledge of the neurological system, and its impact on related systems.

Demonstrate knowledge of how to recognise the influencers of mechanism of injury, psycho-social & family history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people.

Demonstrate a sound understanding of the Mental Capacity Act (2005) and its application in practice including the relative testing procedures including:

The ethos underpinning the Act and the role of family and friends, and advanced directives.

The conditions under which capacity is decided.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Take a structured and appropriate history of a person presenting with a neurological condition or head injury. • Understand the implications of an existing neurological condition. • Perform an appropriate neurological examination/ assessment. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Identify the need for and initiate immediate treatment of a person with obvious neurological emergencies. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient.	• Altered level of consciousness • Fits, faints & funny turns • Dizziness • Altered power, tone, sensitivity • Paraesthesia • Altered level of consciousness • Weakness -localised, general • Altered gait • Facial palsy	• Temperature • Pulse rate, rhythm, volume and character • Blood pressure • Neurological examination – including inspection, palpation, reflexes, power, tone, strength, pupils and nystagmus • Cranial nerve examination • Mini mental state examination (MMSE) • 6CIT/GPCOG

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify and rationalise need for additional tests such as CT head, MRI Scan, blood tests etc. • Identify the need for additional clinical and professional support such as referral, second opinion etc. • Be able to write a comprehensive and appropriate referral letter. • Recognise the effect that the environment, lifestyle and genetics can have on the neurological system and provide information, lifestyle and health promotion advice or referral. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them.	• Tremor • Speech Changes • Headache • Head Injury • Memory problems • Confusion	• Computerised Tomography (CT Scan) • Magnetic Resonance Imaging (MRI Scan) • Routine, urgent and 2 week wait referral criteria including TIA clinic • Glasgow Coma Scale • Blood tests – ESR, U&E, B12, drug levels e.g. anticonvulsants

Paediatrics

FCP Paramedics should be seeing children with acute presentations of illness only unless they have undertaken specific Masters level training and education in the management of chronic paediatric disease or diseases of childhood development. The FCP will agree with their Clinical Supervisor the age range of children who may be seen, and ensure immediate support is available if needed.

Understand factors that affect the child's health, growth/development. E.g. genetic background, family history, demographics, prenatal factors, family & cultural influences.

Be aware of local guidelines & pathways for referral to paediatrics, community paediatrics, health visitors and school health team.

Understand the need for multi-agency working for child protection and know how to liaise with other health professionals/social services regarding children in need or with a child protection plan.

Understand the procedures & protocols in place both within & outside of the practice in relation to child safeguarding. Have a clear understanding of how to make a referral to child safeguarding team and document appropriately.

Understand the role of the midwife, health visitor and school health team and know when and how to make a referral.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand the implications of an existing relevant condition. • Take a history, examine appropriately, make an assessment, refer for further investigation as necessary, and refer to other services effectively, with consideration of the age of the child/young person. • Have a sound understanding of factors that affect the child's/young person's health, growth/development. E.g. genetic background, demographics, prenatal factors, family & cultural influences.	• Vulnerable child • Rashes • Pyrexia of unknown origin • Crying baby • Otalgia and/or ottorhoea • Eye injury, red eye, discharge • Cough/wheeze/stridor/ respiratory distress/nasal symptoms	• Temperature • Pulse rate, rhythm, volume and character • Blood pressure • Respiratory rate • Oxygen saturation • Capillary refill time • Otoscopy

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Promote the health of the child & support parents in making informed choices. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient and/or parent(s)/carer(s). • Be aware of local guidelines & pathways for referral to paediatrics, community paediatrics, health visitors and school health team. • Be able to write a comprehensive and appropriate referral letter. • Manage key conditions and red flag paediatric conditions. • Emphasise the importance of childhood immunisations and promote uptake in accordance with the national schedule. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the child, and seek/identify ways to positively support them and their parent(s)/carer(s).	• Sore throat • Vomiting • Diarrhoea • Acute bowel symptoms • Abdominal pain • Constipation • Muscular-skeletal symptoms • Minor injury	• Appropriate systems review depending on presenting problem • Referral criteria for midwife, health visitor, school health team, paediatrician, community paediatrician, child safeguarding • Blood tests as appropriate to presentation. • Imaging (e.g. x-ray) • Understand the need to limit investigations in children to avoid unnecessary distress or radiation exposure

Pain – assessment and management

Pain physiology as it relates to clinical presentation of pain and the effects of pain on the person.

Pain assessment tools and methods.

Atypical presentation of pain.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand the implications of an existing relevant condition. • Demonstrate the ability to assess both acute and chronic pain. • Recognise and acknowledge the impact and effect of pain on the person's activities of daily living and well-being, and seek/ identify ways to positively support them. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient. • Prescribe appropriately including the need for multimodal analgesic provision considering national and local guidance around the use of addictive analgesia. • Initiate and review treatment options. • Recognise pain as potential cause of delirium and/or agitation. • Promote multi-disciplinary and palliative care teams in working with people in pain. • Carry out an assessment, using appropriate tests and make onward referrals as required. • Be able to write a comprehensive and appropriate referral letter.	• Acute pain • Worsening of pain • Change in type of pain	• Pain Management Teams • Investigations appropriate to presentation • MSK First Contact Practitioner

Palliative & End of Life

(Health Education England, Skills for Health, and Skill for Care (2017), End of Life Care Core Skills Education and Training Framework

Understand and practice within the key legal framework relating to end of life care such as, RESPeCT, DNACPR, Advanced Directives, Lasting Power of Attorney, Allow Natural Death Orders and Treatment Escalation Plans.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Take a structured and appropriate history of a person presenting in palliative care or in the last year to days of life. • Perform appropriate system and symptom assessment and examination. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan, to include the use of non-pharmacological interventions. • Identify the need for immediate treatment of oncology related palliative care emergencies such as metastatic spinal cord compression, superior vena cava obstruction and hypercalcaemia. • Identify and rationalise any need for additional support for the person and carer / family, socially, psychologically and medically. • Identify the need for additional clinical and professional support such as for anticipatory medicines, referral, second opinion etc. • Be able to write a comprehensive and appropriate referral letter.	• Pain • Nausea/vomiting • Agitation • Low mood • Worsening symptoms	• Referral criteria and processes for pain & symptomatic relief • Appropriate systems review depending on presenting problem • Referral for care – e.g. district nurses, palliative care, Macmillan

Renal & Genito-Urinary System

Demonstrate knowledge of the renal system, analysing severity and its impact on related systems.

Demonstrate knowledge of how the influencers of psych-social, family history, age, risk factors, symptomatic and clinical signs, are relevant to the normal and abnormal anatomy and physiology in people.

Understand how the identifying relevant symptoms, clinical signs and the potential anatomical and physiological features are evident in:

People with Acute Kidney Injury.

People with Chronic Kidney Failure.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for and initiate immediate treatment of person with obvious renal emergencies. • Understand the implications of an existing GU/renal condition. • Take a structured and appropriate history of a person presenting with a renal or GU system problem. • Perform appropriate abdominal / genitourinary examination/assessment. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient.	• Loin pain • Groin pain • Haematuria • Urinary symptoms – dysuria, frequency, urgency, hesitancy, incontinence, retention • Family history of kidney problems/diseases • Recurrent infection	• Temperature • Pulse rate • Blood pressure • Blood tests U&Es, PSA, ACR • Abdominal examination – including inspection, auscultation, percussion & palpation • Urinalysis • Mid-stream urine culture • Ultrasound Kidneys, Ureters, Bladder (KUB) • Routine, urgent and 2 week wait referral criteria

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify and rationalise need for additional tests such as urinalysis, ultrasound scan (KUB) and blood tests etc. • Identify the need for additional clinical and professional support such as referral, second opinion etc. • Be able to write a comprehensive and appropriate referral letter. • Recognise the effect lifestyle that the environment, lifestyle and genetics can have the renal & GU systems and provide information, lifestyle and health promotion advice or referral, such as substance misuse or weight loss etc. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person.		

Respiratory System

Demonstrate knowledge of the respiratory system, analysing severity, and its impact on related systems.

Demonstrate knowledge of how to recognise the influence of psycho-social, occupational family history, age, symptomatic and clinical signs, relevant to the normal and abnormal anatomy and physiology in people.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify the need for and initiate immediate treatment of a person with obvious respiratory emergencies including respiratory arrest, respiratory distress and anaphylaxis. • Understand the implications of an existing respiratory condition. • Take a structured and appropriate history of a person presenting with a respiratory condition. • Perform appropriate respiratory assessment including inspection, palpation, percussion and auscultation. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient. • Identify and rationalise need for additional tests such as X-Ray, blood tests, respiratory function tests etc.	• Shortness of breath, breathing difficulties • Pain on breathing • Cough, including haemoptysis • Wheeze • Pallor, cyanosis • Suspected or recurrent infection	• Temperature, • Pulse rate, rhythm, volume and character • Blood pressure • Respiratory rate • Oxygen saturation • Respiratory examination – including inspection, auscultation, percussion & palpation • Assessment for lymphadenopathy • Sputum sample • Imaging (x-ray, CT) • Blood tests – FBC, ESR, iron studies, • Peak flow rate

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Be able to write a comprehensive and appropriate referral letter. • Recognise the effect that the environment, lifestyle and genetics can have on the respiratory system and provide lifestyle and health promotion advice or referral, such as smoking cessation etc. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and seek/ identify ways to positively support them.		• FeNO testing • Spirometry • Epworth Score • Routine, urgent and 2 week wait referral criteria

Additional key clinical presentation Demonstrate knowledge and understanding of a range of additional clinical presentations, pertinent to the scope of practice of the individual practitioner.		
Core Clinical Skills	**Indicative presentations**	**Key clinical investigations / referrals (may include but not be limited to)**
• Take a structured and appropriate history. • Perform an appropriate examination/assessment. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Supply, administer or prescribe appropriate therapies when indicated in agreement with the patient. • Identify the need for and initiate immediate treatment needs of a person. • Make suitable and appropriate referrals.	• Tired all the time • Generalised aches and pain • Lymphadenopathy • Sleep issues • Fever • Substance / alcohol misuse • Overdose / poisoning • Vulnerable adult • Family/carer concern • Genetic predisposition	• Temperature • Pulse • Blood tests – FBC, TFT, HbA1c, LFT, U&Es, haematinics. • Appropriate systems review as per other sections depending on presenting problem • Referral to substance/alcohol misuse treatment services • Support services for carer/families • How to access information from poisons centre • Referral criteria and processes for assessment and support of • Notification of clinically suspected notifiable infectious diseases vulnerable adults • Referral criteria for genetic screening, counselling

Alternative modes of consultation (telephone, email, Skype, home visits, group, via interpreter etc)

Be aware of the challenges of consulting using an alternative mode of consultation.

Be aware of the impact non-verbal communication has when using alternative modes of consultation.

Be able to adapt the consultation appropriately with special consideration of confidentiality (e.g. ensuring you are speaking to the correct person, consent etc).

Be aware of the challenges of history taking remotely (e.g. without visual cues).

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Have the skills to interpret with the use of an interpreter – this may be for language which may require a face to face or telephone interpreter e.g. British sign language interpreter, use of hearing loop, or Makaton interpreter. • Provide information to the person & the interpreter about the purpose and the nature of the interaction. • Agree with the interpreter their role, any interventions they should make, and the level of detail required in the communication. • Explain to the interpreter any specific terms and concepts that the person may not understand. • Clarify with the interpreter any communications from the person that you are not able to understand. • Support the interpreter to work in ways that promote the person's rights and choices, respect their experiences, expertise and abilities and promote inclusion.	• Any of the above presentations in the context of alternative modes of consultation context	• Interpreter services • Advocacy groups • Local Government/Social care • Third-Sector organisations

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Ensure the interpreter allows sufficient time for the person to communicate fully their thoughts, views, opinions and wishes. • Monitor the understanding of all involved and the effectiveness of the interpretation. • Modify interactions to improve communication and understanding. • Summarise communication at appropriate points to ensure that all involved agree what has been communicated and any actions to be taken.		

12.15 Linking to Advanced Practice Portfolio – Top up required to Advanced practice status

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

Domain A: Person-centred Collaborative Working

Capability 1. Communication and consultation skills This section is completed in the FCP capabilities			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			

Capability 2. Practicing holistically to personalise care and promote public and person health			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			
	Analyse data and intelligence to critically appraise a 'practice population' to help identify needs of the people who are served, to add value and be mindful of the need to mitigate the impact of health inequalities on individuals and diverse communities.	A2(c)	ACP2(a)

Capability 3. Working with colleagues and in teams			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			
A4(d, e)	Initiate effective multi-disciplinary team activity as a lead member and understand the importance of effective team dynamics. This may include but is not limited to the following; service delivery processes, research such as audit/quality improvement, significant event review, shared learning and development.	A3(g)	ACP3 (a)

Capability 4. Maintaining an ethical approach and fitness to practice This section is completed in the FCP capabilities			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			

Domain B: Assessment, investigations and diagnosis

Capability 5: Information gathering and interpretation This section is completed in the FCP capabilities			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			

Capability 6: Clinical Examination and Procedural Skills This section is completed in the FCP capabilities			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			

Capability 7: Making a Diagnosis This section is completed in the FCP capabilities			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			

Domain C: Condition management, treatment and prevention

Capability 8: Clinical Management This section is completed in the FCP capabilities			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			

Capability 13: Managing medical and clinical complexity			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
	Understand the complexities of working with people who have multiple health conditions whether physical, mental and psychosocial.	C9(a)	ACP13(a)
	Understand and be able to manage practitioner and patient uncertainty.	C9(c)	ACP13(b)
Critical skills			
	Simultaneously manage acute and chronic problems, including for people with multiple morbidities and those who are frail.	C9(b)	ACP 13(c)
	Recognise the inevitable conflicts that arise when managing people with multiple problems and take steps to adjust care appropriately.	C9(d)	ACP 13(d)
	Communicate risk effectively to people and involve them appropriately in management strategies.	C9(e)	ACP13(e)
	Manage urgent or out of hours presentations appropriately.		ACP13(f)

Capability 14: Independent Prescribing, Medicines Supply and Pharmacotherapy			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
C10(a)	Safely prescribe and/or administer therapeutic medications relevant and appropriate to scope of practice, including (where appropriate) an applied understanding of pharmacology which considers relevant physiological and/or pathophysiological changes and allergies.	C10(a)	ACP14 (a)
C10(b)	Where a non-medical prescriber (NMP), critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental well-being and healthcare provision.	C10(c)	ACP14 (b)
C10(d)	Demonstrate knowledge of, and use appropriate source literature where required (e.g. British National Formulary).		ACP14 (c)
(new)	Understand the legal mechanisms by which drugs may be administered or supplied by paramedics (emergency exemptions, paramedic exemptions, Patient Group Directions, Patient Specific Directions,) and the advantages and limitations of each. Understand the basis on which you may be administering or supplying drugs in your setting.	(new)	ACP14 (d)
Critical skills			
	Advocate personalised shared decision making to support adherence leading to concordance	C10(b)	ACP14 (e)
	Keep up-to-date and apply the principles of evidence-based practice, including clinical and cost-effectiveness and associated legal frameworks for prescribing. Follow Royal Pharmaceutical Framework guidelines (e.g. medicines optimisation).	C10(d)	ACP14 (f)

C10(c)	Where a NMP, or when using Patient Group Directions, practice in line with the principles of antibiotic stewardship and antimicrobial resistance using available national resources.	C10(e)	ACP14 (g)
C10(e)	Where an NMP, appropriately review response to medication, recognising the balance of risks and benefits which may occur. Take account of context including what matters to the person and their experience and impact for them and preferences in the context of their life as well as polypharmacy, multimorbidity, frailty, existing medical issues such as kidney or liver issues and cognitive impairment.	C10(f)	ACP14 (h)
	When prescribing, or supplying/administering medication, be able to confidently explain and discuss risk and benefit of medication with people using appropriate tools to assist as necessary.	C10(g)	ACP14 (i)
C10(f)	Recognise adverse drug reactions and manage appropriately, including reporting where required.		ACP14 (j)
C10(g)	When prescribing, or supplying/ administering medication, advise people on medicines management, including compliance and the expected benefits and limitations and inform them impartially on the advantages and disadvantages in the context of other management options.	C10(h)	ACP14 (k)
C10(h)	Identify sources of further information (e.g. websites or leaflets) and advice (e.g. pharmacists) and be able to signpost people as appropriate to complement the advice given.		ACP14 (l)
	Understand a range of options available other than drug prescribing (e.g. not prescribing, promoting self-care, advice regarding over-the-counter medicines).	C10(i)	ACP14 (m)

	Facilitate and or prescribe non-medicinal therapies such as psychotherapy, lifestyle changes and social prescribing.	C10(j)	ACP14 (n)
	Where an NMP, support people to only take medications they require and de-prescribe where appropriate.	C10(k)	ACP14 (o)
C10(i)	Maintain accurate, legible and contemporaneous records of medication prescribed and/or administered and advice given in relation to medicine or treatments.	C10(l)	ACP14 (p)

Domain D: Leadership and management, education and research

Capability 10: Leadership, management and organisation			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			
	Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working.	D11(c)	ACP10 (a)
	Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit).	D11(e)	ACP10 (b)
	Demonstrate the impact of advanced clinical practice on service function and effectiveness, and quality (i.e. outcomes of care, experience and safety).	D11(f)	ACP10 (d)
	Lead new practice and service redesign solutions with others in response to feedback, evaluation, data analysis and workforce and service need, working across boundaries and broadening sphere of influence.	D11(i)	ACP10 (e)
	Critically and strategically apply advanced clinical expertise across professional and service boundaries to enhance quality, reduce unwarranted variation and promote the sharing and adoption of best practice.	D11(j)	ACP10 (f)

For further details on leadership and management, see the NHS Leadership Academy.

	Demonstrate leadership, resilience and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others.	D11(k)	ACP10 (g)
	Lead actively on developing practice in response to changing population health need, engaging in horizon scanning for future developments and to add value (e.g. impacts of genomics, new treatments and changing social challenges).	D11(l)	ACP10 (h)

Capability 11: Education and development			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
Critical skills			
13(b)	Engage in self-directed learning, critically reflecting on practice to maximise advanced clinical skills and knowledge, as well as own potential to lead and develop both care and services.	D12(b)	ACP11 (a)
	Promote and utilise clinical supervision for self and other members of the healthcare team to support and facilitate advanced professional development.	D12(d)	ACP11 (b)
13(d)	Advocate for and contribute to a culture of organisational learning to inspire future and existing staff.	D12(e)	ACP11 (c)
13(e)	Facilitate collaboration of the wider team and support peer review processes to identify individual and team learning and support them to address these.	D12(f)	ACP11 (d)
13(g)	Enable the wider team to build capacity and capability through work-based and interprofessional learning, and the application of learning to practice.	D12(g)	ACP11 (e)
	Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities.	D12(h)	ACP11 (f)
13(h)	Act as a role model, educator, supervisor, coach and mentor, seeking to instil and develop the confidence of others, actively facilitating the development of others.	D12(i)	ACP11 (g)
	Actively seek to share best practice, knowledge and skills with other members of the team, for example through educational sessions and presentations at meetings.	D12(j)	ACP11 (h)

Capability 12: Research and development			
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	ACP (PCN) competencies	AP Paramedic
14(a)	Critically engage in research/quality improvement activity, adhering to good, ethical research practice guidance, so that evidence-based strategies are developed and applied to enhance quality, safety, productivity and value for money.	D12(a)	ACP12 (a)
14(b)	Evaluate and audit own and others' clinical practice, selecting and applying valid, reliable methods, then act on the findings by critically appraising and synthesising the outcome and using the results to underpin own practice and to inform that of others.	D12(b)	ACP122 (b)
14(c)	Critically appraise and synthesise the outcome of relevant research, evaluation and audit, using the results to underpin own practice and to inform that of others.		ACP12 (c)
Critical skills			
14(d)	Take a critical approach to identify gaps in the evidence base and its application to practice, alerting appropriate individuals and organisations to these and how they might be addressed in a safe and pragmatic way. This may involve acting as an educator, leader, innovator and contributor to research activity and/or seeking out and applying for research funding.	D12(d)	
	Lead on Quality Improvement initiatives/ projects – sharing outcomes and leading change.	D12(e)	
14(f)	Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review.	D12(f)	

14(g)	Disseminate best practice research findings and quality improvement projects through appropriate media and fora (e.g. presentations and peer review research publications).	D12(g)	ACP12 (g)
14(h)	Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical and other active researchers.	D12(h)	ACP12 (h)

12.16 Advanced practice skills in addition to FCP

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

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.

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.