Health Education England

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

A Roadmap to Practice

Developing people for health and healthcare

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Acknowledgements

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Development of the Dietitian 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 Dietetic Knowledge Skills and Attributes document was led by the British Dietetic Association Roadmap Group (Eleanor Johnstone, Fiona Audley, Tanya Rumney, Gill Shinkwin, Lisa Cooke, Natalie Knight, Carlie Bruce, Sophie Hempsall, Susan Meredith and Bernice Tighe with support from the BDA Paediatric, Obesity, Diabetes, Gastroenterology, Older People and Optimising Nutrition). We are extremely grateful to the many stakeholders who have been instrumental in shaping this piece of work, in particular to our patient representatives who sit at the heart of the roadmap.

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Glossary

Abbreviation	Full text
AfC	Agenda for Change
AP	Advanced Practice/Advanced Practitioner
Bioethics	Bioethics is the branch of applied ethics that studies the philosophical, social, and legal issues arising in medicine and the life sciences, in particular the study of the ethical issues emerging from advances in biology and medicine.
BDA	British Dietetic Association
CA125	Cancer antigen 125
CBD	Case-Based Discussion
CCG	Clinical Commissioning Group
CEPs	Clinical Examination Procedural skills
COT	Consultation Observation Tool
CPD	Clinical Professional Development
CRP	C-Reactive Protein
CS	Clinical Supervisor
CSP	Chartered Society of Physiotherapy
ECG	Electrocardiogram
ESR	Erythrocyte Sedimentation Rate
FBC	Full Blood Count
FCP	First Contact Practitioner
FTE	Full Time Equivalent
Functional bowel disease (FBD)	FBD includes: functional constipation, functional diarrhoea, functional bloating/distention, and bile acid diarrhoea
GLP-1 analogues	Glucagon-like peptide 1
GP	General Practice/General Practitioner
HbA1c	Glycated haemoglobin test
HCPC	Health and Care Professions Council
HEE	Health Education England
HEI	Higher Education Institute
IBS	Irritable bowel syndrome
ICS	Integrated Care System
Imumoglobulins test	Measures the amount of immunoglobulins (antibodies) (may include Immunoglobulin M (IgM), Immunoglobulin G (IgG), total (Immunoglobulin A) IgA, IgA tissue transglutaminase antibody (tTGA))
KSA	Knowledge, Skill, Attribute
LFT	Liver Function Test

Abbreviation	Full text
MDT	Multi-Disciplinary Team
mHealth	Mobile health - medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants, and other wireless devices
MPFACP	Multi-Professional Framework for Advanced Clinical Practice
MSF	Multi-Source Feedback
MSK	Musculoskeletal
Nutritional Borderline Substances (NBS)	Nutritional borderline substances items are currently approved by the Advisory Committee on Borderline Substances as NBS. These products are currently listed in the BNF in Appendix 2 Borderline Substances and include a diverse range of products such as gluten free, low protein or protein free foodstuffs, specialised infant formulae, ONS and enteral feeds
NHS DPP	NHS diabetes prevention programme
NHSE	National Health Service England
NMSP	Non-Medical Supplementary Prescribing
OA	Osteoarthritis
PCN	Primary Care Network
PDP	Personal Development Plan
PHQ2	Patient Health Questionnaire-2
PSQ	Patient Satisfaction Questionnaire
QAA	Quality Assurance Agency
QI	Quality Improvement
QIP	Quality Improvement Plan
RCGP	Royal College of General Practitioners
SGLT2 inhibitors	Sodium-glucose transport protein 2 inhibitors
SMART	Specific, Measurable, Attainable, Relevant, Timebound
SP	Supplementary Prescribing
TFT	Thyroid Function Test
U & E	Urea & Electrolytes test
UK	United Kingdom
US	Ultrasound
WPBA	Workplace-Based Assessment
The Centre	HEE Centre for Advancing Practice
Band 7 Band 8a	AfC pay bands, e.g. 7= FCP 8a = AP
Level 7 Level 8	Academic level of practice, e.g. 7 = Master 8 = Doctorate

Introduction

i Purpose

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

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

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

ii Historical background and context

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

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

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

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

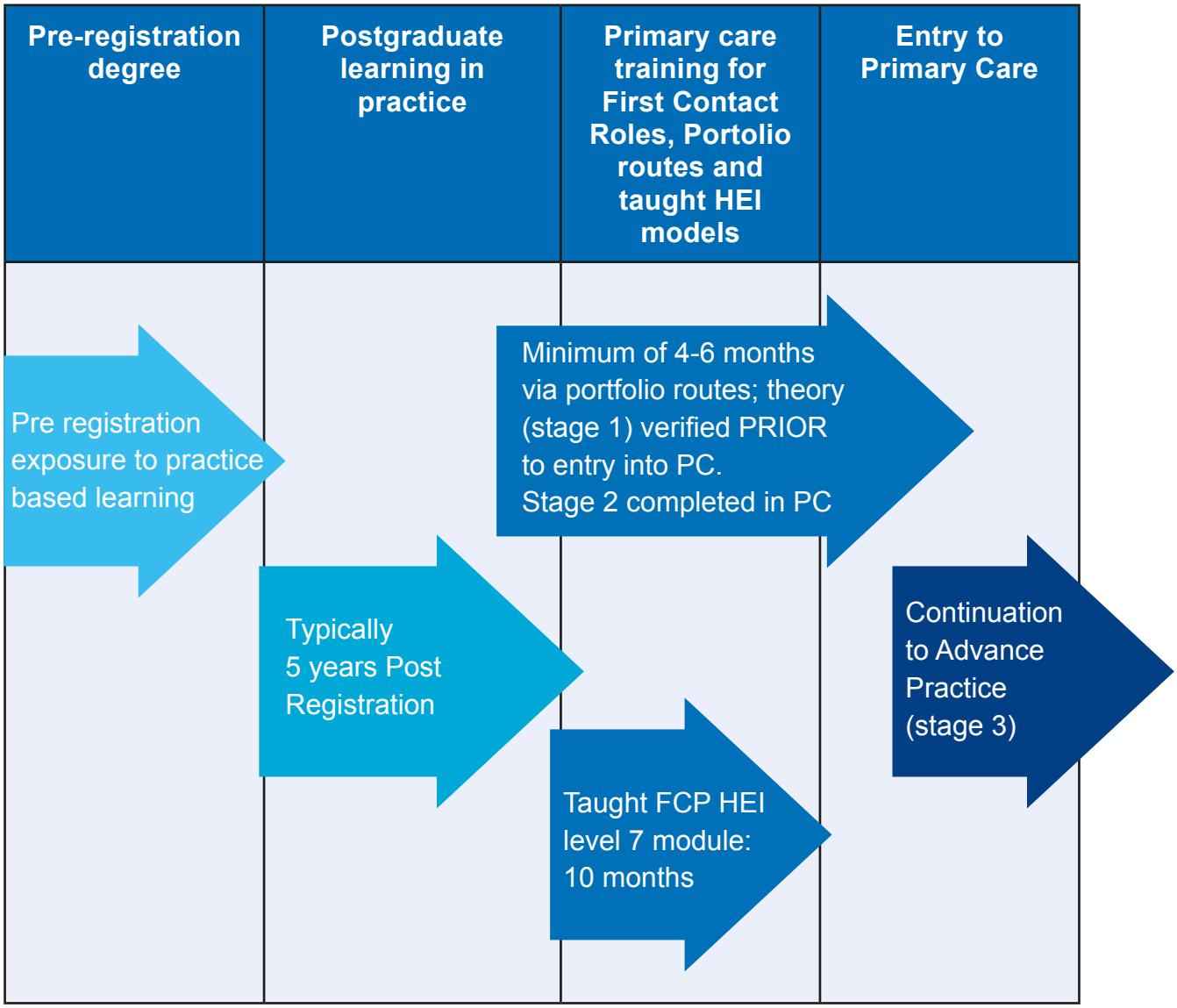


Figure 1: Illustration of career progression for Primary Care roles.

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

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

1. Dietitians in primary care: A guide for general practice
2. A retrospective review of the influences, milestones, policies and practice developments in the first contact MSK model
3. Health Education England: What is Advanced Clinical Practice?
4. NHS England - First contact physiotherapists

iii The Centre for Advancing Practice

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

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

1.0 Declarations

1.1 What is a First Contact Practitioner?

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

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

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

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

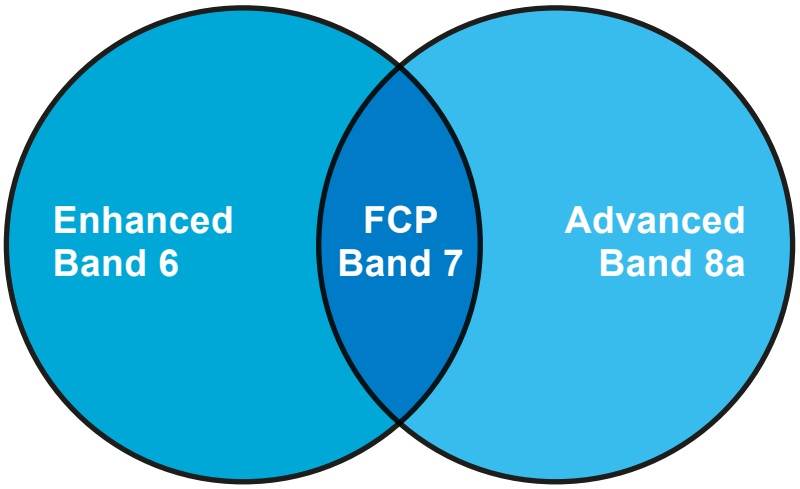


Figure 2: Illustration of AfC role progression within Primary Care.

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

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

1.2 What is an Advanced Practitioner?

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

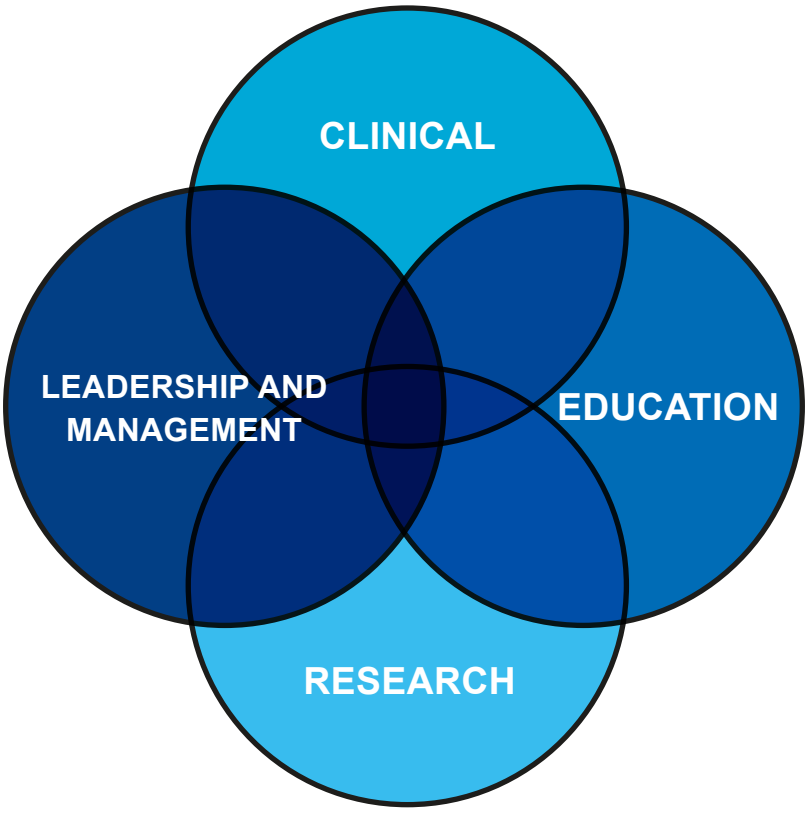


Figure 3: Illustration of inter-linkage of the four pillars of Advanced Practice.

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

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

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

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

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

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

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

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

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

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

2.0 Primary Care educational pathways

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

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

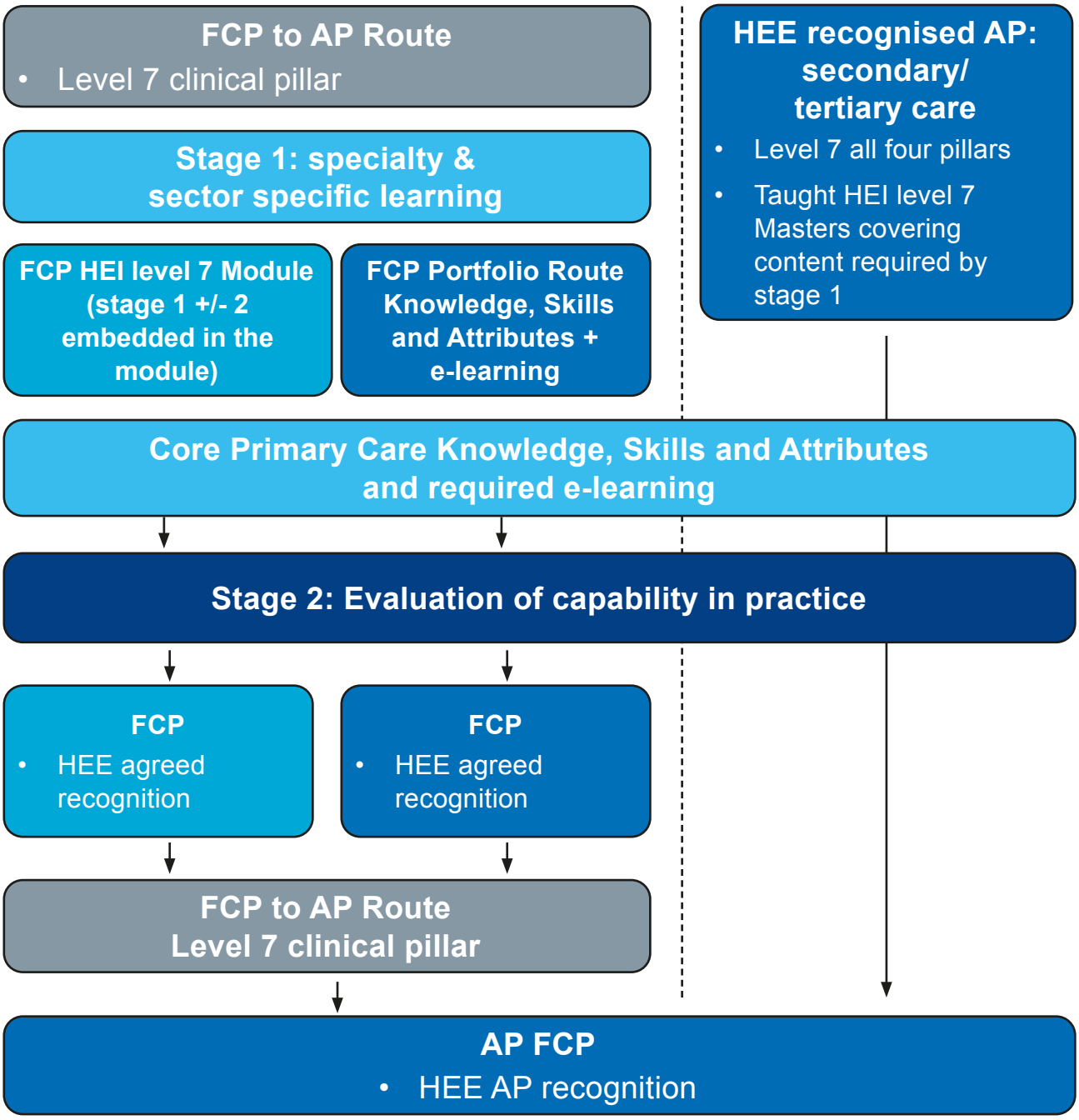


Figure 4: Illustration of pathways to FCP and AP in Primary Care

3.0 National standards and frameworks for Dietitians

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

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

- The capabilities are cross-referenced with the BDA Post Registration Professional Development Framework (advanced level), the HEE Advanced Practice (AP) Credential Specification for Primary Care: Dietetics, the HEE Advanced Practice (AP) Credential Specification: Research in Primary Care Clinical Practice, the HEE Advanced Practice (AP) Credential Specification: Leadership and Management in Primary Care Clinical Practice and the HEE Advanced Practice (AP) Credential Specification: Education in Primary Care Clinical Practice.

- Other guidelines/frameworks that are key to the implementation of these roles include:

  Health Education England, Core Capabilities Framework for Supporting Autistic People (2019)

  NHS, Accessible information standard (2016)

  Royal Pharmaceutical Society: A Competency Framework for all prescribers (2020

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

- FCP Dietitians work within Primary Care to assess, diagnose, formulate, and implement management plans for conditions relating to nutrition and dietetics

Appendix 12.16 outlines several key clinical areas that FCP dietitians may need to manage in primary care, according to the scope of their role. It details assessment and management skills that FCP dietitians must be able to apply appropriately within the context of their role 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 Dietitian** and the context in which they operate and would be **agreed between the FCP Dietitian** 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 Dietitian to have the appropriate knowledge and skills of each system outlined below, they must also understand the complex inter and co-dependencies of systems when providing care to people.

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

In order to meet the capabilities required for FCP and AP, the dietitian will require to complete the following masters level modules:

- Non-medical Supplementary Prescribing (NMSP) course*
- Advanced clinical assessment module
- FCP module

*FCP will be working towards SP and AP will be SP.

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

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

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

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

Importantly, where there is doubt or ambiguity the FCP Dietitians 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 Dietitian is required to put peoples' safety first and to manage risk(s) appropriately.

3.1 Linking the frameworks

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

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

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

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

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

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

3.2 Building the evidence

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

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

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

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

As the Dietitian 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 Dietitian can work within the aforementioned frameworks and use these as a reference for professional development at all stages of career development. **This can occur at any time in a career pathway and even prior to embarking on a formal training pathway.** The KSA, will inform the learner and supervisor of capabilities and standards that the learner can work towards prior to attaining a role as an FCP or AP within Primary Care.

4.0 The Roadmap to FCP

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

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

- **Stage 2** is completed with a portfolio of evidence and verified in Primary Care. This is the recognition process of the application of the KSA in Stage 1 to clinical practice in Primary Care. Best practice is that this should be completed within 6 months for a full time member of staff but this can be longer provided a completion date is agreed with the employer.

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

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

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

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

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

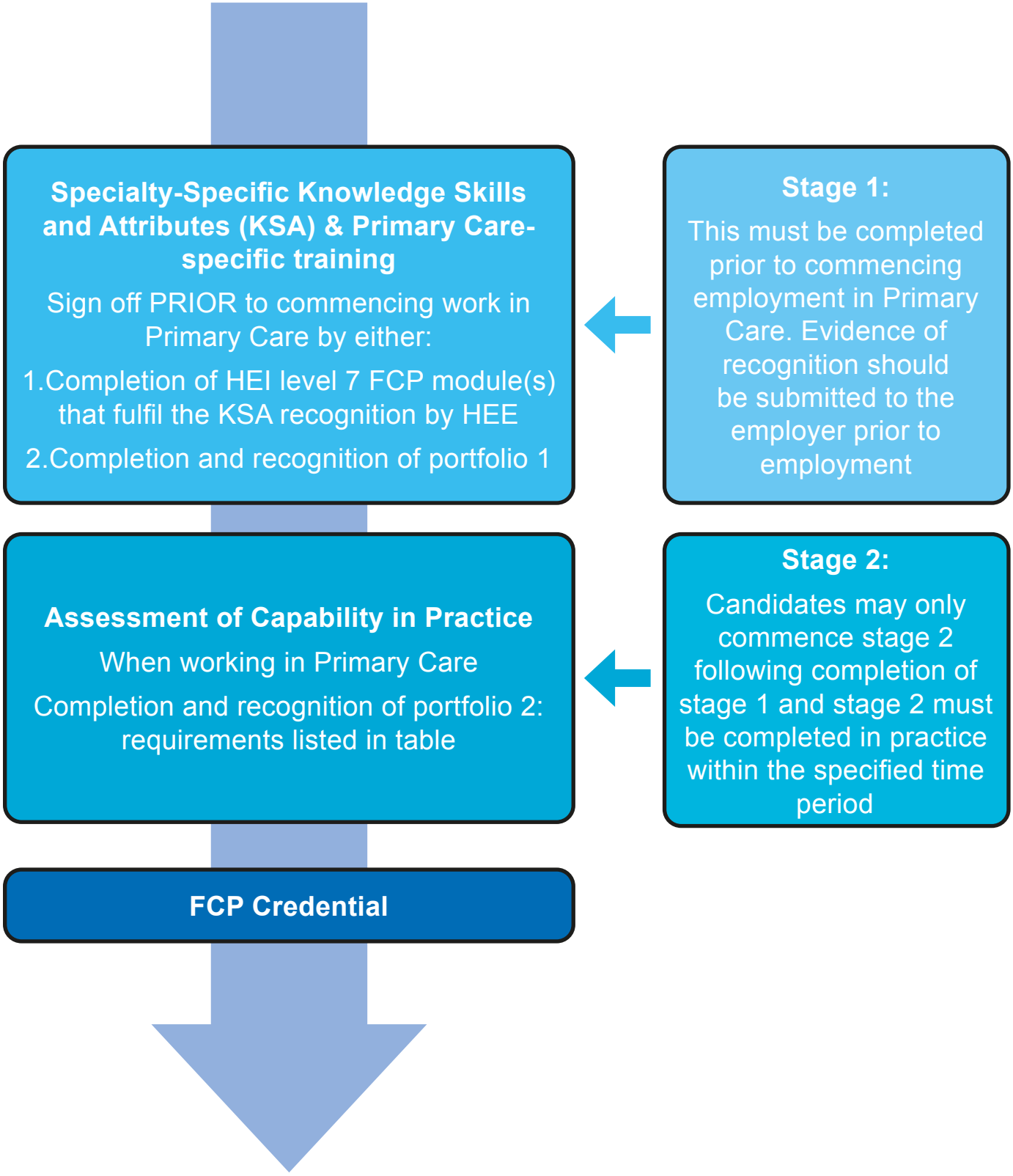


Figure 5: Illustration of the process of FCP recognition.

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

5.1 E-learning

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

- The Primary Care modules cover areas such as managing complexity, mental and public health, illness identification, and red flags and are complemented by a series of e-modules covering personalised care (share decision making, core skills, personalised care and support planning). In addition, there are a wide range of modules relevant to dietitians in primary care, dependent on their scope of practice that the BDA have listed on their website.

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

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

5.2 Next steps

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

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

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

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

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

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

- For the already verified advanced practitioner registered on the Centre for Advancing Practice Directory wishing to also work in Primary Care, the process still requires the e-learning to be completed and the KSA capabilities verified within Primary Care. .

5.3 KSA document

The KSA document found in **appendix 12.15** is for use as part of the process of recognition of an FCP. Each capability is described. To the right of each capability there is indication of cross-referencing to the BDA Post Registration Professional Development Framework and the HEE ACP Credential for Primary Care: Dietetics.

6.0 Stage 2: Moving into Primary Care

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

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

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

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

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

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

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

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

7.0 Building the portfolio

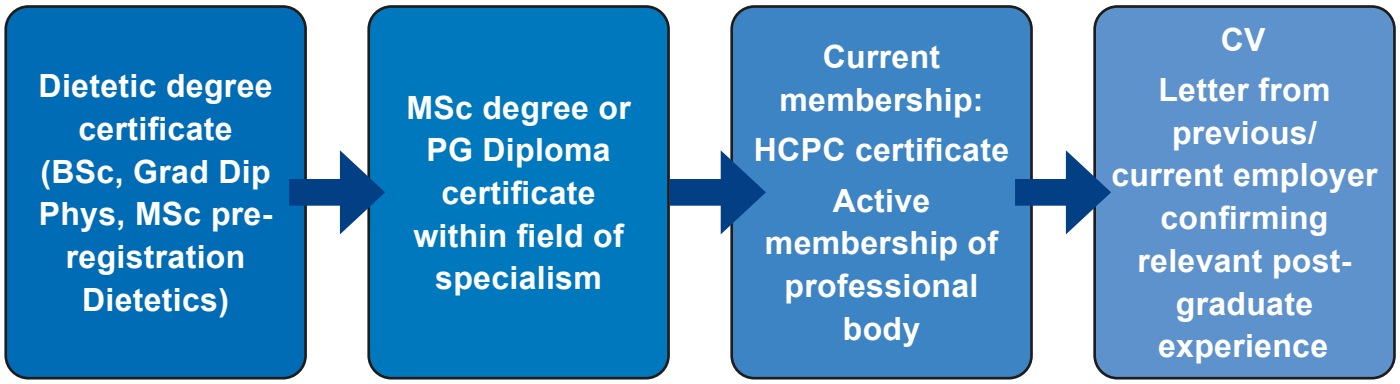
A portfolio is an individual's collection of evidence that illustrates development and learning to date and provides an overview of plans for future development. In addition, it facilitates analysis of current skills and knowledge through critical reflection and evaluation of learning and development.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

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

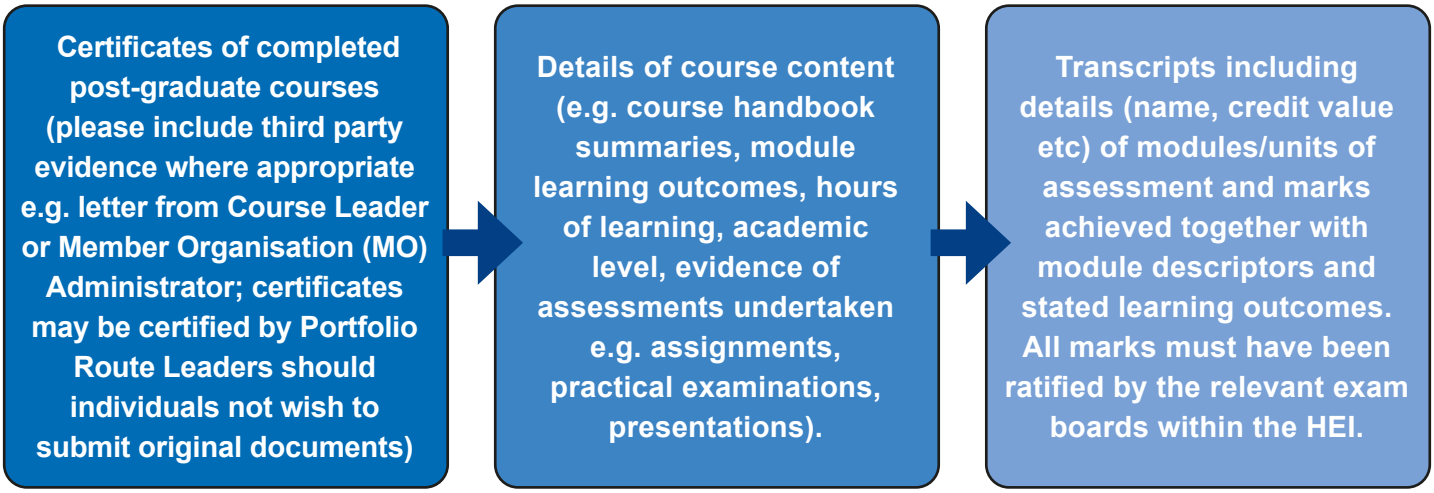
STEP 1: COLLATE KEY DOCUMENTS

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

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



(3) SPECIALIST POSTGRADUATE EDUCATION



STEP 2: ALIGN AND UPLOAD

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

8.0 Recognition and supervision process

8.1 Recognition process

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

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

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

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

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

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

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

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

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

Assessment Criteria Level 7

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

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

9.0 Roadmap supervision and verification

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

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

9.1 Continuing Professional Development (CPD) supervision

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

9.2 Clinical supervision

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

9.3 Educational supervision

Educational supervision is required for those undertaking educational courses/ modules and is the responsibility of the educational provider. Some of the evidence can be captured through clinical supervision and work-place based assessments (WPBA) and often includes:

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

9.4 Supervision requirements

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

This course will include:

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

9.5 Checklist of recognition processes: Stage 1 and Stage 2

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

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

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

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

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

10.0 Stage 3: Roadmap to AP

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

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

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

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

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

10.1 Demonstrating Advanced Practice in a Dietetic Primary Care portfolio

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

- Each FCP prerequisite KSA is mapped to the relevant dimensions of the BDA Post Registration Professional Development Framework (advanced level) and the HEE Advanced Clinical Practice (ACP) Credential for Primary Care: Dietetics, fulfilling a subset of the clinical standards required by Dietetic Advanced Practice within Primary Care.

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

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

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

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

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

11.0 Useful resources

11.1 Online learning

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

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

Cost: Primary Care e-learning bundle £50

BDA Learning Zone is the BDAs online learning hub, providing online access to quality-assured courses and resources to support and track your CPD.

Cost: varies

Practice-based Evidence in Nutrition (PEN) a dynamic knowledge translation tool. The PEN System provides dietitians access to timely, current and authoritative guidance on food and nutrition. It offers evidence-based answers to the questions encountered in every day practice.

Cost: free with BDA membership (£360 for non-members)

There are many more education and training courses which may be useful for dietitians in primary care listed on the BDA education and training webpage.

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

Kings Fund Compassionate Leadership resources supports leaders to create a culture of inclusion and compassion that ensures all voices are heard when delivering and improving care.

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.

Health Education and Improvement Wales have a leading role in the education, training, and shaping of the healthcare workforce in Wales. They deliver education for the health workforce and provide postgraduate and leadership development programs.

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

The **BDA primary care forum** provides a platform for BDA members to share learning and development. Email info@bda.uk.com to join the forum.

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.

Rethink provides mental health specific information and training.

Parkinson's UK website

Diabetes UK website

Coeliac UK website

GUTS UK website

The Patients Association website

BAPEN website

Allergy UK website

Patient webinars website

Hospice UK - dying matters campaign to support those working in end of life care, with advice, guidance and support.

AGE UK 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 section such as telephone consultations and mental health which could be useful. They also run other face-to-face and e-learning courses.

Cost: varies, audio book approximately £49.

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

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

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

Cost: approximately £225.

Some resources require a subscription

NB Medical education

RCGP Learning

GP notebook

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

Clinical Knowledge Summaries

e-learning modules supporting medicines management

British National Formulary

Live well with pain

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

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

12.0 APPENDICES

12.1 Roadmap supervision flow chart

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

Clinical supervision

Must be provided in the clinical setting

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

WHAT?

CPD supervision

Must be provided by the employer

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

Wellbeing and Practitioner Development

Patient Safety and Practitioner Safety

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

Self, Teams & Service Delivery

Is the practitioner & employer:

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

WHY?

WHO?

Clinical Supervisor (CS)

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

CPD Supervisor (CPDS)

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

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

HOW?

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

Educational Supervision

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

12.2 Case-Based Discussion FCP to Advanced Practice

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

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

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

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Working with colleagues and in teams **FCP 3** **AP 3**			
Maintaining an ethical approach & fitness to 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**			
Prescribing, pharmacotherapy & treatment **FCP 9** **ACP 9, 13**			
Leadership, management, and organisation **FCP 10** **AP 10**			
Education and development **FCP 11** **AP 11**			

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

FEEDBACK
ACTION PLAN

12.2.1 Case-Based Discussion (CBD) Guidance

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

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

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

What should be covered in the discussion

The discussion is framed around the actual case rather than hypothetical events.

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

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

Practitioner:	
Clinical Supervisor Name:	
Date:	

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

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

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

Suggested areas for consideration would be:

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

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

Please ensure that your Clinical Supervisor signs off your CEPS.

12.4 Clinical Supervisor's Report

Practitioners Name:	
Clinical Supervisor Name:	
Date:	

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

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

Examines appropriately and correctly identifies any abnormal findings (please comment on specific examinations observed) (FCP Capability 6) Comments/evidence	Grade
Elicits important clinical signs & interprets information appropriately (FCP Capabilities 5, 6) Comments/evidence	Grade
Suggests an appropriate differential diagnosis (FCP Capability 7) Comments/evidence	Grade
Refers appropriately and co-ordinates care with other professionals (FCP Capabilities 3, 8 ACP 3, 13) Comments/evidence	Grade
MANAGEMENT	
Keeps good medical records (FCP Capabilities 1, 2, 10, ACP 2, 10) Comments/evidence	Grade
Uses resources cost-effectively (FCP Capabilities 2, 3, 4, 8, 9, 12, ACP 2, 3, 9, 12, 13) Comments/evidence	Grade
Keeps up-to-date and shows commitment to addressing learning needs (FCP Capabilities 11, ACP 11) Comments/evidence	Grade

PROFESSIONALISM	
Identifies and discusses ethical conflicts (FCP Capability 2, 3, 4, 5, ACP 2, 3) Comments/evidence	Grade
Shows respect for others (FCP Capabilities 1, 3, 4, ACP 3) Comments/evidence	Grade
Is organised, efficient, and takes appropriate responsibility (FCP Capability 4, 10, ACP 10) Comments/evidence	Grade
Deals appropriately with stress (FCP Capabilities 3, 4, 10 ACP 10) Comments/evidence	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, 2 ACP 2		
Responds to cues FCP Capabilities 1, 2 ACP 2		
Places presenting problem in appropriate psychosocial context FCP Capability 2, 5, ACP 13		

Criterion	Grade	Evidence
Explores person's health understanding FCP Capabilities 1, 2, 5, 8, ACP 2, 13		
Defines the clinical problem		
Includes/excludes likely relevant significant condition FCP Capability 5, 6 ACP 13		
Appropriate physical or mental state examination FCP Capability 5, 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, 2, 8 ACP 2		
Addresses the person's problem		
Seeks to confirm the person's understanding FCP Capability 1, 2, 8, 9 ACP 2, 9		
Makes an appropriate shared management/personalised care/support plan FCP Capabilities 1, 2, 3, 8, 9, 10,11, 12 ACP 2, 3, 9,10, 11, 12 13,		

Criterion	Grade	Evidence
Person is given the opportunity to be involved in significant management decisions FCP Capabilities 2, 8, 9, ACP 2, 9, 13, 14		
Makes effective use of the consultation		
Makes effective use of resources FCP Capabilities 3,4, 8, 9, 10, 12 ACP 3, 9, 10, 12, 13,		
Condition and interval for follow-up are specified FCP Capability 8, 9 ACP 13,		

Feedback & recommendations for further development:
Agreed action plan:

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

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

12.5.1 Consultation Observation Tool (COT) Guidance

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

Person consent

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

Selecting consultations for COT

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

Consultations should be drawn from a range of people presentations that reflect the scope of the Practitioner role, for example, different age ranges and clinical conditions, physical and mental health. The Practitioner can include consultations in different contexts – for example, face-to-face, virtual, groups or home visits.

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.

Collecting evidence from the consultation

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

12.5.2 Consent form for recording of Consultations for training purposes

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

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

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

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

TO BE COMPLETED BY PATIENT

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

Signature of patient BEFORE CONSULTATION:

.....Date.....

Signature of person accompanying patient to the consultation:

.....Date.....

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

Signature of patient AFTER CONSULTATION:

.....Date.....

Signature of person accompanying patient to the consultation

.....Date.....

12.6 Multi-Source Feedback (MSF)

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

Part 1

This part should be completed by all respondents

Please state your job title

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

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

Notes: You may wish to consider the following:

The Practitioner:

- Is caring and involving of people
- Is respectful, compassionate and sensitive 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
- Embraces opportunity
- Demonstrates commitment to their work as a member of the team
- Takes responsibility for their own learning

Comments (where possible please justify comments with examples)

Highlights in performance areas (areas to be commented)

Suggested areas for development in performance

Part 2

To be completed by clinical staff only

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

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

You may wish to consider the following about the Practitioner:

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

Comments (where possible please justify comments with examples)

Highlights in performance areas (areas to be commented)

Suggested areas for development in performance

12.6.1 Multi-source Feedback (MSF) Guidance

Multi-Source Feedback is collected from colleagues.

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

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

12.7 Personal development plan (PDP)

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

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

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

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

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

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

LEARNING/ DEVELOPMENT NEED	**DEVELOPMENT OBJECTIVE**	**ACHIEVEMENT DATE**	**STRATEGIES TO USE**	**OUTCOMES/ EVIDENCE**
WHAT BROAD AREA DO YOU NEED TO ADDRESS?	WHAT SPECIFIC GOAL ARE YOU SETTING?	WHEN DO YOU HOPE TO ACHIEVE IT?	HOW WILL YOU ACHIEVE IT?	HOW WILL YOU KNOW YOU HAVE ACHIEVED IT?
An example: To manage functional bowel disorder presentation (FBD)	*To manage a range of different FBD presentations*	*9 months*	*Complete the advanced clinical assessment course and 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 Patients Satisfaction Questionnaire (PSQ) for an FCP or Advanced Practitioner

Hello,

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

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

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

Thank you.

Please rate the Practitioner at:

Please tick your response

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Overall, how would you rate your consultation today?

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

Many thanks for your assistance

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

12.8.1 Patients Satisfaction Questionnaire (PSQ) Guidance

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

Ask reception to give out a questionnaire and a pen to every person who attends to see the FCP and ask the person to hand the questionnaire back to reception after their appointment if they have attended in-person rather than virtually. Alternatively, this process could be carried out by email. It is recommended that this process should look at the responses and give feedback to the FCP. The FCP should reflect on the feedback in a learning log.

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

12.9 Tutorial record

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

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

12.10 Tutorial evaluation

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

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

Signed:	

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

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

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

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

Course overview

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

12.12 FCP Verification of Evidence Form

CAPABILITY	KSA LINKS
COMMUNICATION & CONSULTATION SKILLS	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP1
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** ☐	FCP 2
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** ☐	FCP 3
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** ☐	FCP 4
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** ☐	FCP 5
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** ☐	FCP 6
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** ☐	FCP 7
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** ☐	FCP 8
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** ☐	FCP 9
EVIDENCE TYPE & DATE(S)	

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

CAPABILITY	KSA LINKS
LEADERSHIP, MANAGEMENT & ORGANISATION	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP 10
EVIDENCE TYPE & DATE(S)	

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

CAPABILITY	KSA LINKS
EDUCATION & DEVELOPMENT	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP 11
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** ☐	FCP 12
EVIDENCE TYPE & DATE(S)	

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

PRACTITIONER

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

FCP SIGNATURE ……

FCP HCPC REGISTRATION NUMBER……DATE……..

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

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

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

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

OVERALL RATING OF CAPABILITY FOR STAGE TWO (PLEASE TICK)

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

SUPERVISOR SIGNATURE……DATE……..

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

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

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

12.13 Advanced Practice Verification of Evidence Form

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

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

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

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

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

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

CAPABILITY	AP LINKS
INDEPENDENT PRESCRIBING, MEDICINES SUPPLY & PHARMACOTHERAPY	
TRAINEE SELF-RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 9
EVIDENCE TYPE & DATE(S)	

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

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

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

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

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

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

CAPABILITY	AP 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.

PRACTITIONER SIGNATURE …… ……

PRACTITIONER HCPC REGISTRATION NUMBER……DATE……..

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

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

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

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

OVERALL RATING OF CAPABILITY FOR STAGE TWO (PLEASE TICK)

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

SUPERVISOR SIGNATURE……DATE……..

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

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

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

12.14 Reflection Template – First Contact Practitioner or Advanced Practitioner

Date of tutorial:	

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

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

SUPERVISOR SIGNATURE: ……

CLINICAL SUPERVISOR SIGNATURE: ……

12.15 Knowledge, Skills, and Attributes - FCP

The capabilities as defined in the domains below have been developed to set the standard required for a dietitian working in a First Contact Practitioner (FCP) role within primary care. The capabilities are crossed referenced to the ACP credential for primary care dietetics (HEE - awaiting publication) and the BDA Post-registration Professional Development Framework (BDA PRPDF) (BDA, 2021). This will ensure capability alignment of the core generalist skills previously developed for other healthcare professionals that are also relevant to dietetic practice.

However, it is important to note that dietitians are a distinct profession, hence capabilities have been amended added or removed to fit with the unique skills and attributes dietitians bring to the primary care setting.

Domain A: personalised approaches

Capability 1. Communication and consultation skills		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 1**	ACP primary care dietetic competencies
P3	Demonstrate advanced critical understanding of the processes of verbal and non-verbal communication, clinical documentation, and the common associated errors of communication e.g. use of inappropriate closed questions, appropriate use of lay and professional terminology.	B1
Critical skills: specific skills underpinning capabilities 1		
P3 F1	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	B1.1.9
P3 L3	Autonomously adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to people's communication and language needs and culture and values, including levels of spoken English and health literacy.	B1.1.1
P2 P3	Communicate effectively with individuals who require additional assistance to ensure an effective interaction with a practitioner, including the use of accessible information	B1.1.5

P2 P3	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. Meet the information and communication support needs of people who have learning disabilities, an impairment, sensory loss, are neuro-diverse or have other specific communication needs by following the NHS assessable information standard	B1.1.15
P3	Enable effective communication approaches to non-face to face situational environments e.g. phone, video, email or remote consultation	B1.1.8
P1	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.	B1.1.7
P1	Elicit psychosocial history to provide context for people's problems.	B1.1.11
P2 P3 F3	Manage people effectively, respectfully and professionally (including where applicable, carers and families) especially at times of conflicting priorities and opinions.	B1.1.10
P2 P3 F1 F3	Communicate in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate people's care.	B1.1.3
NEW	Demonstrate emotional intelligence in all interactions to support effective communication.	NEW
P3	Identify and utilise a comprehensive range of behaviour change skills with a range of individuals and groups of people. This would include those with special and/or complex needs, to translate complex nutritional theory into a format which is easily understood, to support self-management of the condition.	A7

Capability 2. Practicing holistically to personalise care and promote public and person health		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 2**	ACP (PCN) competencies
P1 P2 E1	Evaluate 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.	B1.2.10
P1 P2	Interpret how a person's preferences and experience, including their individual cultural and religious background, can offer insight into their priorities and wellbeing and support quality of life.	B1.2.13
P2	Evaluate the implications of, and apply in practice, the relevant legislation for informed consent and shared decision making (e.g., mental capacity legislation, Montgomery consent, Fraser Guidelines).	B1.2.16
NEW	Instigate and or lead best interest decision meetings	NEW
P1	Recognise a wide range of mental ill health needs, including eating disorders, as well as organic disorders such as dementia, and their impact on dietary, physical, behavioural, emotional and psychological wellbeing, and know how to access specialist advice and refer to specialist services as appropriate.	A24
P1	Have an in-depth understanding of and utilise the systems available for social prescribing provision to support effective nutrition and dietetic intervention.	A31
P1 E1	Recognise the effect that long-term conditions, the environment, lifestyle and genetics can have on mental health and provide information, lifestyle and health promotion advice or referral	
Critical skills: specific skills underpinning capabilities 2		
P1 P2	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.	B1.2.1

	Effectively employ the Public Health England "All Our Health" framework in own and wider community of practice	B1.2.8
P2 P3	Engage people in shared decision making about their care by: • Supporting them to express their own ideas, concerns and expectations and encouraging them by 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 a decision on their preferred way forward. • explaining to people the relevant multifactorial causes (if known) of their conditions.	B1.2.3
P1 P2	Recognise and respond appropriately to the impact of psychosocial factors on the presenting problems or general health such as housing issues, work issues, family/carer issues, lack of support, social isolation and loneliness	B1.2.11
P1 P2	Evaluate how the vulnerabilities in some areas of a person's life might be overcome by promoting resilience in other areas.	B1.2.14
P1 P2	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.	B1.2.6
P1 F2	Advise on sources of relevant local or national self-help guidance, information and support and refer to relevant services as required such as coaching and social prescribing	B1.2.7
P1 P2	Explore the impact of the condition on an individual's general health, mental wellbeing, employment status and functional and meaningful activities, including physical activity.	A19
P1 P2	Implement local systems, procedures and protocols for safeguarding children, young people and adults. Including referrals to safeguarding teams and completion of appropriate documentation.	A29

Capability 3. Working with colleagues and in teams		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 3**	ACP (PCN) competencies
L1	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.	B1.3.7
P1	Take appropriate action(s) in a range of emergency situations.	A26
Critical skills: specific skills underpinning capabilities 3		
P1	Ensure own work is within professional and personal scope of practice and access advice when appropriate	B1.3.1
P1	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.	B1.3.2
P3	Communicate effectively with colleagues using a variety of media (e.g. verbal, written and digital) to serve peoples' best interests.	B1.3.4
P1 P2 P3	Engage in effective inter-professional communication and collaboration (with clear documentation) to optimise integrated management and care for people.	B1.3.3
P1 P2	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.	B1.3.5
F1 E3	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.	B1.3.6
F4	Take responsibility for one's own well-being and promote the well-being of the team escalating any causes for concern appropriately.	B2.1.7
P1 P3	Initiate and sustain collaborative working relationships across multi-disciplinary teams to effectively develop and/or enable integration of pathways requiring dietetic interventions in primary and secondary care	A15

Capability 4. Maintaining an ethical approach and fitness to practice		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 3**	ACP (PCN) competencies
F4	Critically reflect on how own values, attitudes and beliefs might influence one's professional behaviour.	B1.4.9
Critical skills: specific skills underpinning capabilities 4		
P1 E1	Demonstrate the application of professional practice in one's own day to day first contact clinical practice.	B1.4.1
L3	Identify and act appropriately to promote positive behaviour around equality, diversity and human rights.	B1.4.8
F4 L3	Reflect on and address 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 and engage with others in these discussions.	B1.4.10
P1 F3 F4	Keep up to date with mandatory training and CPD requirements, encompassing those requiring evidence for a first contact role.	B1.4.3
F4	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.	B1.4.12
F4	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.	B1.4.4
P2 E2 E3 L4	Promote mechanisms such as complaints, significant events and performance management processes in order to improve people's care. Promote mechanisms such as compliments and letters of thanks to acknowledge and promote good practice.	B1.4.6 B1.4.7
NEW	Behave safely, responsibly, legally and ethically online, particularly in relation to social networking sites.	NEW

Domain B: assessment, investigation, and diagnosis

Capability 5: Information gathering and interpretation		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 5**	ACP (PCN) competencies
P1	Discriminate between a range of consultation models appropriate to the clinical situation and apply appropriately across physical and mental health presentations.	B1.4.9
P1	Recognise the limits of own clinical knowledge and recognise when presentations are outside own scope of practice. Ensure history taking is detailed to enable advice or referral as appropriate.	B2.1.7
P1 E1	Appraise and apply the principles of biochemistry, clinical dietetics, clinical medicine, epidemiology, genetics, immunology, microbiology, nutritional science, pathophysiology, pharmacology, mental health, physiology, social history and public health nutrition in the context of complex nutrition and dietetic interventions.	A17
P1 E1	Evaluate and interpret the signs and symptoms of a range of conditions which could impact an individual's nutritional status, and formulate plan for dietetic intervention, if appropriate	A23
Critical skills: specific skills underpinning capabilities 5		
P1	Have an awareness of and be able to recognise a seriously unwell person, and understand escalation protocols to ensure they receive immediate treatment from an appropriate healthcare professional	A26
P2 P3	Structure consultations to encourage the person 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	B2.1.1
P1 E1	Be able to undertake general history-taking, and focused history-taking to elicit and assess 'red flags' and refer on to an appropriate healthcare professional in a timely manner, according to local policy	A25 A.3 B2.1.3

P1 E1	Synthesise information, taking into account 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	B2.1.8
P1 P2	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.	B2.1.9
P2	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.	B2.1.6
P1	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	B2.1.10
P3	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 understanding about what has been communicated.	B2.1.4
P1 P3	Record all pertinent information gathered concisely and accurately for clinical management, and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance, including reporting of patient safety incidence.	A6

Capability 6: Clinical examination and procedural skills		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 6**	ACP (PCN) competencies
P1 E1	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.	B2.2.6
P1 E3	Recognise and have insight into the limits of own knowledge and skills. Practice within those limitations, recognising when referral to another professional to aid examination may be more appropriate.	B1.3.1
Critical skills: specific skills underpinning capabilities 6		
P1 P2 P3	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.	B2.2.2
P1 P2 E1	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	B2.2.3
P1 P2 P3 L3	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	B2.2.5
P1 E1	Apply a range of physical assessment and clinical examination techniques appropriately, systematically and effectively.	B2.2.1
P1 P2	Perform a mental health screen appropriate to the needs of the person, their presenting problem and manage any risk factors such as suicidal ideation promptly and appropriately.	B2.2.6

P1 E1	Use nationally recognised tools where appropriate on assessment	B2.2.7
P1	Using a systematic approach, identify, analyse and interpret potentially significant information from the physical and mental health assessment (including any ambiguities/deviations from normal and understanding their clinical significance)	B2.3.2 B2.3.8
P1	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.	B2.2.4
NEW	Demonstrate an in-depth knowledge and understanding of anatomy, physiology and pathophysiology of all relevant systems such as: respiratory, cardiovascular, gastrointestinal & hepatic, neurological, renal & genitourinary and central and peripheral nervous system. Understand how they interlink in order to perform clinical examination that is relevant to the FCPs scope of practice	NEW

Please see Appendix 1 for a list of Core Clinical Skills and an indicative list of Key Presentations in primary and urgent care.

Capability 7: Making a Diagnosis		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 7**	ACP (PCN) competencies
	Summarise 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.	B2.3.3 B2.3.8
E1	State key diagnostic biases and common errors and the issues relating to diagnosis in the face of ambiguity and incomplete data.	B2.3.6
P1	Critically appraise own decision-making processes by applying underpinning models of complex clinical decision making into practice.	

P1 P3	Understand diagnostic uncertainty and how to share uncertainty with persons. Identify 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.	B2.3.7
Critical skills: specific skills underpinning capabilities 7		
P1 E1	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.	B2.3.10
P1 E1	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.	B2.3.2
P1	Synthesise the expertise of multi-professional teams to aid in diagnosis where needed	B2.3.9
P1	Focus the objective data gathering and prioritise investigations in the context of the persons presentation and the clinical environment.	B2.3.8
P1	Formulate a differential diagnosis based on subjective and where available objective data, identifying where necessary the need for further investigations to aid diagnosis.	B2.3.3
P1	Interpret the subjective and objective findings from the consultation. Exercising clinical judgement, determine differential diagnoses and/or a working diagnosis in relation to all information obtained. This may include the use of time as a diagnostic tool where appropriate.	B2.3.11
P1	Revise hypotheses in the light of additional information and think flexibly around problems, generating functional and safe solutions.	B2.3.4
P1	Recognise when information/data may be incomplete (e.g. persons unable to give a history due to age or illness) and take mitigating actions to manage risk appropriately. Recognise the limitations of collateral information from others	B2.3.6
P1 E3	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.	B2.3.7

Domain C: condition management, interventions, and prevention

Capability 8: Clinical Management		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 8**	ACP (PCN) competencies
F4 P1	Critically reflect on limits of own knowledge, and seek advice, when uncertain about correct clinical management	B1.3.1
Critical skills: specific skills underpinning capabilities 8		
P1 P2 E1	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.	B3.1.8
P1	Consider a 'watch and wait' approach where appropriate.	B3.1.7
P1 P2 P3	Safely prioritise problems in situations where the person presents with multiple issues. Manage any conflict between persons priorities and clinically urgent problems	B3.1.1
P1 P2	Implement shared management/personalised care/ support plans in collaboration with people (and where appropriate carers), families and other healthcare professionals.	B3.1.2
P1 E1	Ensure the management plan considers all options that are appropriate for the care pathway.	B3.1.8
P1	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.	B3.1.3
P1 P2 E1 E2	Evaluate outcomes of care against existing standards and persons outcomes, managing/adjusting plans appropriately in line with best available evidence.	B3.1.9
E1 E2	Critically evaluate the efficacy and validity of nutrition and dietetic interventions utilising appropriate information, techniques and outcome measures	A5

P1 P2 E2	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.	B3.1.4
P2	Promote continuity of care as appropriate to the person and practice setting	B3.1.5
P1 P2 E1	Suggest a variety of follow-up arrangements that are safe and appropriate, whilst also upholding the person's autonomy.	B3.1.6
P1 P3 E1	Ensure safety netting advice is appropriate and the person understands when to seek urgent or routine review.	B3.1.9
P1 P2	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.	A27
P1 E1	Apply advanced clinical reasoning and principles of bioethics and evidence-based practice to formulate and deliver nutrition and dietetic intervention based on comprehensive assessment, strategy, monitoring and evaluation of persons with complex needs.	A1
P1 E1 F2	Critically appraise and apply a variety of techniques, technologies and resources to assess a range of nutritional needs of individuals, groups and populations, as appropriate.	A2
P1	Utilise mHealth, where appropriate to deliver patient education to aid the on-going assessment, management and treatment of conditions related to nutrition and dietetics.	A9
E1 F1	Provide knowledge and advice on eating for health across all age ranges to persons and other professionals within the multi-disciplinary team.	A16
E1	Apply the principles of the 'Gold Standard Framework' and NICE guidelines for end-of-life care. Understand and practice within the key legal frameworks relating to end-of-life care such as, RESPeCT, DNACPR, Advanced Directives, Lasting Power of Attorney, Allow Natural Death Orders and Treatment Escalation Plans	A27
P1 P2	Recognise persons with end stage chronic conditions and assess how these might impact on the individual.	A28

Capability 9: Prescribing treatment, administering drugs/medication, pharmacology		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 9**	ACP (PCN) competencies
	If a nonmedical supplementary prescriber (NMSP), you must be familiar with and work within the Royal Pharmaceutical Society: A Competency Framework for all prescribers.	B3.3.13
	Demonstrate knowledge of drug legislation including medicines management adhering to legal frameworks and use appropriate source literature where required (e.g. British National Formulary).	B3.3.13
NEW	Understand the legal mechanisms by which drugs may be administered or supplied by dietitians (Patient Group Directions, Patient Specific Directions) or supplementary prescribed (if a NMSP) and the advantages and limitations of all. Understand the basis on which you may be administering or supplying drugs in your setting or prescribing (if a NMSP).	NEW
	Apply the principles of medicines optimisation and local prescribing guidance for nutritional borderline substances.	A22
NEW	Have a sound understanding of how repeat prescribing works within the general practice/primary care and wider team – e.g. community pharmacy	NEW
NEW	Understand the local formulary and medications issued only under shared care agreements.	NEW
Critical skills: specific skills underpinning capabilities 9		
	When using a PGD or supplementary prescribing, practice in line with the principles of antimicrobial stewardship and antibiotic resistance using available local or national resources.	B3.3.8

	If supplementary prescribing or when supplying/ administering medication be able to confidently explain and discuss risk and benefit of medication (including reasons for not prescribing) with people using appropriate tools to assist as necessary.	B3.3.10
NEW	Recognise adverse drug reactions and manage appropriately, including reporting as required through the correct route	NEW
	Advise people on medicines management, taking into account the persons individual circumstances and requirements, compliance, the expected benefits and limitations, and inform them impartially on the advantages and disadvantages in the context of other management options and dietary intake, to support medicines optimisation.	A10 A12 B3.3.9
F2	Identify sources of further information (e.g. websites or leaflets) and advice (e.g. pharmacists), and signpost appropriately to complement the advice given.	
P1 P2 E1	Identify and understand the range of options available other than drug prescribing (e.g. not prescribing, promoting self-care, advice on over-the-counter medicines)based on persons choice, appropriateness and cost effectiveness.	B3.3.5
P1	Facilitate and or prescribe non-medicinal therapies such as psychotherapy, lifestyle changes and social prescribing.	B3.3.2
	If supplementary prescribing or when supplying/ administering medication maintain accurate, legible and contemporaneous records of medication prescribed and/ or administered and advice given in relation to medicine or treatment.	B3.3.3
NEW	Identify and initiate appropriate onward referral for support with polypharmacy if required.	NEW
	Work in partnership with the multi-disciplinary team to optimise medicines usage.	A11
	Gather and synthesise information regarding the impact of a wide range of medications on nutritional status, including drug nutrient interactions, and the medical conditions they are used to treat.	A20

	Understand the necessary monitoring requirements in terms of efficacy, need, side effects, safety, clinical cost and in line with prescribing guidelines. Understand and be able to act on the results.	B3.1.6
NEW	Act appropriately on patient safety alerts issued.	NEW
	Where an NMSP, support people to only take medications they require and de-prescribe where appropriate.	B3.3.12
	Where an NMSP, 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.	A1
NEW	Understand how over-the-counter supplements and medications can interact with prescribed medications.	NEW
	Where a NMSP, critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental well-being and healthcare provision.	B3.3.7
	Safely prescribe (if NMSP) and/or supply/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.	A16

Domain D: service and professional development

Capability 10: Leadership, management and organisation		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 10**	ACP (PCN) competencies
P1 L4	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.	L&M 2
Critical skills: specific skills underpinning capabilities 10		
L2	Respond positively when services are under pressure, acting in a responsible and considered way to ensure safe practice	L&M 3
P2	Role model the values of being an FCP (Dietitian) , demonstrating a person-centred approach to service delivery and development.	L&M 4
F3 F4	Actively engage in peer review to inform own and other's practice, formulating and implementing strategies to act on learning and make improvements.	L&M 12
L4 E3	Actively seek and be positively responsive to feedback and involvement from people, families, carers, communities and colleagues in the co-production of service improvements	L&M 13
E3 P3	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.	L&M 25
P1	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.	L&M 28
	Deal with compliments and complaints appropriately, following professional standards and applicable local policy	
E3 L2	Actively participate in Significant Event Review and share the learning.	B1.3.6

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

Capability 11: Education and development		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 11**	ACP (PCN) competencies
F4	Critically assess and address own learning needs, negotiating a personal development plan that reflects a breadth of ongoing professional development.	E1
Critical skills: specific skills underpinning capabilities 11		
P1 E1 F4	Engage in self-directed learning, critically reflecting on practice to maximise skills and knowledge	E3
F4	Actively seek and be open to feedback on own practice by colleagues to promote ongoing development.	E2
NEW	Be aware of and utilise professional MDT networks and specialist interest groups.	NEW

Capability 12: Research and evidence-based practice		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 12**	ACP (PCN) competencies
E1	Demonstrate critical understanding of common quantitative research designs, including strengths and weaknesses.	R1 R5
E1	Demonstrate critical understanding of common qualitative research designs, including strengths and weaknesses.	R1 R5
Critical skills: specific skills underpinning capabilities 12		
E1	Appraise and apply best evidence to inform own practice.	R3
E3 L4	Support quality improvement initiatives/projects – sharing outcomes and promoting change	R2
E1	Support clinical research by signposting research opportunities to people and engaging with recruitment, data collection and other aspects of research when appropriate.	R8 R9

For further details on leadership and management, see the NHS National Institute for Health Research.

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

The table below outlines a number of key clinical presentations that first contact dietitians (FCD) can manage in general practice/primary care, within their individual scope of practice. It details assessment and management skills that FCD 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**, dependant on scope of practice

FCDs work within primary care to effectively manage acute, acute on chronic and chronic presentations

The application of these will be determined by the **scope of the role of the FCD** and the context in which they operate and would be **agreed between the FCD 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 FCD 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 below, the FCD 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.

The knowledge statements below therefore apply to clinical skills that are within this appendix. It will be for the FCD and their Clinical Supervisor to contextualise the knowledge statements appropriate to the clinical environment.

In addition to the above generic capabilities outlined in the framework the FCD will 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 and their impact 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 FCD 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 FCD is required to put peoples' safety first and to manage risk(s) appropriately.

Emergency Presentations 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)**
• Initial ABCDE assessment and action needed. • Identify the need for and initiate immediate treatment • Assess the required degree of urgency and risk when dealing with emergency situations • Identify vulnerable adults and children and understand the need for multi-agency working for adult and child safeguarding and know how to make a referral when there are concerns.	**Patient presentations** • Collapse • Catastrophic bleeding • Shock • Respiratory distress • Allergic reaction • Fits/Faints/Funny Turns • Change in conscious level • Acute change in mental state • Seizure • Light sensitivity – eyes • Non blanching rash • Suspected Overdose/ poisoning • headache • Limp child	• Emergency procedures for seeking assistance and calling ambulance • Provide basic life support (cardiopulmonary resuscitation (CPR), defibrillator) • Management of anaphylaxis based on local agreement which may include administration of adrenaline, hydrocortisone, chlorphenamine • Administration of oxygen • Initiation of the sepsis 6 guidelines

Dietetic-specific FCD Key Areas

The FCD in Primary Care will need to evidence how they meet the dietetic specific requirements for a minimum of one key area. As Primary Care requires clinicians to manage a wide range of undifferentiated and undiagnosed conditions, there is an expectation that the FCD will work towards demonstrating capability in other dietetic specific key areas as their skills develop. This roadmap should be used to support the individual FCD with their development.

Diabetes

Synthesise advanced knowledge of nutrition components of diabetes prevention and diabetes management programmes and have an awareness of regional and national programmes.

Synthesise advanced knowledge of the effect carbohydrates, fats and proteins have on blood glucose control.

Evaluate findings of glucose monitoring, carbohydrate, fat and protein counting, where appropriate, to inform treatment options.

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Support the person with self-management techniques such as glucose monitoring and estimating carbohydrate intake, and evaluate the findings to inform treatment options. • As appropriate to local protocol and in conjunction with the MDT, advise on medication and/or insulin changes linked to dietary intake and weight change (amongst other factors) • Provide education and support for people requiring more complex diabetes treatments e.g. insulin. • Support and advise non-specialist colleagues in interpreting and adapting diabetes guidelines regarding dietary approaches in the specialist areas.	**Acute presentations** • Increased frequency of passing urine • Excessive thirst • Fatigue, tiredness • Visual disturbances • Unexplained weight loss • Recurrent infections such as thrush	• Diabetes/pre diabetes referral to NHS DPP or structured education and online services e/g second nature • Blood tests – FBC, TFT, HbA1c, LFT, U&Es, cholesterol, PSA, ACR • Blood pressure • Referral for peripheral neurological checks

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan, including but not limited to nutrition and hydration needs and activity. • Identify the need for additional clinical and professional support such as referral, second opinion etc following local protocols. • Be able to write a comprehensive and appropriate referral letter. • Supply and/or administer appropriate therapies. • Recognise the effect that the environment, lifestyle and genetics can have on the presenting problem 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. • Understand the implications of an existing relevant condition. • Identify red flag indicators • Be aware of and be able to discuss the role that medication plays in condition management • Understand the need for, and initiate (according to local policies), referral to appropriate pathways including acute admission, 2-week wait, urgent, and routine referrals and crisis team for mental health emergencies.	**Existing diagnosed conditions** • Pre-diabetes • Type 1 diabetes • Type 2 diabetes • Polycystic ovary syndrome (PCOS)	• Referral for annual screening including foot and eye. • Height • Weight • Weight History • Referral for specialist nutritional management as appropriate

Frailty

https://skillsforhealth.org.uk/wp-content/uploads/2021/01/Frailty-framework.pdf

- understand the concept of frailty as a long-term condition and recognise all stages from emergence to end of life care
- know the five conditions often associated with frailty (known as the frailty syndromes) and how they commonly present
- understand that frailty syndromes may be a first presentation of frailty
- understand the importance of early recognition and timely management of frailty syndromes, e.g., that there are interventions to improve independence and quality of life for people living with frailty
- understand and recognise the role that nutrition and physical activity plays in preventing and managing frailty as a long-term condition
- Apply and understanding of the impact of cognition and practical difficulties relating to eating (chewing and swallowing) on nutritional status.
- Identify vulnerability for higher dependency and deterioration of health.

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Assess the typical physical and functional criteria for frailty which may include weight loss, fatigue, physical activity, walking distance and grip strength • Understand the importance of identifying people with frailty in planning healthcare or support interventions • Understand the importance of both proactive and reactive approaches to malnutrition and frailty identification and the need for early treatment of these • Select and utilise acceptable and appropriate nutritional screening tools alongside frailty tools	**Acute presentations** • Dry mouth • Sore mouth **Frailty syndromes** • Confusion • Hallucinations • Recurrent falls • Sudden deterioration in mobility	• Appropriate frailty screening tools. Refer to Frailty framework for examples. • Appropriate malnutrition screening tools. • Initiate onward referral to support a person to optimise their mobility in relation to specific support regarding strength, balance and falls prevention • Weight

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand the importance of equal access to frailty assessment, e.g. for people from diverse communities or with specific needs (such as sensory or cognitive impairment) • Understand reasons for caution about assessing frailty in a person who is acutely unwell as this may not be a true reflection of their baseline function. • Understand the concept of a 'frailty index' as a means of measuring frailty • Initiate, contribute to, or refer on for a multi-disciplinary comprehensive and holistic assessment of frailty, often known as Comprehensive Geriatric Assessment (CGA) • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan, including but not limited to nutrition and hydration needs and activity. • Identify the need for additional clinical and professional support such as referral, second opinion etc following local protocols. • Be able to write a comprehensive and appropriate referral letter. • Supply and/or administer appropriate therapies.	• New or worsening incontinence • Medication side-effects • Unintentional weight loss including signs such as loose-fitting clothes, jewellery not fitting, loss of appetite **Existing diagnosed conditions** • Frailty • Malnutrition • Cachexia	• Weight History • Mid upper arm circumference (MUAC) • Height, or alternatives • Estimated weight changes • Blood pressure • Blood tests – FBC, TFT, HbA1c, LFT, U&Es, haematinics, Vitamin D. • Referral for specialist nutritional management as appropriate • Mini mental state examination

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Recognise the effect that the environment, lifestyle and genetics can have on the presenting problem 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. • Understand the implications of an existing relevant condition. • Identify red flag indicators • Be aware of and be able to discuss the role that medication plays in condition management • Understand the need for, and initiate (according to local policies), referral to appropriate pathways including acute admission, 2-week wait, urgent, and routine referrals and crisis team for mental health emergencies.		

Gastroenterology including functional bowel disorders (FBD)*, irritable bowel syndrome (IBS) and coeliac disease

**FBD: functional constipation, functional diarrhoea, functional bloating/distention, and bile acid diarrhoea.*

- Synthesise knowledge of appropriate treatments for FBD, IBS and coeliac disease.
- Synthesise information around current pharmacological treatments for FBD and irritable bowel syndrome.
- Synthesise knowledge of the role that diet and lifestyle plays in managing gastrointestinal conditions.
- Critically analyse the severity and impact of related symptoms on clinical, nutritional and mental health status.

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Select and modify appropriate treatment for FBD, IBS and coeliac disease. • Support with the correct identification and diagnosis of suspected food allergies and intolerances in line with local pathways • Provide well evidenced suggested management/ personalised care and support plan, including but not limited to nutrition and hydration needs and activity. • Identify the need for additional clinical and professional support such as referral, second opinion etc following local protocols. • Be able to write a comprehensive and appropriate referral letter. • Supply and/or administer appropriate therapies.	**Acute presentations** • Abdominal pain • Abdominal bloating/ distension • Constipation • Incomplete evacuation • Diarrhoea/loose stools • Nausea/vomiting • Urgency to open bowels • Excessive wind/flatulence • Indigestion/heartburn	• Temperature, • Pulse rate • Blood pressure • Respiratory rate • Blood tests – FBC, LFT, U&Es ESR, CRP, coeliac screen, haematinics, amylase, hepatitis and human immunodeficiency virus (HIV) screening, Imumoglobulins test (may include IgM, IgG, total IgA, IgA tTGA), CA125, nutritional deficiency screening

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. • Understand the implications of an existing relevant condition. • Identify red flag indicators. • Be aware of and be able to discuss the role that medication plays in condition management. • Understand the need for, and initiate (according to local policies), referral to appropriate pathways including acute admission, 2-week wait, urgent, and routine referrals and crisis team for mental health emergencies.	**Existing diagnosed conditions** • Acute Stoma issues • Functional constipation • Functional diarrhoea • Functional bloating/distention • Bile acid diarrhoea • Irritable bowel syndrome • Coeliac disease • Gastro-oesophageal reflux • Food allergy or intolerance	• Stool sample – culture and sensitivity, faecal calprotectin, helicobacter-pylori testing, faecal elastase, Faecal Immunochemical Testing, Faecal Occult Blood depending on local availability • Assessment for lymphadenopathy • Digital rectal examination • Referral for abdominal Ultrasound, X-Ray • Referral for specialist nutritional management, as appropriate • Recognises need for direct referral for colonoscopy, gastroscopy and endoscopy.

Overweight and Obesity

- Demonstrate in-depth knowledge of the multifactorial causes of overweight and obesity
- Critically understand the role that diet and lifestyle plays in managing overweight and obesity
- Synthesise knowledge of current pharmacology treatments for obesity, for example, use of weight-loss medication and the impact of weight gaining drugs such as antidepressants, antipsychotic medication and insulin.
- Synthesise knowledge of treatments that help with weight loss in those with overweight and obesity and Type 2 diabetes (including SGLT2 inhibitors and GLP1 analogues).

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify disordered eating and refer to specialist services as appropriate. • Promote an interest in a healthy lifestyle approach, including physical activity e.g. provide opportunistic lifestyle advice to reduce risk of co-morbidities and encourage positive behaviour change. • Use a cautionary approach with weight loss and weight management in older adults and ensure maintenance of muscle mass. • Provide information, including the safety and evidence base of a range of weight management programmes so that people can make informed choices on the weight management options for them. • Support sustainable weight loss outcomes and weight maintenance.	**Acute presentations** • Excess weight • Disordered eating **Existing diagnosed conditions** • PCOS • Overweight • Obesity	• Cardiovascular risk factors • Check pregnancy status • Diabetes/pre diabetes referral to NHS DPP or Type Structured education or local equivalents • Height • Weight • Weight History • Body Mass Index • Blood Tests including FBC, TFT, HbA1c, LFT, U&Es, cholesterol, ferritin, vitamin B12, folate, vitamin D. • Waist Circumference • Referral for specialist nutritional management as appropriate

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Navigate the obesity pathway, including the tiered structure (Tier 1-4), from Primary care to Bariatric surgery. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan, including but not limited to nutrition and hydration needs and activity. • Identify the need for additional clinical and professional support such as referral, second opinion etc following local protocols. • Be able to write a comprehensive and appropriate referral letter. • Supply and/or administer appropriate therapies. • Recognise the effect that the environment, lifestyle and genetics can have on the presenting problem 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. • Understand the implications of an existing relevant condition.		

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify red flag indicators • Be aware of and be able to discuss the role that medication plays in condition management • Understand the need for, and initiate (according to local policies), referral to appropriate pathways including acute admission, 2-week wait, urgent, and routine referrals and crisis team for mental health emergencies.		

Paediatrics

- Dietitians working with undifferentiated diagnosis in paediatric populations must have relevant masters level training and education in the management of nutrition and dietetic practice in paediatrics.
- Clinical application and synthesis of all factors that affect the child's health, growth/development. e.g., genetic background, family history, demographics, prenatal factors, family & cultural influences.
- Working with the procedures & protocols in place both within & outside of the practice in relation to any child or family of concern, children in need, looked after children or any with a child protection plan. Integrating with multi-agencies in safeguarding and liaising with other health professionals/social services, making appropriate referrals to safeguard where necessary, and documenting accordingly.

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• 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. • Critically evaluate factors that affect the child's/young person's health, growth/development. e.g., genetic background, demographics, prenatal factors, family and cultural influences. Provide information, lifestyle and health promotion advice or referral. • Promote the health of the child and support parents or carers in making informed choices.	**Acute presentations** • Rashes • Crying baby • Dehydration • Vomiting • Abdominal pain • Faltering growth • Feeding issues • Constipation • Chronic diarrhoea • Tiredness, looking pale • Weight gain	• Temperature • Pulse rate, rhythm, volume and character • Blood pressure • Respiratory rate • Oxygen saturation • Capillary refill time • Appropriate systems review depending on presenting problem • Referral criteria for midwife, health visitor, school health team, paediatrician, community paediatrician, child safeguarding, infant feeding team

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand own role in the context of local guidelines and pathways for referral to acute paediatrics, community paediatrics, specialist paediatric dietitians, health visitors, school-nursing teams, speech and language therapy and infant feeding teams. • Emphasise the importance of childhood immunisations and promote uptake in accordance with the national schedule. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan, including but not limited to nutrition and hydration needs and activity. • Identify the need for additional clinical and professional support such as referral or second opinion following local protocols. • Be able to write a comprehensive and appropriate referral letter. • Supply and/or administer appropriate therapies. • Recognise the impact of the presenting problem on the lifestyle and day to day living of the person and family. • Understand the implications of an existing relevant condition.	**Existing diagnosed conditions** • Eczema • Colic • Gastro-oesophageal reflux disease (GORD) • Cow's milk protein allergy • Food allergies or intolerances • Dehydration • Gastroenteritis • Constipation • IBS • Behavioural feeding difficulties, selective eaters • Micronutrient deficiencies such as iron deficiency anaemia • Overweight or obesity	• Blood tests as appropriate to presentation. • Imaging (for example x-ray) • ECG • Understand the need to limit investigations in children to avoid unnecessary distress or radiation exposure • Shared decision making with paediatric team and other colleagues. • Referral for specialist nutritional management as appropriate

Core clinical skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Identify red flag indicators • Be aware of and be able to discuss the role that medication plays in condition management • Understand the need for, and initiate (according to local policies), referral to appropriate pathways including acute admission, 2-week wait, urgent, and routine referrals and crisis team for mental health emergencies.		

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

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

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

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

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

Ensure accurate documentation of the type of consultation used, consents obtained (for type of consultation, use of interpreter, destination of any electronic prescriptions etc), persons agreement to the management plan and how this will be delivered, and detailed safety netting advice.

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.	• 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)
• Support the interpreter to work in ways that promote the person's rights and choices, respect their experiences, expertise and abilities and promote inclusion. • 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.		

12.17 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 dietitian is on the Directory at The Health Education England Centre for Advancing Practice, that need to be assessed with triangulated Masters level evidence to be recognised as an Advanced Practitioner (AP).

Domain A: Person-centred Collaborative Working

Capability 1. Communication and consultation skills		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 1**	**ACP PRIMARY CARE DIETETIC competencies**
Critical skills		

Capability 2. Practicing holistically to personalise care and promote public and person health		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 2**	**ACP PRIMARY CARE DIETETIC competencies**
Critical skills		
P2 E1	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	
NEW	Actively take an individualised, personalised care and population centred care approach to enable shared decision making with the presenting person.	NEW
	Contribute to the fit note process and help people remain in or enter work by using vocational focused interventions that address their work ability, the demands of their job and working environment, and advise on and develop return to work plans using the AHP Health and Work Report.	A14

Capability 3. Working with colleagues and in teams		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 3**	**ACP PRIMARY CARE DIETETIC competencies**
Critical skills		
F1 F3 L1	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.	B1.3.6

Capability 4. Maintaining an ethical approach and fitness to practice		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 4**	**ACP PRIMARY CARE DIETETIC competencies**
This section is completed in the FCP capabilities		

Domain B: Assessment, investigations and diagnosis

Capability 5: Information gathering and interpretation		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 5**	**ACP PRIMARY CARE DIETETIC competencies**
This section is completed in the FCP capabilities		

Capability 6: Clinical Examination and Procedural Skills		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 6**	**ACP PRIMARY CARE DIETETIC competencies**
This section is completed in the FCP capabilities		

Capability 7: Making a Diagnosis		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 7**	**ACP PRIMARY CARE DIETETIC competencies**
This section is completed in the FCP capabilities		

Domain C: Condition management, treatment, and prevention

Capability 8: Clinical Management		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 8**	**ACP PRIMARY CARE DIETETIC competencies**
This section is completed in the FCP capabilities		

Capability 9: Managing medical and clinical complexity		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 9**	**ACP PRIMARY CARE DIETETIC competencies**
P1	Understand the complexities of working with people who have multiple health conditions whether physical, mental and psychosocial.	B3.2.9
P1 P2 P3	Understand and be able to manage practitioner and persons uncertainty	B3.2.2
Critical skills		
P1	Simultaneously manage acute and chronic problems, including for people with multiple morbidities and those who are frail	B3.2.1
P1 P2	Recognise the inevitable conflicts that arise when managing people with multiple problems and take steps to adjust care appropriately.	B3.2.9
P1 P2 P3	Communicate risk effectively to people and involve them appropriately in management strategies.	B3.2.3
	Manage urgent or out of hours presentations appropriately, in line with local protocols.	B3.2.5
P1	Undertake complex decision making to inform the diagnosis, investigation, complete management of episodes of care within a broad scope of practice.	
P1	Apply advanced clinical dietetic knowledge in order to carry out in-depth assessment of individuals with complex healthcare needs, including relevant assessments to enable complex differential diagnosis.	A18

Capability 10: Supplementary Prescribing, Medicines Supply and Pharmacotherapy		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 10**	**ACP PRIMARY CARE DIETETIC competencies**
	As a AP in primary care. You will be required to have completed a NMP qualification meeting all of capability 9 (Prescribing treatment, administering drugs/medication, pharmacology) in the FCP KSA. You must be familiar with and work within the Royal Pharmaceutical Society: A Competency Framework for all prescribers	B3.3.13
	As a non-medical supplementary prescriber (NMSP), critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental well-being and healthcare provision.	B3.3.7
Critical Skills		
	As an NMSP, 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.	B3.3.9
	As an NMSP, support people to only take medications they require and de-prescribe where appropriate.	B3.3.12
	Evaluate and assess the interaction between dietary intake and medication in persons with complex medical needs.	A21
NEW	Influence local formulary and medications issued only under shared care agreements.	NEW

Domain D: Leadership and management, education, and research

Capability 11: Leadership, management and organisation		
BDA PRPDF	**Essential knowledge: specific knowledge underpinning capabilities 11**	**ACP PRIMARY CARE DIETETIC competencies**
Critical skills		
P3 F3 L2	Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working	L&M 1
E3 F4 L4	Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit).	L&M 7
E2 E3 L4	Demonstrate the impact of advanced clinical practice on service function and effectiveness, and quality (i.e. outcomes of care, experience and safety).	L&M 9
P1 E2 E3 F1	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 care pathways and broadening sphere of influence.	L&M 13
P1 E1	Apply critical, innovative thinking to develop novel nutrition and dietetic interventions	A4
E2 E3 F1 L4	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.	L&M 17
P1 F3 L2	Demonstrate leadership, resilience and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others.	L&M 20
E1 L4	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).	L&M 22

L1	Synthesise knowledge of national policy drivers and local systems, how they impact on the delivery of nutritional and dietetic services across the local health and social care economy, and influence policy change.	A30
P1 P3 E3	Initiate and sustain collaborative working relationships across multi-disciplinary teams to effectively develop and/or enable integration of pathways requiring dietetic interventions in primary and secondary care	A15

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

Capability 12: Education and development		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 12**	**ACP PRIMARY CARE DIETETIC competencies**
	Critical Skills	
F4	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.	E3
F1 F3 F4	Promote and utilise clinical supervision for self and other members of the healthcare team to support and facilitate advanced professional development	E10
F1 F3	Advocate for and contribute to a culture of organisational learning to inspire future and existing staff	E5
E3 F1 F3	Facilitate collaboration of the wider team and support peer review processes to identify individual and team learning and support them to address these.	E6
F1 F3	Enable the wider team to build capacity and capability through work-based and interprofessional learning, and the application of learning to practice.	E8
P2 F1 F2 F3	Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities.	E4
F3	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.	E9

E1 F1 F3	Actively seek to share best practice, knowledge and skills with other members of the team, and wider networksfor example through educational sessions and presentations at meetings.	E13
F3	Complete the relevant training in order to provide multi-professional clinical practice and CPD supervision to other roles within primary care, for example first contact practitioners and the personalised care roles.	E9

Capability 13: Research and evidence-based practice		
BDA PRPDF	**Essential knowledge: Specific knowledge underpinning capabilities 13**	**ACP PRIMARY CARE DIETETIC competencies**
E1 E2 E3 L4	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.	R1
E3	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.	R2
E1 E2 E3	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.	R5
Critical Skills		
E1 E2 E3	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	R4
E2 E3 L2 L4	Lead on Quality Improvement initiatives/projects – sharing outcomes and leading change.	R2

	Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review.	R6
E1 E3 F1 F2	Disseminate best practice research findings and quality improvement projects through appropriate media and fora (e.g. presentations and peer review research publications).	R7
E1	Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical and other active researchers.	R8

12.18 Agreed Scope of Practice Table - FCP

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

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

Aspect of clinical presentation	In scope of role? (Y/N)	Rationale:	Agreed between FCP & employer? (Y/N)
Diabetes			
Frailty			
Gastroenterology including FBD, IBS and coeliac disease			
Overweight and obesity			
Paediatrics			

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