NHS
Health Education England

First Contact Practitioners and Advanced Practitioners in Primary Care: Occupational Therapy

A Roadmap to Practice

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Acknowledgements

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Development of the Roadmap to First Contact Practice and Advanced Practice in Primary Care was project managed by Amanda Hensman-Crook (Health Education England). The development of the occupational therapy knowledge skills and attributes document was led by Genevieve Smyth, Professional Adviser (Royal College of Occupational Therapists). Supervision of content was led by Paul Cooper, Lead Professional Adviser (Royal College of Occupational Therapists). Chantelle Martin, Occupational Therapist (Alliance for Better Care Ltd), Beth Warburton, Staff Wellbeing Hub Project Lead (Lincolnshire Partnership NHS Foundation Trust), Helen Blomfield, Trainee ACP Occupational Therapist (Primary Care Sheffield), Lyndsay Court, Occupational Therapist (University Hospitals Dorset) provided expert support in the building of this roadmap.

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Glossary

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

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

Introduction

i Purpose

This document provides a roadmap of education for occupational therapy 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 occupational therapists can build a portfolio of evidence for both FCP and AP roles.
- How to support training with relevant supervision and governance, and the link to Health Education England's Centre for Advancing Practice.

This occupational therapy version of the educational pathway and framework is applicable across the life span dependent on the scope of practice, appropriate knowledge and skills that may apply to specific patient groups, and the job description that the FCP Occupational Therapist is working under. Health Education England provide regular updates about the roadmaps here.

ii Historical background and context

- Occupational Therapists working in primary care who are not training to be FCPs, or APs will have a different scope of practice which is outside the remit of this document.
- 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 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 patients with undifferentiated and undiagnosed presentations within an agreed scope of practice.

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

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

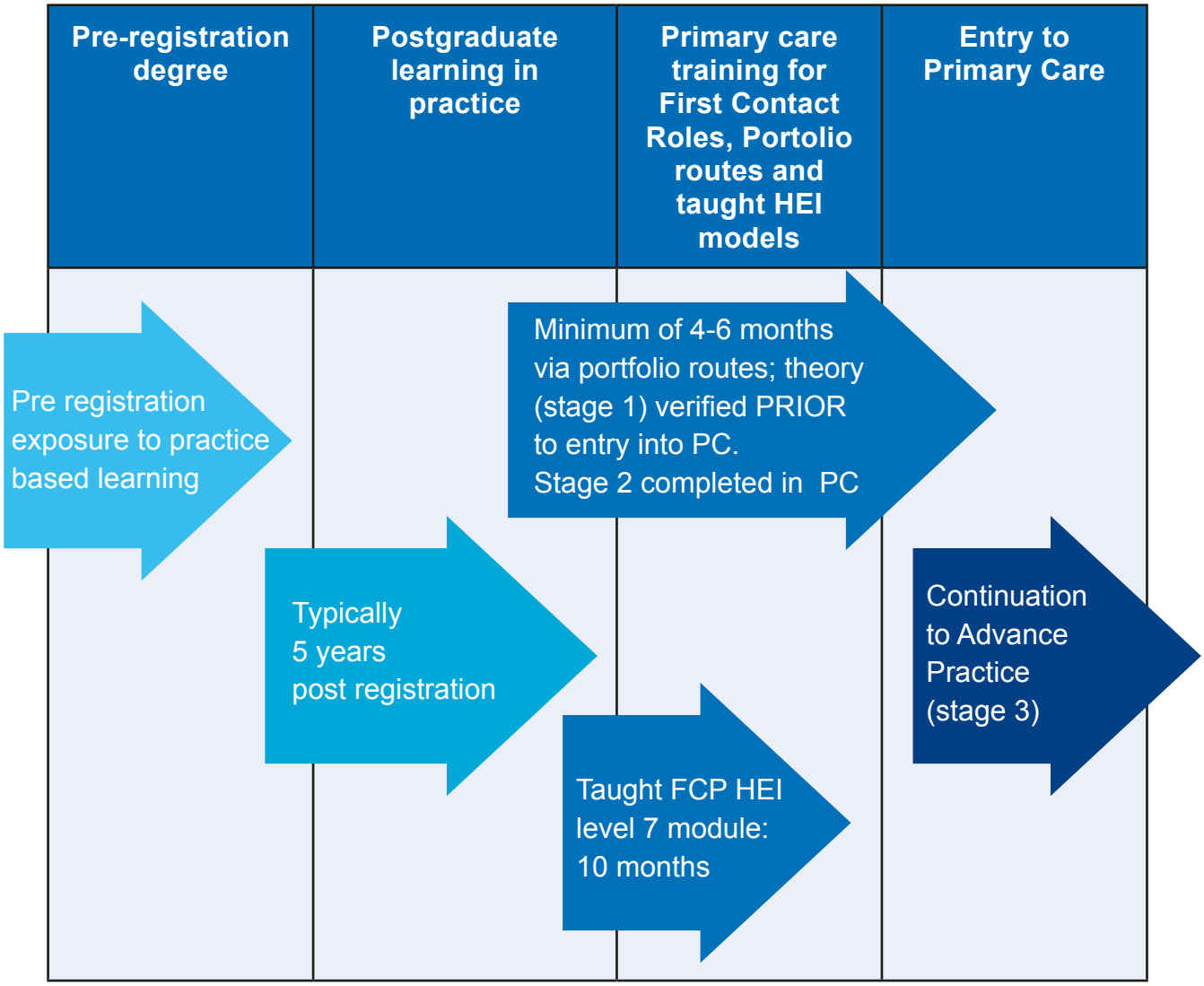


Diagram to illustrate career progression of Primary Care roles.

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

To provide further background to FCP roles in Primary Care and Advanced Practice, please refer to the following:

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

iii The Centre for Advancing Practice

The Health Education England Centre for Advancing Practice (The Centre) has been established, working extensively and collaboratively with professional bodies and other stakeholders to support education and training for Advanced Practitioners in England.

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

- An FCP Directory is held for verified FCPs.
- There are portfolio routes and taught routes to recognition as an FCP in the FCP directory.
- A retrospective route for existing FCPs is available via the portfolio route to gain recognition.
    - *This route is only available for existing experienced Occupational Therapists in primary care that meet the criteria and have undertaken the mapping required to achieve recognition.*
- FCP recognition is not a 'short cut' to AP status and not all FCPs will choose to progress to APs. However, any evidence collected in the FCP portfolio relevant to the AP portfolio domains will be available for further submission, with evidence, for the required unmet domains needed for AP status (see appendix 12.13).

- The Knowledge Skills and Attributes (KSA) document describes the prerequisite knowledge, skills, and attributes stipulated for clinical professionals such as Occupational Therapists moving into FCP roles within Primary Care (appendix 12.14). They are the core skills that all FCP roles require, regardless of professional background. Mapping against the KSA document with a portfolio of evidence is the recognition requirement for Stage 1 (see section 5) prior to entry to Primary Care, alongside the eight Primary Care e-learning modules andthe three personalised care e-learning modules later (see section 5.1).

- The Centre holds a directory of Advanced Practice Roadmap supervisors. Roadmap supervisors are required to have completed an approved Primary Care two-day training programme (see appendix 12.1), which will allow them to support clinicians in achieving both FCP and AP recognition (appendix 12.11).

- GP Trainers can access a shortened version of the above course.

1.0 Declarations

1.1 What is a First Contact Practitioner?

✔ A First Contact Practitioner (FCP) is a diagnostic clinician working in Primary Care at the top of their clinical scope of practice at master's level, Agenda for Change Band 7 (see 1.3) or equivalent and above. This allows the FCP to be able to assess and manage patients with undifferentiated and undiagnosed presentations. They can demonstrate the Knowledge Skills and Attributes (KSA) in appendix 12.14..

✔ It is the minimum threshold for working as a first point of contact with undifferentiated undiagnosed conditions in Primary Care. With additional training, FCP occupational therapists can build towards advanced practice, the competency required for dealing with clinical and contextual complexity using advanced decision-making skills where protocols and pathways may not exist (RCOT 2021a).

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

✔ FCP Occupational Therapists refer patients to GPs and/or other members of the primary care team for the medical management of patient presentations and pharmacology outside their agreed scope of practice.

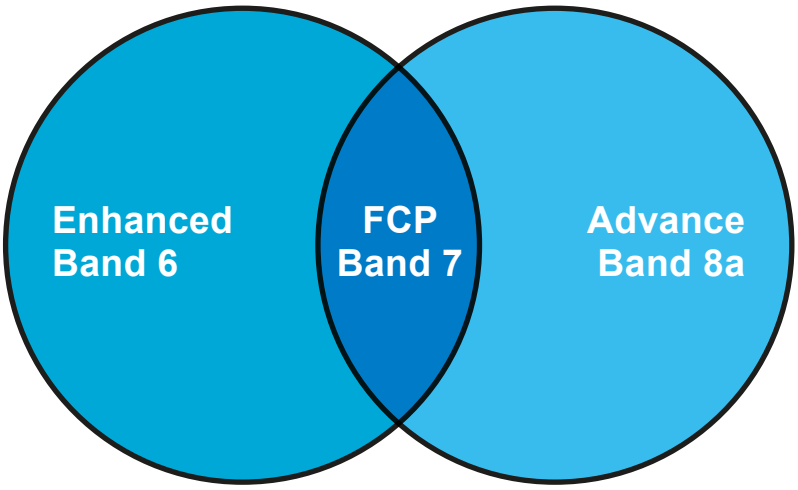


Diagram illustrating the relationship between Bands 6, 7, 8a (AfC), and Enhanced, FCP, and AP.

✔ FCP Occupational Therapists work at master's level (QAA level 7 see 1.4) in their clinical pillar of practice but have not yet reached an advanced level in all four pillars of practice (HEE 2017).

✔ The Occupational Therapist must typically have 3-5 years post preceptorship experience before starting primary care training to become an FCP.

1.2 What is an Advanced Practitioner?

- An AP is an Occupational Therapist working at an advanced level across all four pillars of advanced practice at master's level (QAA level 7 – see 1.4). They can demonstrate the Advanced Clinical Practice Capabilities for Primary Care Occupational therapy (appendix 12.17).

- The four pillars of AP are: Research, Leadership and Management, Education, and Clinical Practice (RCOT 2021a).

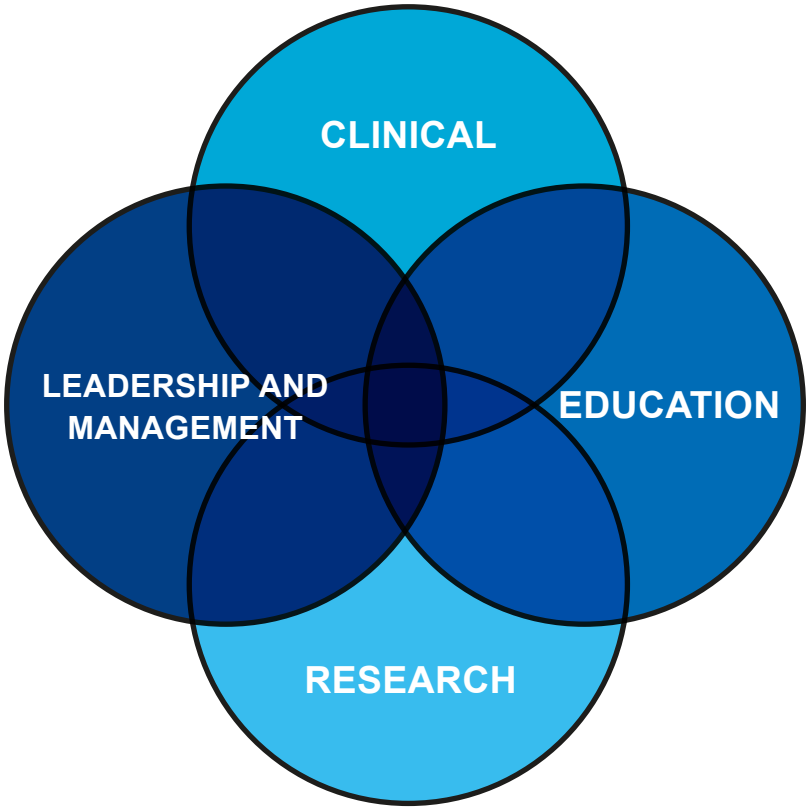


Diagram that illustrates interlinkage of the four pillars of advanced practice.

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

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

- 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 Occupational Therapist demonstrates all the capabilities listed for FCP plus the additional capabilities listed for AP.

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

First Contact Practioner Band 7	Advanced Clinical Practioner Band 8a
• Manages undifferentiated undiagnosed conditions. • Able to identify red flags and underlying serious pathology and take appropriate action. • Works within practice, across PCN, multi-organisational, cross professions and across care pathways and systems including health, social care, and the voluntary sectors. • High level complex decision making to inform the diagnosis, investigation, management, and referral across broad aspects of service delivery, within scope of practice. • Actively takes a personalised care approach to enable shared decision making with the presenting person. • Contributes to and co-creates audit and research projects. • Contributes to education and supervision within their scope of practice for the multi-professional team. • Facilitates and co-creates interprofessional learning in area of expertise. • Promotes and develops area of expertise across care pathways and systems. • Can be working toward Advanced Clinical Practice (level 7 across all pillars).	• Manages undifferentiated undiagnosed conditions. • Able to identify red flags and underlying serious pathology and take appropriate action. • Works within practice, across PCN, CCG and ICS, multi organisational, cross professionals and across care pathways and systems including health, social care, and the voluntary sectors. • High-level of complex decision making to inform diagnosis, investigation, complete management of episodes of care within a broad scope of practice, taking responsibility for service delivery. • Flexible skill set to adapt to and meet needs of the PCN Population and support public health. • Manages medical complexity and unpredictable contexts. • Actively takes a personalised care and population- centred care approach to enable shared decision making with the presenting person. • Actively engages in care from a Population care viewpoint. • Leads audit and research projects taking responsibility for overall delivery. • Provides multi-professional AP clinical and CPD supervision across all four pillars with relevant training. • Leads education in their area of expertise, taking responsibility for overall delivery. • Enables, facilitates, and supports change across care pathways and traditional boundaries at regional and national level. • Working toward level 8 across all 4 pillars..

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

- The Quality Assurance Agency (QAA) Level 7 is the UK academic master's (MSc) level..
- **FCP Occupational Therapists work at master's level in their Clinical Practice pillar of practice but have not yet reached that level in all four pillars of practice to be verified as an AP** (Research, Leadership and Management, Education, and Clinical practice) (see appendix 12.13).
- Level 7 practice requires complex clinical reasoning skills and critical thinking, using advanced decision making where protocols and pathways may not exist. (RCOT 2021b)
- The QAA (2014) MSc Level 7 descriptors are found below (table *) and via the link.

QAA (2014) MSc Level 7 descriptors (click to view)

Graduates of specialised/advanced study master's degrees typically have:

Subject-specific attributes:
A systematic knowledge and comprehensive understanding of the discipline, informed by the forefront of current scholarship and research, including a critical awareness of current issues and developments in the subject.

The ability to complete a research project in the subject, which may include a critical review of existing literature or other scholarly outputs.

Generic attributes (including skills relevant to an employment-setting):

A range of generic abilities and skills that include the ability to:

- ✔ Use initiative and take responsibility
- ✔ Solve complex problems in creative and innovative ways, making sound judgements
- ✔ Make decisions in challenging and unpredictable situations
- ✔ Continue to learn independently and to develop professionally to a high level
- ✔ Communicate effectively, with colleagues and a wider audience, in a variety of media to specialist and non-specialist audiences

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

See also SEEC - Credit Level Descriptors for Higher Education (2016)

2.0 Primary Care Educational Pathways

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

- FCP portfolio and taught routes with onward portfolio route or a taught AP master's to AP in Primary Care.
- AP portfolio or taught routes with the addition of the required Primary Care KSA training and e-learning.

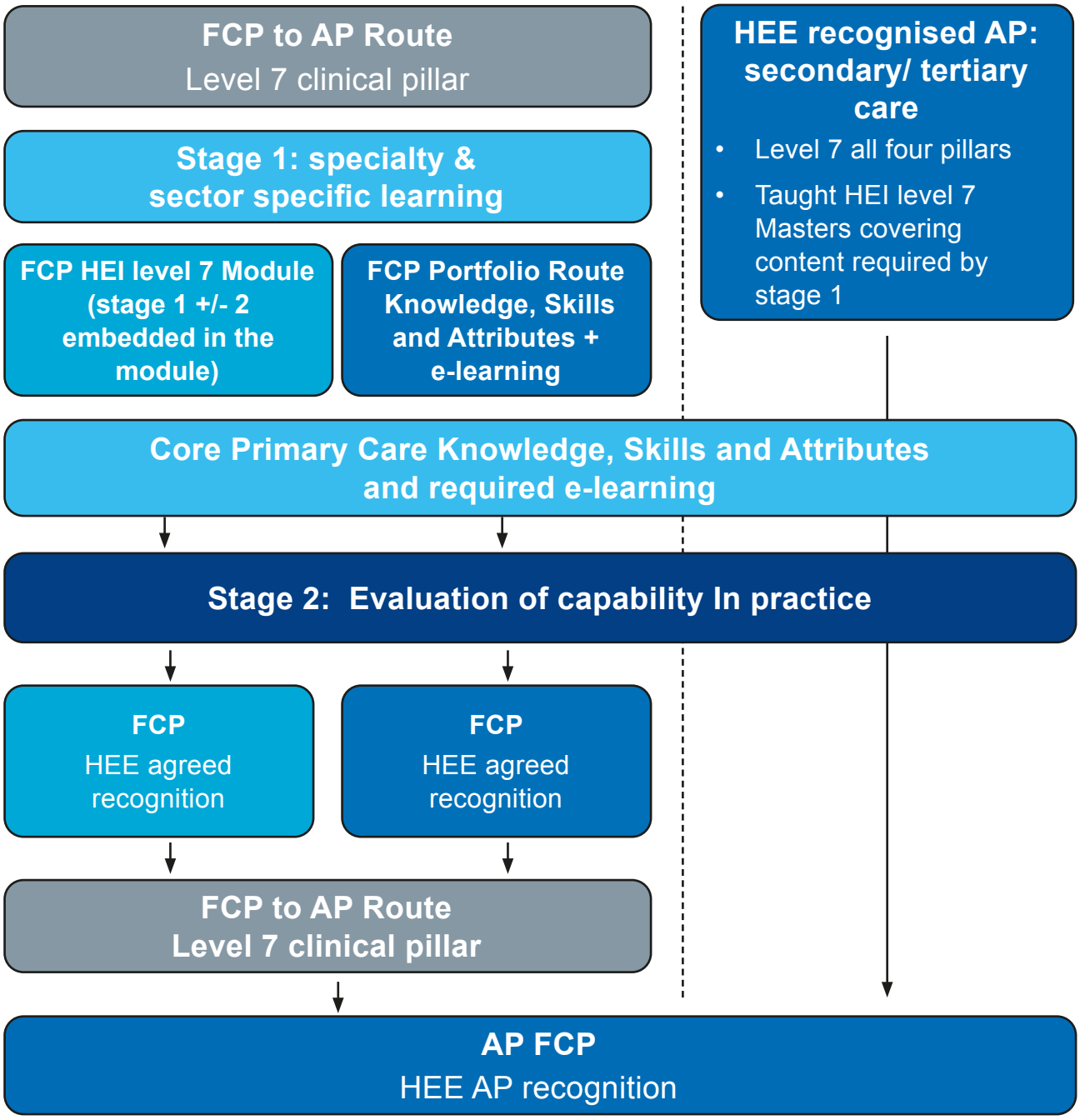


Diagram to illustrate pathways to FCP and AP in Primary Care

3.0 National standards and frameworks for Occupational Therapists

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

- The capabilities are cross referenced to the Advanced Clinical Practice Capabilities for Primary Care occupational therapy (appendix 12.17).

- The document is also cross-referenced to the RCOT Career Development Framework -Guiding Principles for occupational therapy at Level 7 (RCOT 2021a) to ensure capability alignment.

FCP Occupational Therapists can work with urgent and unscheduled care and patients with acute presentations that have had an acute or chronic onset. Appendix 12.15 outlines several key clinical areas that FCP Occupational Therapists may need to manage in general practice/primary care, according to the scope of their role. It details assessment and management skills that FCP Occupational Therapists 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. It includes people with suspected mental health problems, frailty, or vocational needs.

The application of these clinical presentations will be determined by the scope of the **role of the FCP Occupational Therapist** and the context in which they operate and would be **agreed between the FCP Occupational Therapist 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 Occupational Therapist to have the appropriate knowledge and skills of each system, it is also important that they understand the complex inter and co dependencies of systems when providing care to people.

For each of the clinical skills outlined, the FCP Occupational Therapist will also need to have sufficient theoretical and practical underpinning knowledge and understanding of each system to demonstrate capability in the provision of care for each of the core clinical skills.

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

It will be for the FCP Occupational Therapist and their Clinical Supervisor to contextualise the knowledge statements appropriate to the clinical environment.

In addition to the generic capabilities outlined in the KSA framework (appendix 12.14) the FCP Occupational Therapist will need to know and understand:

- *When a more focused 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 an individuals current medication and existing conditions may affect their presenting symptoms, relevant medicines mechanisms and how to ensure appropriate medicines management to maintain health and wellbeing.*

- *The anatomy, physiology and mental state of the human body and mind as it applies to the clinical condition/presentation to be assessed, including impact of people's values and beliefs and the context of local population health.*

- *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 social 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, carers, families, and communities through shared decision making 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 Occupational Therapist 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 Occupational Therapist is required to put peoples' safety first and to manage risk(s) appropriately.

3.1 Building the evidence

To develop a coherent, professional career infrastructure, the workplace should include several key features:

- The provision of high-quality supervision to individual clinicians is crucial and this will provide a structure for the evaluation of learning and future development (see 8.0).

- Occupational Therapists and roadmap supervisors should familiarise themselves with the national frameworks concerning FCP and AP (see 3.0), on which the structure of a portfolio of evidence can be based. The core KSA (appendix 12.14) can be evaluated to determine any immediate learning needs prior to any FCP role. The learning needs can be traced dependent upon whether the clinician is working towards FCP or AP.

- Essential requirements of the clinician in their journey are ongoing reflective practice, peer review, patient feedback, and the monitoring of personal wellbeing to provide an enriched learning experience. The appendices of this document provide further information on this. Both Occupational Therapist 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 where indicated.

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

- As the Occupational Therapist 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 to identify learning needs. The practitioner can work within the frameworks and use these as a reference for professional development at all stages of career development. **This can occur at any time in a career pathway and even prior to embarking on a formal training pathway.** Frameworks will inform the learner and supervisor of capabilities and standards that the learner can work towards even prior to attaining a role as an FCP or AP.

- The core KSA document (appendix 12.14) aids the learner to build their evidence prior to embarking on their FCP recognition process (Stage 1), working up to Primary Care (Stage 2), and allows the learner to build evidence against the QAA level 7 criteria.

- This portfolio of evidence will demonstrate their progress and evidence which capabilities they have met. Evidence across all the FCP capabilities relevant for the occupational therapy profession and scope of role will be required for verification.

4.0 The Roadmap to FCP

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

- **Stage 1** – It is best practice that this is completed with a portfolio of evidence and verified before employment in Primary Care (unless the trainee FCP is an experienced Occupational Therapist already employed in Primary Care).

- **Stage 2** is completed with a portfolio of evidence and verified in Primary Care. This is the recognition process of the application of the core KSA (appendix 12.14) in Stage 1 to clinical practice in Primary Care. Best practice is this should be completed within six months for a FT staff member, but this can be longer provided a completion date is agreed with the employer.

- **Once Stage 1** and **Stage 2** are verified, the Occupational Therapist is placed on the FCP directory at the Centre for Advancing Practice and would be able to continue building evidence towards AP if they wish to continue along the educational pathway.

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

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

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

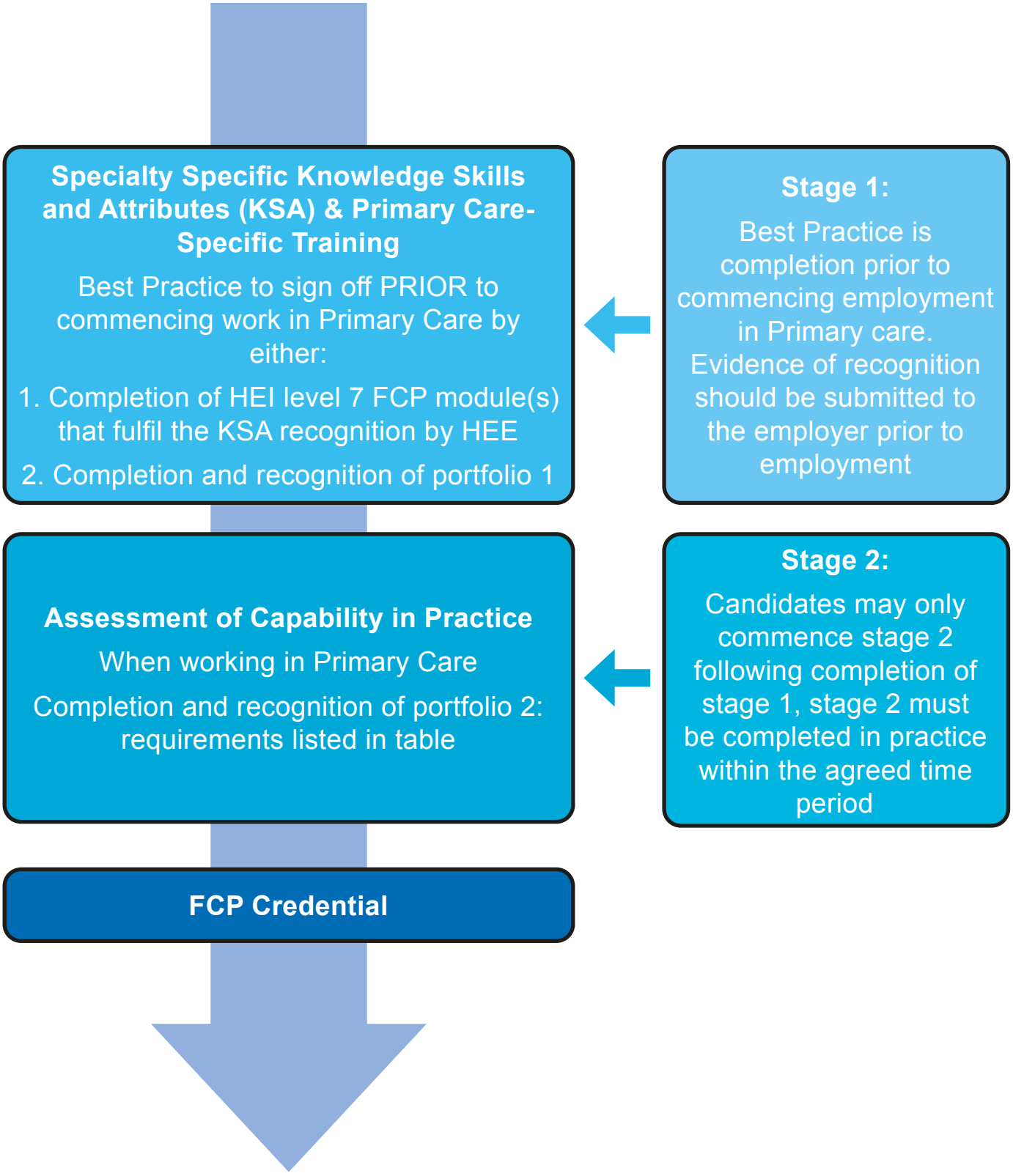


Diagram to illustrate the process of FCP recognition.

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

5.1 E-learning

- The early stages of creating a portfolio of evidence towards FCP start with the completion of a number of important electronic modules, which are housed within the E-Learning For Health portal. These are free to access for NHS staff and can be accessed by external partners for a small fee (e-integrity).

- The Primary Care modules cover areas such as managing complexity, mental and public health, illness identification, and red flags. Although labeled as MSK these are generic modules relevant to all professions. Complementing these modules are three personalised care modules. For more information about these modules see appendix 12.18. Best practice is for Occupational Therapists to complete all modules associated with both programmes. For external partners, eIntegrity Registration links the clinician to an external annual licence agreement. In addition, there are a wide range of modules relevant to occupational therapy in primary care listed in appendix 12.19, dependent on role and scope of practice.

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

- Once agreed, the supervisor will work with the 'trainee' FCP Occupational Therapist to review their current portfolio of knowledge and assess any learning needs required against the core KSA document (appendix 12.14).

5.2 Next steps

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

- The 'trainee' FCP Occupational Therapist is advised to register with the HEE advanced practice process and utilise the online portal and CPD portfolio. This will allow the 'trainee' FCP Occupational Therapist to upload evidence against this pathway, which can be transferable across all CPD including Primary Care.

- The 'trainee' FCP Occupational Therapist then begins the process of portfolio of evidence development against the core KSA document. Evidence can be from practice, from educational institutions, or from both as required.

- If an individual does not wish to complete a portfolio route to FCP, they could access an HEI FCP MSc level 7 module for Occupational Therapists. It will still be best practice to complete the online e-learning modules and have their KSA verified, but their Primary Care recognition will occur within the module itself and will not require any further process.

- Throughout the clinical experiences, it is recommended that evidence is continually uploaded into the HEE advanced practice portal, enabling the 'trainee' FCP Occupational Therapist to continue their learning/career journey towards AP if they wish.

- For the already verified advanced practitioner Occupational Therapist registered on the HEE AP directory wishing to also work in Primary Care, best practice will require the e-learning to be completed and the KSA capabilities verified within Primary Care.

5.3 KSA document

The KSA document found in **appendix 12.14** is for use as part of the process of recognition of an FCP. Each capability is described. To the left of each capability there is a cross reference to the Advanced Clinical Practice Capabilities for Primary Care Occupational Therapy (appendix 12. 17) and to the right of each capability there is a cross reference to the RCOT Career Development Framework -Guiding Principles for Occupational Therapy at Level 7 (RCOT 2021a). This allows the trainee FCP to build evidence for their portfolio for Primary Care and towards AP if indicated.

6.0 Stage 2: Moving into Primary Care

On completion of the KSA recognition (Stage 1), the trainee FCP Occupational Therapist can then build their Primary Care portfolio in practice (Stage 2). These tasks comprise the core Primary Care knowledge and skills (appendix 12.14 outlines the requirements for Stage 1 and Stage 2 as a checklist).

A range of portfolio materials have been derived from tools used by GP Specialty Trainees and adapted with kind permission from the Royal College of General Practitioners (RCGP) (see appendices 12.2 -12.10). The portfolio and Workplace-Based Assessment (WPBA) materials have been developed to support FCPs, Roadmap Clinical Supervisors, and other stakeholders to evidence capability. The portfolio tools offer the opportunity to collate a range of triangulated evidence.

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

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

In addition, RCOT has many resources for practice-based learning including conceptual models, reflection tools, learning and development plans and toolkits for self-directed learning all available at.

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

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

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

For FCP (see appendices for tools)

- Personal Development Plan (PDP) identifying SMART objectives (with formal six-month and yearly reviews)
- A record of modules successfully completed at university, if this route is used
- A contemporary record of mandatory training, including BLS and Safeguarding
- Reflective learning logs – it is suggested that this be a minimum of one a week
- A record of Workplace-Based Assessments to include a minimum of:
    - *consultation observation tool (COT) – suggested one per month (FTE)*
    - *a case-based discussion (CBD) – suggested one per month (FTE)*
    - *a range of clinical examination procedural skills (CEPs) (including any mandatory for the profession), if appropriate to role and scope*
- Quality Improvement Projects/Audit - showing ongoing engagement with QIP/audit – audits follow the audit cycle, shows systematic change/leaves a legacy
- Any patient compliments or complaints
- Significant Event Analysis
- Patient satisfaction questionnaires (PSQ) – at least one full round with 40 respondents is recommended
- Multi-source feedback (MSF) – at least one full round with 10 respondents – five clinical and five non-clinical is recommended

7.0 Building the portfolio

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

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

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

Step 2: collate and document

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

8.0 Recognition and supervision process

8.1 Recognition process

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

- For FCP and AP Occupational Therapists, 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 patients with undifferentiated and undiagnosed conditions, often within the context of multi-morbidity and polypharmacy. This requires the FCP Occupational Therapist 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 Occupational Therapist must have:

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

2. Completed the relevant e-learning requirements - Stage 1

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

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

Assement Criteria Level M

Study at master's level will have been at, or informed by, the forefront of an academic or professional discipline. Students will have shown originality in the application of knowledge, and they will understand how the boundaries of knowledge are advanced through research. They will be able to deal with complex issues both systematically and creatively and they will show originality in tackling and solving problems (QAA Framework for Higher Education Qualifications, 2014).

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

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

9.0 Roadmap Supervision and Verification

Roadmap supervision and verification is a process of developing a portfolio of evidence both academically and through application of that knowledge into practice. This is marked and signed off by a recognised Roadmap Supervisor.

For this document and the FCP to advanced practice occupational therapy 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 directories, relevant regular practice supervision is put into place (HEE 2021).

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. (RCOT 2015)

9.1 Continuing Professional Development (CPD) supervision

CPD supervision with respect to practitioners working in established roles should encompass the supervision requirements of the appropriate professional regulatory body. Regular meetings (such as six-weekly) allow for discussion around ways of working, identifying learning needs/opportunities, opportunities for feedback, peer review maintaining standards/capabilities, and embracing life-long learning. CPD supervision provides an excellent opportunity to develop teams and promote self-care/ resilience and wellbeing. Educational opportunities can form part of this and can be inter-professional, uni-professional, or ideally a mix of both (see appendix 12.1).

9.2 Clinical supervision

Clinical supervision within the context of new/emerging roles or in a new clinical setting, involves regular supervision within practice, and includes, particularly in primary care, a debrief (usually daily) to ensure patient and practitioner safety. This short type of daily debrief is common for GPs too. It should provide good-quality feedback to help with safely managing practitioner and patient uncertainty. Clinical supervision should help to build confident capability, clinical reasoning, and critical thinking. It also includes Workplace-Based Assessment (WPBA) to assess the application of knowledge, skills, and behaviours in Primary Care. The WPBA allows for a portfolio of triangulated evidence against the

appropriate framework. Clinical supervision is mainly formative but there may be a summative element (see appendix 12.1).

Educational supervision

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

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

9.3 Supervision requirements

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

This course will include:

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

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

9.4 Checklist of recognition processes: Stage 1 and Stage 2

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

Documents for the completion of each section are found in appendices: **Stage 1:**12.14 (KSA), **Stage 2:**12.2 – 12.10

The recognition surveys can be done upon completion of both Stage 1 and 2 to log verified FCPs in preparation for the Centre for Advancing Practice 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 - best practice to be completed BEFORE entry to Primary Care, Stage 2 in Primary Care Once both parts are completed, the recognition survey must be completed		
CONTENT	**NUMBER**	**DATE & CS SIGNATURE**
STAGE 1		
1. Knowledge, Skills and Attributes verified	Portfolio of evidence required	
2. All eight Primary Care e-learning modules completed	Certificates from modules required	
3. Personalised care e-learning modules	Certificates from modules required	
STAGE 2		
Personal Development Plan (PDP) identifying SMART objectives	Need evidence that it has been developed – regularly updated	
A record of modules successfully completed at university – dates of completion		

A record of mandatory training including BLS and Safeguarding – dates of completion	As per mandated requirement. Can be from Primary Care Training Hub or equivalent	
Reflective log entries	Minimum of one a week over a range of capabilities suggested – verified when capable	
Consultation observation tool (COT)		
To include face-to-face, telephone, and video	Minimum of one per month suggested – verified when capable	
Case-based discussion (CBD)	Minimum of one per month suggested – verified when capable	
A range of clinical examination procedural skills	To reflect any required procedural skills or any required for the profession – verified when capable	
Participation in Quality Improvement Projects (QIP)/audit – showing ongoing engagement with QIP/audit – audits follow the audit cycle, shows systematic change/leaves a legacy	At least one completed audit or QIP but demonstrating an ongoing involvement	
Patient Satisfaction Questionnaires (PSQ)	At least one full round with 40 respondents	
Multi-source feedback (MSF) – at least one full round with 10 respondents – five clinical and five non-clinical	Minimum of one round recommended	
Significant Event Analysis	At least one then one per year	
Any patient compliments or complaints		
Complete FCP Verification Form		
RECOGNITION SURVEYS TO BE COMPLETED Primary Care Clinical Level 7 - FCP Survey Primary Care Clinical Level 7 - FCP Supervisor Survey		

Verification Process for First Contact Practitioners

- Best practice would be to ensure that the stage one and stage two checklists have been completed and signed by both the trainee FCP Occupational Therapist and the Roadmap Supervisor.

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

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

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

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

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

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

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

10.0 Stage 3: Roadmap to AP

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

1. Have a portfolio of triangulated evidence cross-referencing against the domains of the Knowledge, Skills and Attributes document, having completed the e-learning modules plus the outstanding domains as referenced in the **Linking to Advanced Practice Portfolio Top up Required to Advanced Practice status** document (appendix 12.16).

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

Checklist for recognition from FCP to AP

FOR ADVANCED PRACTICE – ALL OF THE ABOVE FOR FCP PLUS		
Evidence of managing medical/clinical complexity/ case load	Range of WPBA & reflective learning logs	
Leading audit/QIP and sharing the learning, impact on PCN practice	At least one full audit cycle/ QIP recommended	
Evidence of management and leadership pillars E.g. chairing meetings, leading teams, working across PCN teams, across boundaries with other settings	Reflective learning log entries - minimum of one per week over a range of capabilities & all four pillars recommended MSF feedback	
Evidence relating to the education pillar E.g. teaching, working with HEI, faculties of AP	Reflective learning log entries - minimum of one per week over a range of capabilities & all four pillars recommended MSF feedback	
Complete the Advanced Practice Verification Form (in addition to the FCP Verification Form if not already recognised as an FCP by the HEE Centre)		
Advanced practice portfolios will require external verification – the process for this is currently under development		

Verification Process for Advanced Practice

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

- If the FCP Occupational Therapist is already recognised by the HEE Centre they will need to 'top up' and evidence the additional capabilities identified in stage 3 of the roadmap (appendix 12.16) and on the Advanced Practice Verification Form.

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

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

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

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

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

10.1 Linking to Advanced Practice in Primary Care portfolio for Occupational Therapists

- The document in Appendix 12.16 **Linking to Advanced Practice Portfolio - Top up Required to Advanced practice status** allows evidence to be built against the KSA **(Stage 1)** requirements and as the clinician develops further into Primary Care **(Stage 2)** and on to AP **(Stage 3)**.

- At this stage the use of the occupational therapy specific framework (appendix 12.17) becomes important, and this document supports the process.

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

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

The clinician then needs to build their evidence against the three other pillars that are **not fulfilled** during FCP training (either KSA/Stage 1 or Primary Care/Stage 2). To aid this, the document in appendix 12.16 shows both the FCP and AP capabilities/ competencies in one document so that it is explicit as to what is required for FCP roles, and what is needed to become an occupational therapy Advanced Practitioner in Primary Care on completion of the AP level of practice.

When an FCP has completed their FCP portfolio, they would then need to build the evidence against the capabilities shown in white in appendix 12.16 to work towards AP. This could be completed through an appropriate registered AP pathway or directly via the HEE portal.

11.0 Useful resources

11.1 Online learning

Below is a list of resources that may support Occupational Therapist's learning needs in an FCP role.

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

Cost: Primary Care e-learning bundle £50.

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.

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 has 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.

RCOT Resources include publications (for example about risk, complexity, and supervision), practice guidelines (for example about care homes, equipment, falls, hip replacement, amputation, and Parkinson's), frameworks (e.g., the Career Development Framework, 2021), and strategies (e.g., the Research and Development Strategy, 2019) to support development at an advanced level of practice. RCOT also runs Specialist Sections (e.g., Older Adults, Mental Health and Work) and two networks to promote Advanced Practice and Primary Care:

RCOT Publications

RCOT Leadership

RCOT Medicines Optimisation

RCOT Research and Development

RCOT Specialist Sections

RCOT Advancing Clinical Practice Network

RCOT Primary Care Network

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:

NHS has a range of self-help resources.

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

Parkinsons UK - promoting conversations about death and dying with dying matters.

Asthma UK

ACAS provide return to work support and information:

Citizens Advice Bureau provide support for problems such as debt, immigration and housing

Refuge - for Women and Children against domestic violence

Stop Hate provide support and training for people who are experiencing hate crime due to their disability, gender identity, race, religion, or sexual orientation.

11.4 Primary Care

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

Cost: varies, audio book approximately £49.

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

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

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

Cost: approximately £225.

Some resources require a subscription

NB Medical education

RCGP Learning

GP notebook

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

Clinical Knowledge Summaries

British National Formulary

Primary Care Womens Health Forum

Bladder Matters

Live well with pain

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

Primary care guidelines - Paediatric Pearls provides information about the management of children with a range of conditions that present in primary care and has been designed to be used in primary care consultations.

The Children's Bowel and Bladder Charity

Social Prescribing and Occupational Therapy

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

Usually be provided in the clinical setting

- For those in **training or in new/emerging roles/new clinical setting**, daily clinical supervision/ 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 may be some summative element.

WHAT?

CPD supervision

Usually 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?

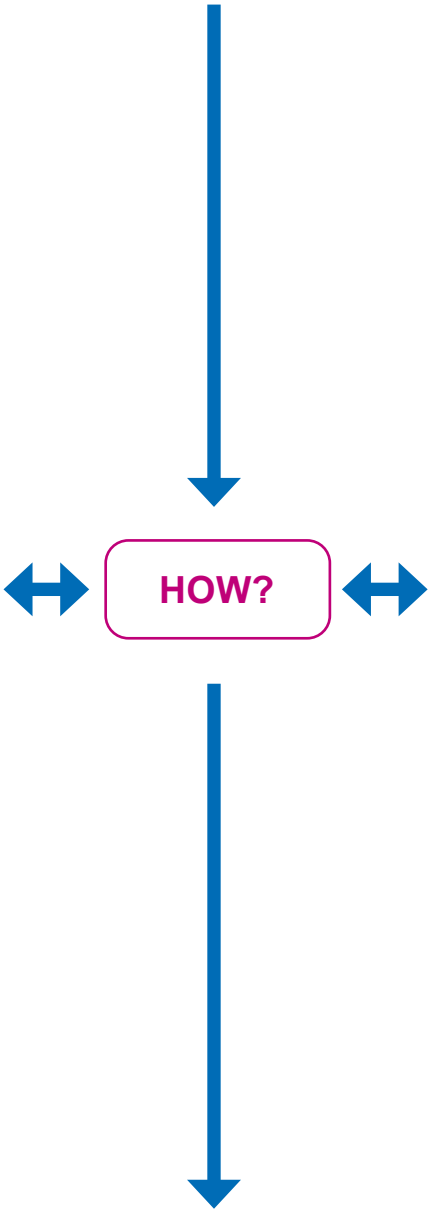
Clinical Supervisor (CS)

- 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 a 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 but, when undertaken by a CS, affords the opportunity to encourage the **development of clinical reasoning and critical thinking.** It should be a balance of support and challenge.
- As well as regular timetabled debrief the CS will need to undertake **workplace-based assessment** (WPBA) to allow the practitioner to develop a **portfolio of evidence** of capability against the appropriate framework.



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

CAPABILITIES	QUESTIONS POSED	EVIDENCE OBTAINED	GRADE
Working with colleagues and in teams **FCP 3** **ACP 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 13, 14**			
Leadership, management, and organisation **FCP 10** **ACP 10**			
Education and development **FCP 11** **ACP 11**			

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

FEEDBACK
ACTION PLAN

Cased-Based Discussion (CBD) – Guidance

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

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

Good practice would be for the Practitioner to send the Clinical Supervisor (CS) three or four cases – they could do this by sending a task on SystemOne, for example. The CS can have a look at the cases/records and choose one to discuss. Consultations should be drawn from a range of patient contacts that reflect the scope of the FCP role, e.g. older adults, mental health, etc.

The CS should ask the Practioner to 'present' the chosen case to them.

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

What should be covered in the discussion

The discussion is framed around the actual case rather than hypothetical events. Questions should be designed to elicit evidence of competence andthe discussion should not shift into a test of knowledge. The Clinical Supervisor should aim to cover as many relevant capabilities as possible in the time available. It is unrealistic to expect all capabilities to be covered in a single CBD, but if there are too few you won't have enough evidence of progress. At the start of the discussion it is helpful to establish the capability areas the supervisor is expecting to look at. The Clinical Supervisor records the evidence harvested for the CBD in the portfolio, against the appropriate capabilities. It is recommended that each discussion should take about 30 minutes, including the discussion itself, completing the rating form, and providing feedback. At the end the CS should provide some written feedback for the FCP - what went well and why? Any working points?

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

Practitioner:	
Clinical Supervisor Name:	
Date:	

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

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

CEPS is a Workplace-Based Assessment.

It provides a way of assessing what the trainee does in practice day-to-day, how they apply their knowledge, skills, communication skills etc. While CEPS exist to capture skills, it is important to assess some common shared themes.

Suggested areas for consideration would be:

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

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

Please ensure that your Clinical Supervisor signs off your CEPS.

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

12.4 Clinical Supervisor's Report

Practitioner's Name:	
Clinical Supervisor Name:	
Date:	

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

RELATIONSHIP	
Explores person's agenda (their Ideas, Concerns and Expectations). (FCP Capability 1, 2) Comments/evidence	Grade
Works in partnership to negotiate a plan. (FCP Capability 2, 3) Comments/evidence	Grade
Recognises the impact of the problem on the person's life. (FCP Capabilities 1, 2 ,5) 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 10) Comments/evidence	Grade
Uses resources cost effectively. (FCP Capabilities 2, 3, 4, 8, 9, 12, ACP 3, 12, 13, 14) 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) Comments/evidence	Grade
Shows respect for others.(FCP Capabilities 1, 3, 4) Comments/ evidence	Grade
Is organised, efficient and takes appropriate responsibility. (FCP Capability 4, 10) Comments/evidence	Grade
Deals appropriately with stress. (FCP Capabilities 3, 4, 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		
Responds to cues FCP Capabilities 1, 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 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		
Addresses the person's problem		
Seeks to confirm the person's understanding FCP Capability 1, 2, 8, 9		
Makes an appropriate shared management/personalised care/support plan FCP Capabilities 1, 2, 3, 8, 9, 10,11, 12 ACP 3, 10, 11, 12 13, 14		

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

Feedback & recommendations for further development:
Agreed action plan:

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

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

Consultation Observation Tool (COT) – guidance & consent form

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

Person consent

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

Selecting consultations for COT

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

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

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

When the Practitioner is selecting a recorded consultation, it's natural to choose one where they feel they've performed well. The ability to discriminate between good and poor consultations indicates professional development, but don't spend a lot of time recording different consultations. COT is not a pass/fail exercise, it's part of a wider picture of FCP.

Collecting evidence from the consultation

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

Consent form for recording for training purposes

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

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

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

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

TO BE COMPLETED BY PATIENT

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

Signature of patient BEFORE CONSULTATION:

.....Date.....

Signature of person accompanying patient to the consultation:

.....Date.....

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

Signature of patient AFTER CONSULTATION:

.....Date.....

Signature of person accompanying patient to the consultation

.....Date.....

12.6 Multi-Source Feedback (MSF)

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

Part 1

This part should be completed by all respondents

Please state your job title

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

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

Notes: You may wish to consider the following:

The Practitioner:

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

Comments (where possible please justify comments with examples)

Highlights in performance areas (areas to be commented)

Suggested areas for development in performance

Part 2

To be completed by clinical staff only

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

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

You may wish to consider the following about the Practitioner:

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

Comments (where possible please justify comments with examples)

Highlights in performance areas (areas to be commented)

Suggested areas for development in performance

Multi-Source Feedback (MSF) Guidance

Multi-Source Feedback is collected from colleagues.

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

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

12.7 Personal development plan (PDP)

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

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

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

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

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

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

LEARNING/ DEVELOPMENT NEED	**DEVELOPMENT OBJECTIVE**	**ACHIEVEMENT DATE**	**STRATEGIES TO USE**	**OUTCOMES/ EVIDENCE**
WHAT BROAD AREA DO YOU NEED TO ADDRESS?	WHAT SPECIFIC GOAL ARE YOU SETTING?	WHEN DO YOU HOPE TO ACHIEVE IT?	HOW WILL YOU ACHIEVE IT?	HOW WILL YOU KNOW YOU HAVE ACHIEVED IT?
E.g., to improve management of older patients with depression	*To manage range of different presentations of depression in older people.*	*Three months*	*Complete relevant eLearning on older persons 'mental health*	*When I have passed 2 CEPS assessments with my Clinical Supervisor.*

FCP - Advanced Practice Roadmap

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

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

Practitioner: .....

Supervisor: .....

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

Hello,

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

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

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

Thank you.

Please rate the Practitioner at:

Please tick your response

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Overall, how would you rate your consultation today?

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

Many thanks for your assistance

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

Person Satisfaction Questionnaire (PSQ) Guidance

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

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

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

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

12.9 Tutorial record

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

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

12.10 Tutorial evaluation

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

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

Signed:	

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

To supervise a practitioner through the roadmap to FCP and onward to Advanced Practice via the portfolio routes. There is a two-session multi-professional Roadmap supervisor course that 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 that will be transferred to the Centre for Advancing Practice Directory, once it has been fully established.

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

Course overview

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

12.12 FCP Verification of Evidence Form

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** ☐	FCP1
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
PRACTICING HOLISTICALLY TO PERSONALISE CARE & PROMOTE HEALTH	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP2
EVIDENCE TYPE & DATE(S)	

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

CAPABILITY	KSA LINKS
WORKING WITH COLLEAGUES & IN TEAMS	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP3
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
WORKING WITH COLLEAGUES & IN TEAMS	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP3
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
MAINTAINING AN ETHICAL APPROACH & FITNESS TO PRACTICE	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP4
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
MAINTAINING AN ETHICAL APPROACH & FITNESS TO PRACTICE	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP4
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
INFORMATION GATHERING & INTERPRETATION	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP5
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
INFORMATION GATHERING & INTERPRETATION	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP5
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
CLINICAL EXAMINATION	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP6
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
CLINICAL EXAMINATION	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP6
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
MAKING A DIAGNOSIS	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP7
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
MAKING A DIAGNOSIS	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP7
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
CLINICAL MANAGEMENT	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP8
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
CLINICAL MANAGEMENT	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP8
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
INDEPENDENT PRESCRIBING/PHARMACOTHERAPY/PRESCRIBING THERAPIES	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP9
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
INDEPENDENT PRESCRIBING/PHARMACOTHERAPY/PRESCRIBING THERAPIES	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP9
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
LEADERSHIP, MANAGEMENT & ORGANISATION	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP10
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
LEADERSHIP, MANAGEMENT & ORGANISATION	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP10
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
EDUCATION & DEVELOPMENT	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP11
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
EDUCATION & DEVELOPMENT	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP11
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
TRAINEE SELF RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP12
EVIDENCE TYPE & DATE(S)	

CAPABILITY	KSA LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	FCP12
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 CAPABILITYIN THIS PORTFOLIO YES ☐ NO ☐

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

OVERALL RATING OF CAPABILITY FOR STAGE TWO (PLEASE TICK)

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

SUPERVISOR SIGNATURE……DATE……..

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

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

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

12.13 Advanced Practice Verification of Evidence Form

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

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

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

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

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

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

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

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

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

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

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

CAPABILITY	ACP LINKS
RESEARCH & EVIDENCE BASED PRACTICE	
SUPERVISOR RATING & COMMENTARY **Underperforming** ☐ **Needs further development** ☐ **Capable** ☐ **Excellent** ☐	ACP 12
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 Knowledge, Skills and Attributes document

Domain A: Person-centred Collaborative Working

The knowledge, skills and attributes (KSA) here describe the prerequisite for all occupational therapist moving into FCP roles within primary care. They are the core skills that all FCP roles require regardless of professional background..

In the following table, the knowledge, skills and attributes are cross-referenced to the RCOT Career Development Framework Level 7 (right hand column) and the Advanced Clinical Practice (ACP) OT capabilities (left hand column).

NB. The ACP OT capabilities reference both the Area Specific Capabilities: Primary Care Occupational Therapy (prefixed 'A', found in section 12.17) and the Generic Capabilities: Primary Care Clinical Practice (prefixed 'B'), relevant to all primary care advanced practice credentials.

Capability 1. Communication and consultation skills		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A1.1 B.1.1.13	Critically appraise communication strategies and be able to optimise communication approaches appropriately using skills such as active listening e.g. frequent clarifying, paraphrasing and picking up verbal cues such as pace, pauses and voice intonation.	RCOT Career Development Framework Level 7.9
Critical skills		
A3.4 B1.1.9	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.	P7.1
A1.4 B1.1.1	Adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to people's communication and language needs and preferences, including levels of spoken English and health literacy.	P7.9
A3.2 B1.1.5	Communicate effectively with individuals who require additional assistance to ensure an effective interface with a practitioner, including the use of accessible information.	P7.9

A2.4 B1.1.15 B1.1.4	Evaluate situations, circumstances or places which make it difficult to communicate effectively (e.g. noisy, distressing or emergency environments), and have strategies in place to overcome these barriers. Adapt communication styles to meet the needs of people who have learning disabilities, are neuro-diverse or other disabilities that impair communication.	P7.4
A2.3	Enable effective communication approaches to non-face to face situational environments e.g. phone, video, email or remote consultation.	
A2.4 B1.1.7	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.	
A2.1 B1.1.11	Elicit psychosocial history to provide context for peoples' problems or presentations.	
A3.1 B1.1.10	Manage people effectively, respectfully, and professionally (including, where applicable, carers and families), especially at times of conflicting priorities and opinions.	P7.3
A3.1 B1.1.3	Communicate in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate people's care.	P7.2
	Recognise that effective consultation skills are a subset of advanced communication skills highlighted in the capability for history taking and consultation skills.	

Capability 2. Practicing holistically to personalise care and promote public and person health		
Cross-referenced OT ACP Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A1.5 B1.2.10	Critically appraise the impact that a range of social, economic, and environmental factors can have on health outcomes for people, and, where applicable, their family and carers.	L7.11
A3.3 B1.2.13	Evaluate how a person's preferences and experience, including their individual, cultural and religious background, can offer insight into their priorities and wellbeing.	P7.2
A3.5 B1.2.16	Evaluate the implications of, and apply in practice, the relevant legislation for informed consent and shared decision making (e.g. mental capacity legislation, Fraser Guidelines).	P7.7
Critical skills		
A2.5 B1.2.1	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.	
B1.2.8	Effectively employ the Public Health England "All Our Health" framework in own and wider community of practice.	L7.6

A3.4 B1.2.3	Engage people in shared decision making about their care by: • supporting them to express their own ideas, concerns and expectations and encouraging them to ask questions • explaining in non-technical language all available options (including watch and wait approaches or doing nothing) • exploring with them the risks and benefits of each available option and discussing any implications • supporting them to make decisions on their preferred way forward	P7.2
A2.10 B1.2.11	Recognise and respond appropriately to the impact of psychosocial factors on the presenting problem, condition or general health such as housing issues, work issues, family/carer issues, lack of support, social isolation and loneliness.	L7.11
A3.2 B1.2.14	Evaluate how the vulnerabilities in some areas of a person's life might be overcome by promoting resilience in other areas.	L7.7
A1.6 B1.2.6	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.	
A1.6 B1.2.7	Advise on sources of relevant local or national self-help guidance, information and support including coaching and social prescribing.	

Capability 3. Working with colleagues and in teams		
Cross-referenced OT ACP Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A1.6 B1.3.7	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.	L7.16
Critical skills		
A2.7 B1.3.1	Ensure own work is within professional and personal scope of practice and access advice when appropriate.	L7.25
A1.6 B1.3.2	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.	P7.6
A3.7 B1.3.4	Communicate effectively with colleagues using a variety of media (e.g., verbal, written and digital) to serve peoples' best interests.	L7.8
A3.7 B1.3.3	Engage in effective inter-professional communication and collaboration (with clear documentation) to optimise integrated management and care for people.	L7.18
A2.6 B1.3.5	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.	P7.13
A1.6 B1.3.6	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.	P7.6
	Take responsibility for one's own well- being and promote the well-being of the team escalating any causes for concern appropriately.	L7.12

Capability 4. Maintaining an ethical approach and fitness to practice		
Cross-referenced OT ACP Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A1.1 B1.4.9	Critically reflect on how own values, attitudes and beliefs might influence one's professional behaviour.	P7.3
Critical skills		
A1.3 B1.4.1	Demonstrate the application of professional practice in one's own day to day first contact clinical practice.	P7.5
A1.7 B1.4.8	Identify and act appropriately to promote positive behaviour around equality, diversity, and human rights.	P7.12
A2.10 B1.4.2	Reflect on, and address and engage appropriately ethical/moral dilemmas encountered during one's own work which may impact on care. Advocate equality, fairness and respect for people and colleagues in one's day to day practice	
B1.4.3	Keep up to date with mandatory training and CPD requirements, encompassing those requiring evidence for a first contact role.	F7.1
B1.4.12	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.	L7.12
B1.4.4	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.	L7.12
B1.4.6	Promote mechanisms such as complaints, significant events and performance management processes in order to improve people's care.	P7.10
B1.4.7	Promote mechanisms such as compliments and letters of thanks to acknowledge and promote good practice.	L7.2

Domain B: Assessment, investigations and diagnosis

Capability 5: Information gathering and interpretation		
Cross-referenced OT ACP Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A2.1 B2.1.5	Understand and apply a range of consultation models appropriate to the clinical situation and appropriately across physical and mental health presentations.	B5(d)
Critical skills		
A1.1 B2.1.1 B2.1.2	Structure consultations to encourage the patient and/or their carer to express their ideas, concerns, expectations and understanding, using active listening skills and open questions to effectively engage with people and carers.	P7.2
A2.4 B2.1.3	Be able to undertake general history-taking, and focused history-taking to elicit and assess “red flags”. Be aware that “red flags” may differ in a primary/urgent care setting compared to an emergency setting (e.g. symptoms suggestive of cancer).	P7.13
A2.1 B2.1.8	Synthesise information, considering 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.	P7.4
A2.8 B2.1.9	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.	P7.1
A1.4 B2.1.6	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.	P7.2
A2.3 B2.1.10	Critically appraise complex, incomplete, ambiguous, and conflicting information gathered from history-taking and/or examination, distilling and synthesising key factors from the appraisal, and identifying those elements that may need to be pursued further.	P7.4

A2.7 B2.1.4	Deliver diagnosis and test/investigation results, (including bad news), sensitively and appropriately in- line with local or national guidance, using a range of mediums including spoken word and diagrams, for example, to ensure the person has understands what has been communicated.	P7.9
A3.7 B2.2.4	Record all pertinent information gathered concisely and accurately complying with local guidance, legal and professional requirements for confidentiality, data protection and information governance.	P7.8

Capability 6 Clinical examination and procedural skills		
Cross-referenced AP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A2.10 B2.2.6 B2.2.1	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.	
Critical skills		
A2.1 B2.2.2	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.	P7.9
A2.10 B2.2.3	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.	P7.7
A1.8 B2.2.5	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.	P7.12
A1.1 B2.2.6	Apply a range of physical assessment and clinical examination techniques appropriately, systematically and effectively.	P7.8
A3.5	Perform a mental health assessment appropriate to the needs of the person, their presenting problem and manage any risk factors such as suicidal ideation promptly and appropriately.	P7.13
A3.6 B2.3.7	Use nationally recognised tools, where appropriate, during assessment.	

A2.9	Using a systematic approach, identify, analyse and interpret potentially significant information from the physical and mental health assessment (including any ambiguities).	P7.5
A3.7	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.	P7.7

Capability 7: Making a Diagnosis Occupational Therapists have extensive experience of assessing patients and their presenting situations, using occupational formulation to reach working diagnoses and provide appropriate treatment. These skills are adapted to a primary care setting to include recognising the possibility of serious underlying pathology (red flags).		
Cross-referenced AP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A2.1 B2.3.2	Understand how to make a diagnosis in a structured way using a problem-solving method informed by an understanding of probability based on prevalence, incidence and natural history of illness to aid decision making.	P7.4
A2.3	Understand key diagnostic biases and common errors and the issues relating to diagnosis in the face of ambiguity and incomplete data.	P7.4
	Critical skills	
A2.7 B2.3.10	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.	P7.13
A2.4	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.	P7.13
A1.6 B2.3.9	Synthesise the expertise of multi- professional teams to aid in diagnosis where needed.	P7.6
A2.9 B2.3.1	Focus the objective data gathering and prioritise investigations in the context of the patient presentation and the clinical environment.	P7.4
A2.1 B2.3.3	Formulate a differential diagnosis based on subjective, and where available, objective data, identifying where necessary the need for investigations to aid diagnoses.	P7.5

A2.1 B2.3.11	Interpret the subjective and objective findings from the consultation. Exercising clinical judgement, determine differential diagnoses and a working diagnosis in relation to all information obtained. This may include the use of time as a diagnostic tool where appropriate.	P7.5
A2.8 B2.3.4	Revise hypotheses in the light of additional information and think flexibly around problems, generating functional and safe solutions	P7.4
A2.8 B2.3.6	Recognise when information/data may be incomplete (e.g., patient personally unable to provide a comprehensive history) and take mitigating actions to manage risk appropriately. Recognise the limitations of collateral information from others.	P7.13
A2.4 B2.3.7	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.	P7.8

Domain C: Condition management, treatment and prevention

Capability 8: Clinical Management		
Cross-referenced AP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		
A3.2 B3.1.8	Vary the management options responsively according to the circumstances, priorities, needs, preferences, risks and benefits for those involved with an under-standing of local service availability and relevant guidelines and resources.	P7.4
B3.1.7	Consider a “watch and wait” approach where appropriate.	
A2.4 B3.1.1	Safely prioritise problems in settings where the person presents with multiple issues. Manage any conflict between patient priorities and clinically urgent problems.	P7.13
A3.1 B3.1.2	Implement shared management/ personalised care/ support plans in collaboration with people and, where appropriate, carers, families and other healthcare professionals.	P7.6
A3.8 B3.1.2	Ensure the management plan considers all options that are appropriate for the care pathway.	
A2.4 B3.1.3	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.	P7.13
A3.3 B3.1.9	Evaluate outcomes of care against existing standards and patient outcomes, managing/ adjusting plans appropriately in-line with best available evidence.	P7.14
B3.1.4	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.	P7.14
A1.6 B3.1.5	Promote continuity of care as appropriate to the person and practice setting.	P7.8

A2.4 B3.1.6	Suggest a variety of follow-up arrangements that are safe and appropriate, whilst also upholding the person's autonomy.	P7.8
A2.4 B3.1.10	Ensure safety netting advice is appropriate and the person understands when to seek urgent or routine review.	P7.13
A2.5 B3.1.11	Support people who might be classed as frail and work with them utilising best practice.	P7.13
A2.5	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.	P7.4

Capability 9: Prescribing treatment, administering drugs/medication, pharmacology.		
Cross-referenced AP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A2.7 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).	P7.7
Critical skills		
A2.7 B3.3.4	Promote personalised, patient-shared decision-making to support adherence leading to concordance.	P7.2
A2.7 B3.3.8	When using PGD's practice in line with the principles of antimicrobial stewardship and antibiotic resistance using available local or national resources.	P7.7
A2.11 B3.3.10	Be able to confidently explain and discuss the risks and benefits of medication with people, using appropriate tools to assist as necessary.	P7.2
A2.11 B3.3.9	Recognise adverse drug reactions and manage appropriately, including reporting as required through the correct route.	P7.13
A2.7 B3.3.11	Advise people on medicines management, including compliance, the expected benefits and limitations, and inform them impartially on the advantages and disadvantages in the context of other management options.	P7.8
A2.7	Identify sources of further information (e.g., websites or leaflets) and advice (e.g., pharmacists), and signpost appropriately to complement the advice given.	P7.8
A2.11 B3.3.5	Understand a range of options available other than supplying, administering, or prescribing (e.g., not prescribing, promoting self-care, advice on over-the-counter medicines).	P7.8
A3.8 B3.3.2	Facilitate and/ or prescribe non-medicinal therapies such as psychotherapy, lifestyle changes and social prescribing.	P7.8
B3.3.3	Maintain accurate, legible, and contemporaneous records of medication prescribed and/or administered and advice given in relation to medicine.	P7.7

Domain D: Leadership and management, education and research

Capability 10: Leadership, management and organisation		
Cross-referenced AP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A2.5 L&M 2	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.	L7.10
Critical skills		
A2.4 L&M 3	Respond positively when services are under pressure, acting in a responsible and considered way to ensure safe practice.	L7.1
A1.1 L&M 4	Role model the values of being an FCP Occupational Therapist and their place of work, demonstrating a person-centred approach to service delivery and development.	L7.9
A1.6 L&M 12	Actively engage in peer review to inform own and other's practice, formulating and implementing strategies to act on learning and make improvements.	P7.10
A3.1	Actively seek and be positively responsive to feedback and involvement from people, families, carers, communities and colleagues in the co-production of service improvements.	L7.16
A2.2 L&M 25	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.	L7.25
A2.7 L&M 28	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.	L7.25

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

L&M 27	Deal with compliments and complaints appropriately, following professional standards and applicable local policy.	P7.10
	Actively participate in Significant Event Review and share the learning.	P7.17

Capability 11: Education and development		
Cross-referenced AP OT capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A1.2 E 1	Critically assess and address own learning needs, negotiating a personal development plan that reflects a breadth of ongoing professional development.	P7.8
Critical skills		
A1.2 E 3	Engage in self-directed learning, critically reflecting on practice to maximise skills and knowledge.	F7.8
A1.6 E 2	Actively seek, and be open to, feedback on own practice by colleagues to promote ongoing development.	F7.18

Capability 12: Research and evidence based practice		
Cross-referenced AP OT capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		
A2.10 R 3	Understand and utilise the evidence of best practice to in-form own practice.	E7.6
A2.2 R 1	Support quality improvement initiatives/ projects – sharing outcomes and promoting change.	E7.4

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

12.15 Key Clinical Areas for FCP Occupational Therapists - key knowledge, skills, indicative presentations, and investigations/ referrals

This appendix outlines several key clinical areas that Occupational Therapists can manage in general practice/primary care as First Contact Practitioners according to the scope of their role. This means that primary care staff, such as receptionists or patients who are self-referring for the first time before having a diagnosis, can be directly triaged to the FCP occupational therapist when they present as:

- Adults with undiagnosed mental health problems contacting the surgery for the first time
- Older adults who are presenting with their first episode of frailty-related problems
- Working age adults requesting their first GP Fit note

The appendix details the indicative presentations that primary care staff and/or patients can use so that the correct type of patients can be appropriately seen by the FCP Occupational Therapist. Patients may be experiencing one or more of these presentations.

It also includes key knowledge, core clinical skills and investigations/onward referrals that may be required by the FCP occupational therapist so they can treat according to presentation, formulate an impression/differential diagnosis as to what might be the cause of the problem and escalate when alternative input is required.

This is not an exhaustive list but describes the most prominent areas of clinical practice for FCP occupational therapy in primary care at time of publication. New areas may evolve in the future for example FCP Occupational Therapists in paediatrics.

Adults presenting with undiagnosed Mental Health Problems

Key knowledge of the FCP Occupational Therapist from Advanced Practice Mental Health Curriculum and Capabilities Framework (HEE 2020)

The FCP Occupational Therapist will demonstrate critical knowledge and application of psychological, biological, social and occupational theories of mental health and wellbeing, including impact of local population health, social determinants and health inequalities.

They will critically appraise and apply evidence about therapeutic factors that influence engagement, empowerment, and recovery for those with mental ill health.

They will demonstrate knowledge of how to undertake comprehensive mental health history and occupational assessment.

They will show critical application of knowledge of mental health risk awareness and how to complete risk assessment in uncertain and/or emergency situations.

They can demonstrate and apply thorough understanding of mental health intervention theories, techniques, and therapies, balanced with an understanding of potential unwanted outcomes.

They will have a systematic knowledge of local mental health care systems and how to access different parts to enhance health, safety and occupational engagement.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand mental health related presentations including the complex interplay of factors that affect mental health, activity, and occupation, including the wider determinants of health. • Understand local, statutory, and legal duties related to the care and treatment of those with mental ill health.	• Anxiety • Low mood • Elation • Distress • Guilt • Anger • Paranoia	• Warwick Edinburgh Mental Wellbeing Scales (WEMWBS) • Generalised Anxiety Disorder Assessment (GAD-7) • Patient Health Questionnaire 9 (PHQ-9) • Beck Depression Inventory (BDI)

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Demonstrate expertise at maintaining therapeutic alliance that is collaborative, non-discriminatory and non-judgmental, including therapeutic use of boundaries, inclusivity, hope and optimism. • Ability to carry out mental health assessments which focus on psychological, biological, social, and occupational perspectives, including mental capacity, mental state and physical health assessment, where appropriate. • Ability to use validated mental health and occupational assessments recognising key biases and common errors to diagnosis and formulation. • Recognise and explore the potential risks and benefits of risk averse, least restrictive and/or positive risk-taking options during the risk assessment process. • Ability to lead collaborative decision making that balances the complexity of risk, safety and occupational opportunity.	• Seeing or hearing things • Confusion • Poor concentration • Distraction • Suicidal thoughts/plans • Self-harm • Changes in sleep, appetite, energy, weight • Inability to carry out activities of daily living, work, relationships, leisure • Experience of abuse, domestic violence, bullying, harassment • Recent life event stressors such as job loss, eviction, debt, divorce, death in close family	• Hospital Anxiety and Depression Scale (HADS) • Canadian Occupational Performance Measure (COPM) • Occupational Self-Assessment (OSA) • Goal Attainment Scaling (GAS) • Recovery Star • Pharmacist, Social Prescribing Link Worker, Health and Wellbeing Coach, Care Coordinator, Physician Associate, Mental Health Practitioner, Dietician

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Delivery of strengths-based, clinically effective and technology enabled interventions including occupational, environmental, social, psychological and pharmacological within agreed scope of practice, including use of motivational interviewing and health coaching approaches. • Ability to collaborate and independently refer on knowledge of occupational and other available resources in partnership with a range of multiagency, interprofessional networks across organisation and setting.		

Older adults presenting with first episode of frailty

Key knowledge of the FCP occupational therapist From Frailty - A Framework of Core Capabilities (Skills for Health 2018)

The FCP Occupational Therapist will demonstrate critical knowledge and application of older adults and frailty as a complex and multi-dimensional state linked to concepts of occupation for healthy ageing, personal resilience, multi-morbidity, disability, levels of independence/dependency for activity/occupation, in the context of local population health, social determinants and health inequalities.

They will demonstrate systematic knowledge of how to carry out a comprehensive, holistic and occupational assessment of older people and their carers in partnership with people living with frailty, carers and other members of the multi- professional team, including appropriate risk assessment.

They will critically appraise and apply thorough understanding of a wide range of interventions to prevent, reduce risk of and maintain physical, mental health and wellbeing for frail older adults and their carers including specific expertise for occupation focused and rehabilitative approaches to care.

They demonstrate understanding and ability to lead on the adaptation of activities/occupations to suit a person and their carer's changing needs, assisting to achieve meaningful personalised goals and the contribution assistive technology can make.

They demonstrate understanding and ability to lead on the provision of specific advice and guidance on changing or adapting the physical and social environment to promote independence, ensure physical safety, comfort and emotional security of people and their carers.

They will show a critical application of high degree of autonomy to rapidly intervene in complex, crisis situations where urgent assistance is required, including rapid changes in accommodation and dependence level; palliative and end of life care.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Recognise how living with frailty affects, and is affected by, many different aspects of a person's life such as physical and mental health, levels of independence and function, mobility, loneliness, cognitive function, their social and home environment, occupational performance and participation.	• Falls • Difficulty walking • Difficulty coping at home • Memory problems	• Relevant Frailty Index such as the Electronic Frailty Index (eFI) • Gait (Walking) Speed Test; Time Up and Go (TUG) Test; PRISMA-7 Questionnaire; Edmonton Frail Scale; Clinical Frailty Scale

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand asset-based, goal-orientated approaches alongside phenotype and cumulative deficit models of frailty; conditions often associated with frailty and how they commonly present; how to identify the underlying causes of frailty syndromes and how to deliver interventions to improve independence and quality of life for people living with frailty and their carers. • Ability to contribute to comprehensive older age assessment as part of multidimensional holistic approach often known as a Comprehensive Geriatric Assessment, and plan to address needs, concerns and priorities of older adults and their carers, considering the complexities of ageing and frailty during the risk assessment process, • Delivery of appropriate responses and treatment options for dementia, delirium, anxiety, depression and chronic pain. • Ability to assess a carers physical and practical needs; know the relevant support available such as carers assessments and respite, including where the carer may be living with frailty themselves; young carers and carers who are in employment or have multiple role demands.	• Confusion • Low mood • Anxiety • Increasing carer stress • Difficulty carrying out everyday tasks and activities • Social isolation • Experience of abuse	• Patient Reported Outcomes Measurement Information system (PROMIS) • Assessment of Motor and Process Skills (AMPS) • Barthel Index (BI) • Australian therapy Outcome Measures (AusTOMs) • Goal Attainment Scaling (GAS) • Allen Cognitive Level Screen (ACLS) • Residential Environment Impact Scale (REIS) • Bristol Activities of Daily Living Scale • Pharmacist, Social Prescribing Link Worker, Physician Associate, First Contact Physiotherapist, Dietician, Podiatrist, Paramedic, Nursing Associate

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Ability to work collaboratively to attend to the complex occupational, environmental, medical, functional, social and psychological aspects of frailty to reduce gaps or duplication in care and develop a more flexible workforce in primary care across all settings, including residential and nursing care homes. • Demonstrate ability to facilitate environmental change, adaptation or moves to new accommodation, promoting independence, privacy, orientation, thermal comfort and safety. • Ability to develop and improve overall physical, mental, social and occupational functioning, including the practical skills of people living with frailty and their carers via rehabilitative approaches building on motivational interviewing and health coaching, networks of support, community development, assistive technology for self-care and monitoring and providing opportunities for activities that give meaning, purpose and satisfaction.		

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understanding of the range of medication and medicines mechanisms to address common physical and mental health problems of people living with frailty; how to support the person take the correct medication at the right time in the correct format as prescribed; administering medication safely where appropriate; knowing when and how to access a medication review by the independent prescriber; advocating to minimise use of psychotropic/antipsychotic medication and promote use of non-pharmacologic options where appropriate. • Ability to provide information on, and contribute, occupational perspectives to advance decision planning and advanced statements.When a mental capacity assessment may be required, when and how to share safeguarding information.		

Working age Adults requesting first GP Fit Note

Key knowledge of the FCP Occupational Therapist from Workplace Health: Long-Term Sickness Absence and Capability to Work (NICE Guideline NG146, 2019)

The FCP Occupational Therapist will demonstrate critical knowledge and application of the links between health and work; the complex reasons for sickness absence or unemployment including those related to the person (such as health, disability, life events/stressors); the work duties required (task demands) and the work environment (physical, social and cultural) in the context of local population health, social determinants and health inequalities.

They will demonstrate systematic knowledge of how to carry out a comprehensive, occupational assessment that considers all contributory factors including the skills, assets and health problems of the person; the range and quantity of the work demands in the person's specific form of employment and supportive or inhibiting factors in the person's work and home environment, including where risk assessment is required.

They have systematic knowledge of common health conditions likely to cause sickness absence such as musculoskeletal and common mental health problems, anticipated lengths of absence, interventions to support self-management, provision of advice regarding work adjustments and where alternative support may be required.

They can critically appraise and apply knowledge of relevant legal frameworks such as the Equality Act (2010) and the Health and Safety at Work Act (1974) and know how to contribute to statutory fit note processes, provision of the Allied Health Professions Health and Work Report including detailed, tailored advice regarding adjustments that may help people remain in employment.

They demonstrate ability to create and lead integrated approaches to help people who are unemployed and/or have a health condition or disability, who wish to gain paid or unpaid work.

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)

• Understanding of the statement of fitness for work (fit note) and how it should be completed with the most relevant recent knowledge of the person's health, reason for absence and prognosis for return to work after a facilitative health and work conversation drawing on motivational interviewing and health coaching skills.
• Understanding of the role of consent, confidentiality, risk assessment and advocacy relating to the provision of health and work information, including its role in empowering the person to negotiate changes at work.
• Ability to encourage people who are assessed as not fit for work to maintain regular contact with their workplace so the employer can provide support and help them return to the workplace when they are ready.
• Demonstrate the ability to encourage the person to reflect on factors in their work or personal life that may be contributing to their current absence or causing concern about return to work.
• Recognise that those who are likely to be absent from work for more than four weeks should consider provision of relevant interventions and/or referral onto, for example, health rehabilitation, physiotherapy, counselling, social prescribing, Job Centre Plus.
	• Fit note requests for:
	  • Less than four weeks
	  • More than four weeks
	  • Recurring requests
	• Workers continuing to go to work despite health problems and struggling
	• Unemployed who wish to enter or return to paid or unpaid work.
		• General Self- Efficacy Scale (GSE)
		• Readiness for Return-to-Work Scale (RRTW)
		• EuroQol- 5D (EQ-5D)
		• Worker Role Inventory (WRI)
		• Work Environmental Impact Scale (WEIS)
		• Assessment of Work Performance (AWP)
		• Social Prescribing Link Worker, Health and Wellbeing Coach, First Contact Physiotherapist, Dietician, Podiatrist

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Recognise the importance of signposting people to other possible expert sources of vocational advice and support relevant to their condition/situation, such as online resources, telephone advice from external bodies, an occupational health service or employee assistance program. • Ability to deliver information for the employer that provides sufficient detail in clear, non-technical language about how the employees' health condition or treatment could affect them on their return to work. • Ability to provide information about how a person's condition may affect their ability to work using an Allied Health Professions Health and Work Report, including the use of the "Maybe fit for work" option. • Delivery of detailed, specific advice regarding what adjustments or other support may be needed if any ongoing health needs are anticipated when the person returns to work such as flexible working, phased return, reduced duties, changes to workstations or duties. • Understand the vital role of the relationship between employee and employer, particularly line managers and colleagues, to facilitate return to work.		

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• Understand that when circumstances or adjustments are more complex that human resources, trade unions or occupational health may also participate in the process of return of work. This may include the employer sharing information (with the employees' consent) with primary care about why adjustments that have been suggested cannot be made. • For people who have been absent for four or more weeks for musculoskeletal conditions consider programs of graded activity, problem solving therapy, worksite assessments, meeting with employee and line manager to discuss return to work and modifications. • For people who have been absent for four or more weeks for common mental health problems consider a three-month structured support intervention with regular meetings during this period to discuss any issues encountered since their return to work, possible solutions and support needs.		

Core Clinical Skills	Indicative presentations	Key clinical investigations / referrals (may include but not be limited to)
• For people with a health condition or disability, who are not currently employed, consider a combination of interventions such as vocational training including help producing a CV, interview training and help to find a job or work placement and use of condition management programs. Additional support that can be provided before and after returning to work can include provision of mentoring, use of job coaches, occupational health support and financial/benefits advice.		

12.16 Linking to Advanced Practice Portfolio - top up required to Advanced Practice Status

The capabilities below are the remaining capabilities, once the FCP Occupational Therapist is on the FCP directory, that need to be assessed with triangulated Masters level evidence to be recognised as an Advanced Practitioner. The capabilities are cross referenced to the Advanced Clinical Practice Capabilities for Primary Care Occupational Therapy (appendix 12.17) required to be recognised as an Advanced Practitioner and to the RCOT Career Development Framework -Guiding Principles for Occupational Therapy at Level 7 (RCOT 2021a) to ensure capability alignment.

Domain A: Person-centred Collaborative Working

Capability 1. Communication and consultation skills This section is completed in the FCP capabilities		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		

Capability 2. Practicing holistically to personalise care and promote public and person health		
Cross-referenced SPUC Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		
A1.8	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.	E7.7

Capability 3. Working with colleagues and in teams		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		
A1.6 B1.3.6	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.	P7.6

Capability 4. Maintaining an ethical approach and fitness to practice **This section is completed in the FCP capabilities**		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		

Domain B: Assessment, investigations and diagnosis

Capability 5: Information gathering and interpretation This section is completed in the FCP capabilities		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		

Capability 6: Clinical Examination and Procedural Skills This section is completed in the FCP capabilities		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		

Capability 7: Making a Diagnosis This section is completed in the FCP capabilities		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		

Domain C: Condition management, treatment and prevention

Capability 8: Clinical Management This section is completed in the FCP capabilities		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		

Capability 13: Managing medical and clinical complexity		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A2.9 B3.2.9	Understand the complexities of working with people who have multiple health conditions whether physical, mental and psychosocial.	P7.4
A2.4 B3.2.2	Understand and be able to manage practitioner and patient uncertainty.	F7.12
Critical skills		
A1.4 B3.2.1	Simultaneously manage acute and chronic problems, including for people with multiple morbidities and those who are frail.	P7.5
B3.2.9	Recognise the inevitable conflicts that arise when managing people with multiple problems and take steps to adjust care appropriately.	P7.9
A2.5 B3.2.3	Communicate risk effectively to people and involve them appropriately in management strategies.	P7.13
A2.6 B3.2.5	Manage urgent or out of hours presentations appropriately.	L7.10

Capability 14: Independent Prescribing, Medicines Supply and Pharmacotherapy Occupational Therapists cannot use independent or supplementary prescribing but can make use of the full scope of their practice for medicines management including the use of Patient Specific and Patient Group Directions where appropriate (RCOT 2019b, 2020		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A2.7 B3.3.1	Safely prescribe and/or administer therapeutic medications relevant and appropriate to scope of practice, including,where appropriate, an applied understanding of pharmacology which considers relevant physiological and/or pathophysiological changes and allergies.	P7.8
A2.11 B3.3.7	Where a non-medical prescriber (NMP), critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental wellbeing and healthcare provision.	P7.4
A.2.7	Demonstrate knowledge of, and use appropriate source literature, where required (e.g., British National Formulary).	P7.7
A2.7 B3.3.13	Understand the legal mechanisms by which drugs may be administered or supplied by Occupational Therapists (exemptions, Patient Group Directions, Patient Specific Directions,) and the advantages and limitations of each. Understand the basis on which you may be administering or supplying drugs in your setting.	P7.7
Critical skills		
A3.1 B3.3.4	Advocate personalised shared decision making to support adherence leading to concordance	P7.2
A2.10 B3.3.13	Keep up-to-date and apply the principles of evidence-based practice, including clinical and cost-effectiveness and associated legal frameworks for prescribing. Follow Royal Pharmaceutical Framework guidelines (e.g., medicines optimisation).	P7.7
A2.7 B3.3.8	Where a NMP, or when using Patient Group Directions, practice in-line with the principles of antibiotic stewardship and antimicrobial resistance using available national resources.	P7.7

A2.7 B3.3.9	Where an NMP, or when using PGDs, 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.	P7.13
A2.7 B3.3.10	When prescribing, or supplying/administering medication, be able to confidently explain and discuss risk and benefit of medication with people using appropriate tools to assist as necessary.	P7.9
A2.11	Recognise adverse drug reactions and manage appropriately, including reporting where required.	P7.13
A2.7 B3.3.11	When prescribing, or supplying/ administering medication, advise people on medicines management, including compliance and the expected benefits and limitations and inform them impartially on the advantages and disadvantages in the context of other management options.	P7.9
A1.6	Identify sources of further information (e.g., websites or leaflets) and advice (e.g., pharmacists) and be able to signpost people as appropriate to complement the advice given.	P7.6
A3.4 B3.3.5	Understand a range of options available other than drug prescribing (e.g., not prescribing, promoting self-care, advice regarding over-the-counter medicines).	P7.4
A3.8 B3.3.2	Facilitate and or prescribe non-medicinal therapies such as psychotherapy, lifestyle changes and social prescribing.	P7.5
A2.7 B3.3.12	Where an NMP, support people to only take medications they require and de-prescribe where appropriate.	P7.8
B3.3.3	Maintain accurate, legible and contemporaneous records of medication prescribed and/or administered and advice given in relation to medicine or treatments.	P7.7

Domain D: Leadership and management, education and research

Capability 10: Leadership, management and organisation		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		
A1.6 L&M 1	Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working.	L7.16
L&M 7	Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit).	L7.15
A2.8 L&M 9	Demonstrate the impact of advanced clinical practice on service function and effectiveness, and quality (i.e., outcomes of care, experience, and safety).	L7.19
A2.2 L&M 13	Lead new practice and service redesign solutions with others in response to feedback, evaluation, data analysis and workforce and service need, working across boundaries and broadening sphere of influence.	L7.21
A3.3 L&M 17	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.	L7.16
A2.3 L&M 20	Demonstrate leadership, resilience, and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others.	L7.7
A1.7 L&M 22	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).	L7.4

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

Capability 11: Education and development		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
Critical skills		
A1.2 E 3	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.	F7.1
E 10	Promote and utilise clinical supervision for self and other members of the healthcare team to support and facilitate advanced professional development.	F7.8
E 5	Advocate for, and contribute to, a culture of organisational learning to inspire future and existing staff.	F7.10
A1.6 E 6	Facilitate collaboration of the wider team and support peer review processes to identify individual and team learning and support them to address these.	F7.17
A1.6 E 8	Enable the wider team to build capacity and capability through work-based and interprofessional learning, and the application of learning to practice.	F7.13
A3.4 E 4	Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities.	F7.5
A3.4 E 9	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.	F7.6
A1.6 E 13	Actively seek to share best practice, knowledge, and skills with other members of the team, for example through educational sessions and presentations at meetings.	F7.13

Capability 12: Research and development		
Cross-referenced ACP OT Capabilities	**Essential knowledge: Specific knowledge underpinning capabilities**	RCOT Career Development Framework Level 7
A2.10 R 1	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.	E7.6
A2.8 R 2	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.	E7.2
B (b), blue	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.	E7.6
Critical skills		
A1.7 R 4	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.	E7.7
R 2	Lead on Quality Improvement initiatives/ projects – sharing outcomes and leading change.	E7.9
R 6	Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review.	E7.1
R 7	Disseminate best practice research findings and quality improvement projects through appropriate media (e.g., presentations and peer review research publications).	E7.10
A1.6 R 8	Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical, and other active researchers.	E7.12

12.17 Advanced Clinical Practice Capabilities for Primary Care Occupational Therapy

These are the required capabilities for Advanced Clinical Practice Occupational Therapists in Primary Care. They were devised by a Skills for Health/HEE multi-disciplinary Steering Group with representation from Wales, Northern Ireland, Scotland, and England. The Steering group, with expert patient experience, clinicians and academics was fundamental in ensuring the accuracy of the capabilities, which were then further refined following public consultation. All contributions to the development of these capabilities are gratefully acknowledged.

Area Specific Capabilities: Primary Care Occupational Therapy

A.1. Personalised and collaborative occupational therapy including population health

Skills and Behaviours:

1. Utilise therapeutic use of self, empathy, professional reasoning, co-production and personalised approaches to inform the comprehensive and detailed investigation of why people, groups and communities are not able to engage in occupations that have health benefits. This will include the advanced ability to identify stigmatised and segregated groups at risk of occupational injustice.

Knowledge and Understanding:

2. Explore and critically appraise theoretical knowledge underpinning occupational therapy including the ability to synthesise, choose and apply all relevant frameworks and models in primary care in new, innovative and transformative ways.

3. Evaluate the principles enabling individuals, families, groups and communities to engage in occupations which promote physical, psychological and emotional health.

4. Critically analyse enablers and barriers to occupational performance, engagement and participation including multiple dimensions of health inequalities, comorbidities, health literacy and the social determinants of health for primary care populations within rapidly changing systems and environments.

5. Evaluate the complex relationship between physical, social, cultural and economic environments, their impact on occupation and the need for population level analysis, cultural sensitivity and occupational justice for prevention, maintenance and recovery.

6. Appraise the transformative links between occupational therapy theory and other disciplines / services / providers which may include medicine, pharmacology, psychology and sociology, social prescribing approaches, pertinent to primary care.

7. Critically evaluate current and emerging complex issues at societal and local level to enhance decision making about the link between occupation, health and wellbeing. This may include the effects of occupational dysfunction, injustice, deprivation, alienation, marginalisation, and imbalance on individuals, families and communities in primary care.

8. Synthesise understanding of disease trajectories and complex patterns of social inequalities across groups and communities and how engagement in occupations is impacted across the lifecycle and across different populations in primary care.

A.2. Occupational therapy assessment and diagnosis

Skills and Behaviours:

1. Undertake comprehensive detailed and holistic assessments using multifactorial and complex reasoning in order to formulate plans for investigation and treatment/therapy, diagnosis and differential diagnosis of conditions impacting on health, occupational performance and engagement. This may include physical and psychosocial assessments for individuals, their carers, families and communities that consider health and home management, education, work, play, leisure, social participation, rest and sleep.

2. Identify new, innovative ways to assess, pinpoint and resolve underlying issues that result in unplanned service use, frequent visits or lack of contact with primary care such as reduced functional ability and independence, loss of ability to cope and social isolation, work stress and sickness absence, mental health crises and multiple, cumulative social stressors.

3. Flexibly and creatively carry out occupational assessment in unfamiliar contexts with incomplete and contradictory information including advanced risk assessment and digital delivery, in a range of environments such as general practices, community facilities, people's homes, care homes and workplaces.

4. Analyse information from the assessment, in the immediate dynamic situation when supporting individuals, groups and communities with emergency problems including maintenance of safety, positive risk-taking where appropriate and when alternative input is required.

5. Complete assessments of extrinsic environmental and behavioural risk factors within homes, workplaces and communities in the management of conditions and health risks (such as the management of falls) to prevent admission to or speed discharge from hospital to maximise and maintain independence in preferred home, work and community environments.

6. Lead in triaging and coordinating referral, for assessment via patient or carer self-referrals, from clinical professionals within or outside primary care, or generated via wider community need, screening the appropriateness and priority of referrals, to minimise crisis situations that could result in hospital presentation or admission recognising the need for onward referral when required.

7. Develop and make use of the full scope of practice including skills for medicines management, coordination of investigations to support the individual's occupational performance and use of Patient Specific and/or Patient Group Directions where appropriate.

8. Triangulate evidence from a variety of sources such as interview, observation and standardised measures to ensure most accurate assessment of occupational performance is made.

Knowledge and Understanding:

9. Critically analyse the function of the human mind and body and recognition of a range of biopsychosocial needs, their impact on physical, behavioural, emotional, psychological and occupational wellbeing that typically arise or need to be addressed in primary care.

10. Explore and appraise how to assess people, groups and communities, their environments and chosen occupations, and their biopsychosocial determinants of health, in highly complex and unpredictable contexts using ethical, evidence informed assessment across a continuum of care, age and setting.

11. Evaluate medicines and other interventions relevant to those receiving assessment, how they are used, their possible side effects and the impact on occupational performance and engagement.

A.3. Occupational therapy interventions for individuals, groups and communities

Skills and Behaviours:

1. Proactively apply occupational therapy knowledge, skills and experience in partnership with the individual, carers and communities to find innovative, transformative solutions / interventions that are community based and population driven to prevent, maintain and improve recovery and occupational participation. This will include anticipatory skills for proactive, complex interventions and health promotion.

2. Co-create and select specifically graded and adapted occupations as therapy that intervene at multiple levels and support capacity for self-determination. This will include communities' rights to participate in valued occupations where barriers exist for marginalised, stigmatised groups at risk of health disadvantage and inequality.

3. Initiate problem solving to lead new, innovative interventions that promote health, wellbeing and occupational participation for populations experiencing occupational injustice and that will bring about meaningful occupational engagement and change, working with the impact of culture, spirituality and socioeconomic factors and collaboration with the third sector.

4. Empower people, groups and communities to self-manage and use peer support to build activation, enhance feelings of control and make informed choices regarding plans to enhance occupational performance and participation using collaboration and reassurance where extra support is required, signposting as required to existing local resources.

5. Facilitate person-centred decision-making for interventions for those with mental health or mental capacity problems. Advocate for applying the relevant legislation such as the Mental Health or Mental Capacity Act in a way that enables people to maintain their desired activities/occupation in order to maintain safety using positive risk taking where appropriate.

6. 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.

7. Use occupational formulation to present accurate, detailed and comprehensive reports to others that outline for example:

    h. levels of occupational performance in the context of everyday living/working and capacity to develop new skills and strategies.

    i. the outcome of assessments including, for example, work ability.

    j. the viability of independent living or return to work.

    k. specific, tailored recommendations regarding the level of support needed to carry out chosen occupations in chosen places such as living at home or returning to a particular job.

Knowledge and Understanding:

8. Use occupational formulation to present accurate, detailed and comprehensive reports to others that outline for example:

12.18 Further information about E-Learning Modules

These modules were originally designed to support the earliest cohorts of FCPs into safe working in primary care. They have recently been extended to FCPs of all professional backgrounds including occupational therapy. They are required because all clinicians in primary care may see patients with symptoms that fall outside their normal area of expertise. Occupational Therapists need to be prepared to deal with these in a way that ensures patient safety. The Primary Care modules are estimated to take approximately four hours to complete all of them and are as follows:

Identification of the ill and at Risk – Including frailty, sepsis, chest and abdominal pain, acute diabetic mellitus, anaphylaxis and other allergic reactions, dementia.

Mental Health in Primary Care – Including anxiety and depression and use of PHQ9 and GAD7.

Complex Decision Making – Including information to support clinicians when proven protocols may not exist, including narrative and hypothetic deductive reasoning, complexity thinking, social prescribing and differential diagnosis.

Public Health – Including health inequalities, local populations and data, models of health behaviours, Making Every Contact Count, motivational interviewing, NHS Health check, National Diabetes Prevention Programme.

Persistent Pain - Including meaning and context of pain, links with fear/ anxiety/ low mood, biopsychosocial models of pain.

Overview of Medicines and Prescribing – Although Occupational Therapists cannot use independent or supplementary prescribing, this module contains relevant information about providing advice about medicines, medicolegal frameworks for supply and administration of medicines under Patient Specific and Patient Group Directions (which are available to Occupational Therapists), contraindications and side effects. More information is also available here: https://www.rcot.co.uk/practice-resources/occupational-therapy-topics/medicines-optimisation/pgds

Serious Pathology of the Spine – Litigation related to this area in primary care is high and this module is intended to improve practice in this area for all clinicians. It includes red flags associated with malignancy, spinal infections due to tuberculosis, low impact fractures and cauda equina syndrome.

The Personalised Care modules have been designed to promote best practice in this

area. Although many clinicians practice in a personalised way, feedback from those who use services suggests this is not the case all the time. In a culture of reflective practice and continuous improvement, there are still opportunities to extend these skills. The Personalised Care modules take approximately two hours to complete and are as follows:

Core Skills – Challenges to delivery of personalised care including lack of time and risk, how to address these challenges.

Shared Decision Making - Including consent, decision making aids, communicating about risk and legal duties.

Personalised Care and Support Planning – Including the criteria to guide this process.

12.19 Additional e-Learning for Health modules

The following modules are not mandatory but may provide Occupational Therapists with additional learning and development opportunities in primary care:

- Advanced Practice Toolkit
- Autism Awareness (AUT)
- Cancer in the Community (CCC)
- Communicating with empathy (CWE)
- Community Centred approaches to Health Improvement (CMH)
- Covid19 Recovery and Rehabilitation Programme
- Dementia (DEM)
- Disability Matters
- Eating Disorder Training
- Embedding Public Health into Clinical Services
- End of Life Care for All
- Frailty (Tier 2b) (FTY)
- Health Equity Assessment Tool (HEAT)
- Health Literacy (HL)
- Helping People Living in Cold Homes (HOU)
- Identifying and responding to Sexual Assault and Abuse
- Literature Searching (LTS)
- MindED
- National Bereavement Care Pathway
- NHS Healthcare for the Armed Forces
- Obesity (BMI)
- Patient Group Directions
- Personal Health Budgets (PHB)
- Person Centred Approaches
- Physical activity and Health (PHA)
- Physical Health Checks for Severe Mental Illness
- Population Health Management (PHM)
- PRosPer (Personalised care for people with cancer)

- Recognising and Managing Deterioration (Sepsis)
- Safeguarding
- Social Prescribing -Learning for Link Workers (SPL)
- Statutory and Mandatory Training (SMT)
- Substance Misuse (PWP)
- Suicide Prevention (SPV)
- Supporting Self Care (SSC)
- Supporting Unpaid Carers (SUC)
- TECS Practice Learning Toolkit
- Wellbeing and Mental Health (PWP)
- Work and Health (PHW)

All available at: www.e-lfh.org.uk/

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