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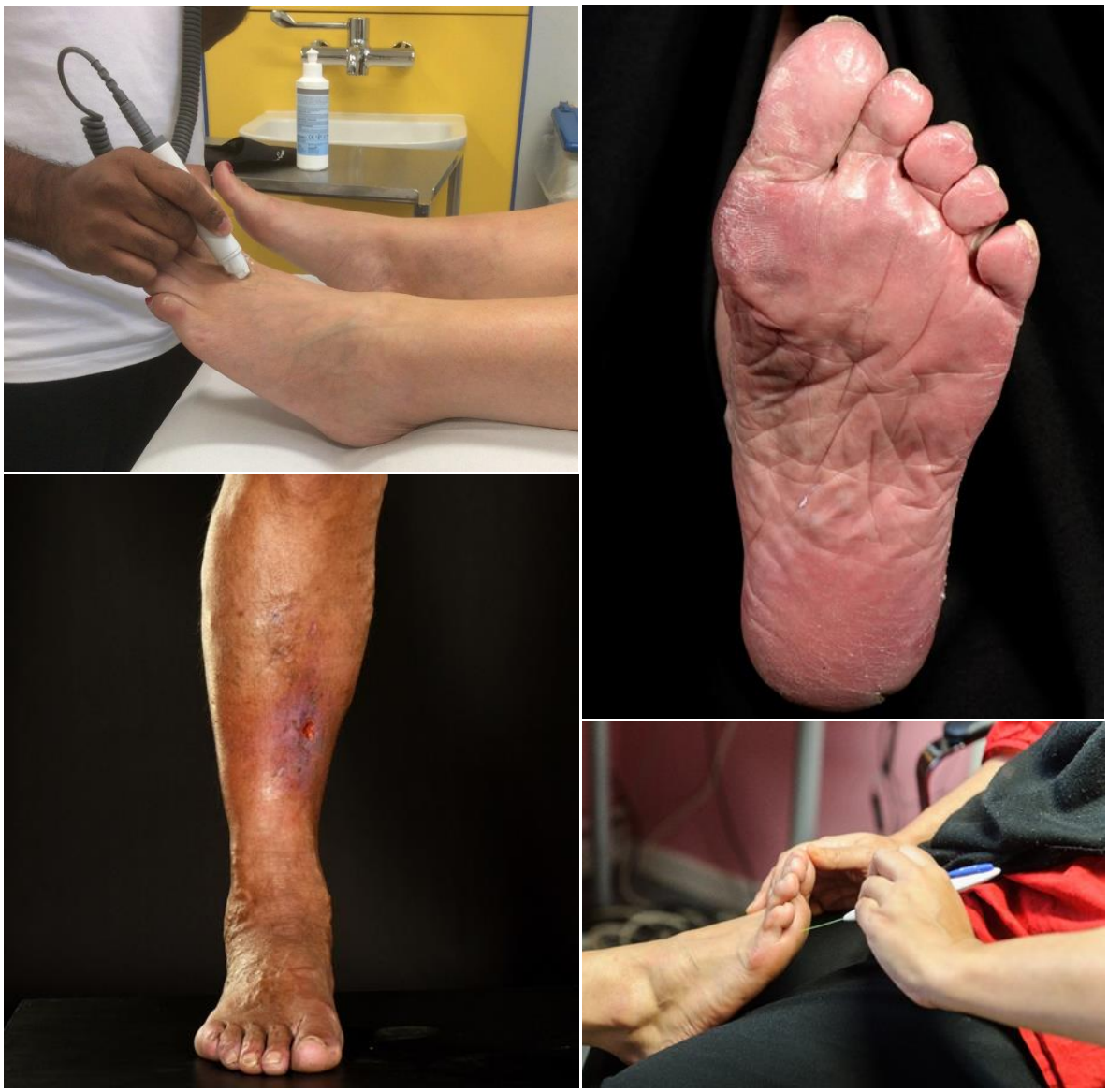

Multi-Professional Advanced Capabilities Framework for Lower Limb Viability

The COLLEGE of PODIATRY

Skills for Health

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Belfast Health and Social Care Trust

British Association of Prosthetists and Orthotists

Foot in Diabetes UK

Great Western NHS Trust

Guy's and St Thomas' NHS Trust

Health Education England

Manchester University NHS Foundation Trust

Mid Yorkshire Hospitals NHS Trust

NHS Greater Glasgow & Clyde

NHS London Clinical Network: Foot Care

NHS Wales

Skills for Health

The Chartered Society of Physiotherapy

The College of Podiatry

The University of Huddersfield

University Hospitals of Derby and Burton NHS Foundation Trust

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[1] See Appendix 5 for more information

Promoting equality and addressing health inequalities are at the heart of our values.

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Foreword

Dr Paul Chadwick

Clinical Director, The College of Podiatry

The delivery of high-quality care for the lower limb relies upon a highly skilled and well-integrated workforce, consistently ensuring patient safety, and effectiveness across service delivery. This Multi-Professional Advanced Capabilities Framework for Lower Limb Viability describes the capabilities required by advanced practitioners providing care for people with lower limb disease and aligns with the multi-professional Advanced Clinical Practice (ACP) framework published in 2017[2]. The framework is similarly constructed around the four pillars of advanced practice: clinical practice, leadership and management, education and research and has been developed by a multidisciplinary steering group from the four home nations. Their commitment, hard work, expertise, collaborative approach and contributions have been essential in progressing the document to publication.

Lower limb viability complications carry a high cost to people and society in terms of adverse outcomes, loss of function and disability, and to the NHS in terms of finance. It is estimated that around 5 billion pounds is spent on wound care in the UK (Guest 2015). A large proportion of this is spent on wounds in the lower limb. Every two hours, two people over 50 in England have a minor foot amputation, and someone loses their whole leg. The main contributing causes are diabetes, peripheral arterial disease, venous disease and lymphoedema. Up to half of these amputations may be preventable with the correct early assessment, diagnosis and management plan. As well as amputations, early modifiable deaths from diabetes related foot ulcers, amputations and peripheral arterial disease are comparable to common cancers, unacceptably high and potentially reducible.

This framework therefore represents a consensus of current evidence and expert opinion, providing clinicians with opportunities to identify their own development needs, to maximise their scope of practice and support career progression. It also provides clarity for employers and commissioners, to support and develop the workforce to deliver service transformation and better patient outcomes, and educationalists who provide education for clinicians working with lower limb pathologies. With an overarching common goal to protect lives and save limbs.

It is hoped that this framework will provide a helpful resource to support all involved in the development of capabilities to improve Lower Limb Viability in the UK and beyond.

[2] Health Education England (2017), Multi-professional framework for advanced clinical practice in England.

Introduction

Health Education England is working together with the Department of Health, providers, clinical leaders, and other partners “to improve the skills and capability of the workforce”.

The commitment to improve services through developing the workforce is supported by introducing a *common framework of core skills and knowledge* promoting a higher level of consistency with respect to quality of service provision, assessing performance, and providing the basis of a common language for both practitioners and for their external audience.

Many thousands of patients receive healthcare for an underlying illness or condition that puts their legs and feet at increased risk of difficult healing, injury and disability or the loss of a foot or lower limb. Examples of these conditions include poor circulation leading to fragile skin that injures easily and takes a long time to heal and lack of feeling in the feet or lower legs which may mean that injuries go unnoticed and lead to ulceration. People with diabetes, rheumatoid arthritis, cerebral palsy, venous hypertension, peripheral arterial disease and peripheral nerve damage (neuropathy) can be prone to these kinds of conditions[3].

This Multi-professional Advanced Capabilities Framework for Lower Limb Viability focuses on the capabilities of advanced practitioners working with individuals with high risk and chronic wounds, difficult healing and who are at risk of losing a foot or lower limb and dying early as a result of their underlying condition(s). It is relevant to multi-disciplinary practice and is multi-professional rather than being applicable to one area of practice only. The framework has been designed for advanced clinical practice in England but it is hoped to also be of relevance to the devolved nations. This framework is focussed specifically on high risk foot and lower limb conditions, including venous, arterial and neuropathic conditions. It does not include musculoskeletal conditions which are covered within other frameworks[4].

The development of this Multi-Professional Framework for Lower Limb Viability will support the workforce development aims of Health Education England to engender consistency and ensure greater accuracy in the delivery of education and training across the healthcare sector. It will help to reduce duplication of education and training and result in a greater return on investment in this important area.

The prevention and early management of lower limb conditions are embedded within this Framework and are key to the personalisation of care. As such, this Multi-Professional Framework aligns closely to The Person-Centred Approaches Framework[5]

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[3] University Hospitals of Leicester NHS Trust (2011) High Risk Foot Management https://www.leicestershospitals.nhs.uk/aboutus/departments-services/podiatry/what-do-podiatrists-do/high-risk-foot-management/

[4] Musculoskeletal Core Capabilities Framework (2018) https://www.skillsforhealth.org.uk/news/latest-news/item/689-new-musculoskeletal-core-capabilities-framework?highlight=WyJtc2siXQ==

[5] Person Centred Approaches Framework (HEE and SfH) (2017) https://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download

"A person-centred approach puts people, families and communities at the heart of health, care and wellbeing. It means people feeling able to speak about what is important to them and the workforce listening and developing an understanding of what matters to people. It means working in a system in which people and staff feel in control, valued, motivated and supported… the values and behaviours of being person-centred are about a fundamental approach. This approach is about enabling the workforce to develop genuine partnerships with people, families, carers, communities and colleagues. This means that we can plan, design and deliver care and support with people and collectively plan and design services and systems".

Engaging and supporting people to live healthier, longer lives should be an on-going activity with people and communities, rather than a single event or intervention. The importance of addressing health inequalities is also a central theme within this Multi-Professional Framework; deprivation, poverty and homelessness impact massively on the viability of lower limbs.

There are many correlations between this Multi-Professional Framework and the Diabetic Lower Limb framework[6]. However, this framework is multi-professional and is intended for the multi-disease environment; it is not condition specific. It is focussed more widely on lower limb protection, for example the patient at risk of amputation or non-healing ulceration and chronic wounds and associated mortality. It aims to be applicable to practitioners across the healthcare system, including acute, community and primary care. Given the reconfiguration of vascular services there is also a need to equip the workforce to cope with the shift from the "traditional" approach to service delivery in the future – and there is a need to shift the population's expectations towards personalised and shared care.

This Framework describes the capabilities required by advanced practitioners in order to improve life, limb and wound outcomes for patients, rather than upon functional/task-based competences. A holistic, personalised approach is fundamental to this.

[6] The Diabetic Foot Journal (2019) Capability Framework for Integrated Diabetic Lower Limb Care: A User's Guide

Scope of the framework

The framework comprises **capabilities** which are common and transferable across different organisations and models of service provision. For the purposes of this framework we define capabilities as:

> The attributes (skills, knowledge and behaviours) which individuals bring to the workplace. This includes having the potential to be competent and beyond this, to adapt to and manage change, be flexible, deal with situations which may be unpredictable and continue to improve performance.

This framework builds upon the definitions of advanced clinical practice provided by the Multi-professional framework for advanced clinical practice (HEE 2017)[7]. This aims to provide clarity for employers, service leads, education providers and healthcare professionals, in addition to practitioners working towards, or already practising at an advanced level.

> **Advanced clinical practice** is a level of practice delivered by experienced, registered health and care practitioners, characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of; clinical practice; leadership and management; education; and research.

Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve life, limb and wound outcomes.

The Lower Limb advanced practitioner must have clinical-reasoning and problem-solving capabilities and critical self-awareness skills both to apply their knowledge and skills within their professional scope of practice, and to know when to seek advice and to make referrals to others to meet the best interests of the individuals they serve.

[7] Health Education England (2017), Multi-professional framework for advanced clinical practice in England.

Structure of the framework

All health and care professionals working at the level of advanced clinical practice can demonstrate knowledge, skills and behaviours to the standards outlined in the Multi-Professional Framework for Advanced Clinical Practice (HEE 2017)[8]; the capabilities are common across this level of practice enabling standardisation.

The four pillars that underpin practice at this level are:

1. Clinical Practice
2. Leadership and Management
3. Education
4. Research

As illustrated in the table below, the structure of this Framework aligns directly with the pillars of the Multi-professional framework for advanced clinical practice.

Multi-Professional Framework for Advanced Clinical Practice	Multi-Professional Advanced Capabilities Framework for Lower Limb Viability
Pillar 1. Clinical Practice	Advanced Clinical Practice Capabilities for Lower Limb Viability Area A. Specific Advanced Clinical Practice Capabilities for Lower Limb Viability Area B. Core Advanced Clinical Practice Capabilities
Pillar 2. Leadership and Management	Core Leadership and Management in Advanced Clinical Practice
Pillar 3. Education	Core Education in Advanced Clinical Practice
Pillar 4. Research	Core Research in Advanced Clinical Practice

[8] https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf

Advanced Clinical Practice Capabilities for Lower Limb Viability are presented in two sections:

Area A. Specific Advanced Clinical Practice Capabilities for Lower Limb Viability – these capabilities are specific to lower limb viability and would be integrated in practice with the core clinical practice capabilities in Area B.

Area B. Core Advanced Clinical Practice Capabilities – these capabilities are common/transferable across all areas of advanced clinical practice.

Within the Framework, each capability articulates the skills/behaviours and knowledge/understanding demonstrated by this area and level of practice.

The ACP must be able to:	**ACP knowledge and understanding:**
These are the skills and behaviours which can be observed / demonstrated in advanced practice.	This is the knowledge and understanding which underpins advanced practice.

In addition to demonstrating that health professionals have developed to a defined level of practice, there is an expectation that this is sustained through participation in organisational mechanisms such as appraisal and support for continuing professional development.

The framework does not prescribe how individual practitioners' fulfilment of the capabilities should be demonstrated or assessed. This will depend upon the context or setting where the framework is used and how individuals have developed their capability. However, key principles for the implementation of advanced clinical practice are presented in Appendix 2.

How to use the framework

Service commissioners

The framework enables commissioners of services to specify minimum standards for clinical employment/placement; it sets out clear expectations about advanced clinical practice delivered in Lower Limb services.

The capabilities support the development and planning of the workforce to meet local population need and support a common understanding and expectation of operating at this level of practice, in order to facilitate the development and progression of this workforce.

Service providers

The framework enables managers to demonstrate that Lower Limb practitioners meet core capabilities or have developmental plans in place to meet the nationally recognised framework. This underpins the continuing professional development of practitioners to ensure their practice remains up-to-date, safe and effective and supports the process of quality assurance to ensure the safety and effectiveness of advanced clinical practice roles.

A further aspiration in providing this framework is to support service transformation i.e. that organisations use the framework to review their current arrangements for advanced clinical practice in Lower Limb services and use the capabilities in developing roles and teams. This framework also provides a suggested benchmarking of service provision at an organisational level and can enable providers and managers to identify appropriate development.

Education and training providers

The framework helps those who design and deliver training and development opportunities to focus on the key capabilities that learners need to achieve, which in turn will guide the content to be included and the use of appropriate learning and teaching strategies.

Education providers can use the framework to inform the design of their curricula and the delivery of education, training and development programmes, including how they articulate their intended learning outcomes. This will ensure that their learning and development provision contributes to students and practitioners acquiring and demonstrating the full range of knowledge to support the capabilities required for advanced clinical practice in this clinical area.

Use of this national framework also supports organisational and system wide effectiveness and efficiencies by encouraging the delivery of education and training that is focused on developing core capabilities and optimises opportunities for inter-professional learning. In so doing, it should help to increase consistency in knowledge and skills development, prevent unnecessary duplication in education and training delivery and strengthen skill mix and teamworking.

Practitioners – people and teams

The framework sets out clear expectations for practitioners about the requirements of effective and safe extended practice roles and transferable skills. It can be used to review and recognise how capabilities are shared across teams and to conduct formal or informal appraisal and training needs analysis, comparing current skills and knowledge with required skills and knowledge. The framework also provides a structure for career progression and development in new and challenging clinical environments and engagement in continuing professional development.

Practitioners may have different starting points, due to their background, clinical training and scope of practice - most practitioners are already likely to meet all or some of the capabilities but may need to develop and orientate themselves to delivery of high risk foot and lower limb services.

Service users and the public

The framework can be used by service users and the public to understand the functions of the Lower Limb workforce and to plan effectively for their own current and future care. In particular, the framework highlights that people must be able to make informed choices about their care and support and be assured that services are delivered safely and effectively alongside healthcare and other practitioners, i.e. to participate in shared decision-making.

Professional values and behaviours

The Lower Limb advanced practitioner will adhere to legal, regulatory and ethical requirements, professional codes, and employer protocols.

Specifically, this means working in accordance with the Health & Care Professions Council (HCPC) Standards of conduct, performance and ethics and; Standards of proficiency for chiropodists / podiatrists.

The HCPC Standards of conduct, performance and ethics sets out standards for the following professional skills, knowledge and behaviour:

- promote and protect the interests of service users and carers, including obtaining valid consent;
- communicate appropriately and effectively;
- work within the limits of their knowledge and skills, including keeping professional knowledge and skills up to date;
- delegate appropriately;
- provide and make use of appropriate supervision;
- respect confidentiality;
- manage risk, including the management of own health;
- report concerns about safety;
- be open when things go wrong;
- be honest and trustworthy;
- demonstrate high standards of personal conduct, and
- keep records of their work.

HCPC (2016): Standards of conduct, performance and ethics: https://www.hcpc-uk.org/publications/standards/index.asp?id=38

See also:

BAPO Ethical Code 2018: Standards of Conduct, Performance and Ethics for Prosthetists, Orthotists, Associates and Affiliates: https://www.bapo.com/wp-content/uploads/2018/08/Ethical-Code-Update-April-18.pdf

Chartered Society of Physiotherapy (2011) Code of Members' Professional Values and Behaviours: https://www.csp.org.uk/system/files/csp_code_of_professional_values_behaviour_full.pdf

College of Podiatry, Standards of Podiatry Practice: https://cop.org.uk/members/practice/clinical-practice/standards-for-clinical-practice/

College of Podiatry, Code of Conduct, Articles of Association and By-laws: https://cop.org.uk/members/governance/

College of Podiatry, Clinical Guidelines: https://cop.org.uk/members/practice/clinical-practice/clinical-guidelines/

The Institute of Chiropodists and Podiatrists, Code of Ethics: https://iocp.org.uk/about/code-of-ethics/

NHS Constitution: Commitments to service users and staff, and the responsibilities that the public, service users and staff owe to one another to ensure that the NHS operates fairly and effectively: https://www.gov.uk/government/publications/the-nhs-constitution-for-england

NMC (updated 2018): The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

About Advanced Clinical Practice Capabilities for Lower Limb Viability

A1. Personalised and collaborative working

At the heart of personalised care is the relationship between people; that is built from meaningful communication, and is strongly influenced by how we say things, how we listen and our non-verbal communication. Individuals should be engaged in shared decision-making about their care and supported to actively make the decision about their preferred care and treatment plan, whilst understanding their concerns and beliefs.

Advanced clinical practitioners working with individuals at risk of complications including devastating outcomes such as chronic wounds and foot or lower limb amputation have the interpersonal and communication skills to engage in effective, appropriate interactions with individuals, carers and colleagues in the clinical environments in the roles and multi-disciplinary teams within which they practise. They have the listening, information-processing and empathetic skills to ascertain, understand and respond to individuals' needs, concerns and beliefs. They use appropriate language and media, are sensitive to individual preferences and needs, and uphold the safeguarding of individuals' interests. Advanced clinical practitioners take account of individuals' specific needs, wants and circumstances to guide the care and treatment they offer. They respect individuals' expertise in their own life and condition, empowering and supporting them to retain control and to make choices that fit with their goals. Avoiding paternalistic practice, they apply their knowledge and skills in a personalised way rather than sticking rigidly to predetermined protocols/guidelines or workplace imperatives. At advanced clinical practice level, a practitioner will demonstrate not only an awareness of the need for personalised approaches and collaborative working in relation to individuals but also across the wider team or service environment. An advanced practitioner working to maintain the viability of lower limbs and feet will take a holistic approach and consider the person first before the affected limb and the wound.

A2. Assessment, investigations and diagnosis

Advanced clinical practitioners work with individuals who may have serious or complex conditions, and/or are at high risk of devastating outcomes such as non-healing wounds or limb amputation: they have the ability to conduct detailed clinical assessments, synthesise such information and form a clinical impression or diagnosis that will ensure the development of the most effective management plan. This includes identifying and requesting the appropriate investigations, imaging and tests.

Advanced practitioners demonstrate skills in problem-solving and critical thinking, evaluating the impact and outcomes of the interventions on their decision making. They analyse and synthesise complex information, particularly in relation to unfamiliar contexts and presentations where information may be incomplete or contradictory. They work autonomously and ethically, underpinned by their professional standards of care. They incorporate a critical analytical approach to risk and uncertainty and work actively with others to resolve conflict.

Additionally, advanced practitioners working in this clinical area demonstrate safe, effective, autonomous and reflective practice, informed by available evidence and established best practice. They work effectively as part of a team, either as a leader or as a team member, contributing to multi-disciplinary team working to optimise the quality of service and clinical outcomes delivered to individuals. Advanced practitioners support and encourage shared decision-making such as to agree tests and investigations based upon clinical need and individuals' informed preferences. A holistic and personalised approach underpins assessment, investigation and diagnosis of the lower limb and wounds.

A3. Condition management, treatment/therapy and care

Advanced clinical practitioners support and encourage individuals to make behaviour changes to manage their individual risk by providing evidence-based care in line with national guidance. ACP's focus on how they can have a positive impact on the health and wellbeing of individuals, communities and populations. They advise on interventions and formulate and enable the development and implementation of management plans. They work in collaboration with health and social care colleagues (across services, agencies and networks) to meet individuals' best interests.

Advanced clinical practitioners are able to develop, advise on and enact an integrated management plan that considers all the options and needs and wishes of the individual, also considering options outside of their individual scope of practice. They will support and encourage shared decision-making, i.e. working together with service users and carers to select treatments, management or support packages, based upon clinical evidence of all the options and peoples' informed preferences. The management plan needs to support self-management and consider health promotion and lifestyle interventions, dependent on the possibilities and on the needs and wishes of the individual.

A holistic and personalised approach is required. The key to the provision of high-quality condition management, interventions and prevention is to focus on the person, their life, limb and then the wound.

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Lower Limb Viability Advanced Clinical Practice

Area A. Specific Capabilities for Lower Limb Viability

The following advanced capabilities are **specific** to lower limb viability and would be integrated in practice with the **core** clinical practice capabilities in Area B.

The ACP must be able to:	**ACP knowledge and understanding:**
A1. Personalised and collaborative working	
a) Empower individuals to get the most from conversations about the management of their Lower Limb condition(s) and its impacts (e.g. loss of independence) by supporting and encouraging them to ask questions relating to their priorities and concerns. b) Promote and advise on i) the importance of social networks and communities for individuals, their families and carers in managing a Lower Limb condition. ii) the importance of physical activity (e.g. continuing work/exercise participation), diet and nutrition for Lower Limb health. iii) the effects of smoking, obesity and inactivity on Lower Limb health and conditions and, where appropriate promote change or refer to relevant services. iv) the effects of injuries on Lower Limb health and conditions. v) strategies and approaches relating to the prevention and condition management for particular defined groups, such as children, homeless people and those living with frailty. c) Promote a culture of wellbeing to minimise distress and suffering and enable individuals to understand and cope with	a) Critically appraise how high-risk foot and lower limb viability can impact on an individual and society recognising barriers to recovery or a return to usual activity or work including; i. frailty ii. multimorbidity iii. dementia iv. learning disabilities v. psycho-social, economic and other determinants of health and health inequalities. b) Synthesise understanding of biological and psycho-social sciences applicable to high risk foot and lower limb viability.

The ACP must be able to:	ACP knowledge and understanding:
their Lower Limb condition, its treatment and its consequences. d) Engage with the impact of persistent pain and disability on the lives of individuals with complex or serious conditions and co-morbidities which place them at risk of poor outcomes. Such outcomes include a minor or major lower limb amputation, the potential effects on their relationships, self-esteem and ability to participate in what they need and want to do (including paid and unpaid work). e) Progress care, recognising that reducing pain, restoring and maintaining function and independence, and improving quality of life are all clinical outcomes and meaningful goals of treatment. f) Recognise in their management approach that Lower Limb conditions are often coupled with mental health issues, frailty, multimorbidity or other determinants of health.	
A2. Assessment, investigations and diagnosis	
a) Understand and interpret a variety of advanced diagnostics modalities, including haematology, biochemistry, microbiology, pathological sampling, radiological and advanced imaging requests in full compliance with IRMER and utilise results to inform diagnosis. b) Undertake preliminary interpretations of radiological images (in the absence of radiological reporting), communicate the results to the individual in terms that they understand and reassess the management plan in light of the results. c) Develop a working diagnosis by systematic consideration of the various possibilities (differential diagnoses) in complex cases, recognising key diagnostic biases, common errors and issues relating to the diagnosis and decision making in the face of ambiguity and incomplete data. d) Identify risk factors for severity or impact and use tools where they exist to analyse and stratify risk of progression to long term pain and disability.	a) Demonstrate comprehensive understanding of the normal structure and function of the foot and lower limb, and disease processes that can affect this e.g. i) Biological and psycho-social sciences applicable to high risk foot and lower limb viability. ii) Disease processes relevant to the diagnosis of high risk foot and lower limb viability. iii) Pathological processes relating to high risk foot and lower limb viability, including the ageing process, injury and disease states. b) Explore and appraise features of high-risk foot and lower limb viability that are relevant to making a diagnosis, including: i) Arterial insufficiency. ii) Deformity. iii) Dermatological conditions.

The ACP must be able to:	ACP knowledge and understanding:
e) Recognise how conditions associated with the lower limb can impact on and interact with mental health and identify when this is relevant. f) Consider if safeguarding issues are attributable to injury or trauma, recognising particular vulnerable groups (such as older people with frailty and those with cognitive impairment) can be more at risk of such issues, following local Safeguarding policies when there are any concerns.	iv) Infection. v) Lower limb ulceration. vi) Oedema. vii) Pain: nature, location, severity. viii) Peripheral sensory neuropathy. ix) Variation of symptoms over time. x) Venous insufficiency. c) Review syndromes that high-risk foot and lower limb viability conditions present as, their differential diagnoses and the characteristics of the different conditions including systemic features and their expected progression / prognosis to support making a diagnosis and management plan. Commonly seen patterns and syndromes may include: i) Deformity. ii) Dermatological conditions. iii) Generalised pain. iv) Infection. v) Lower limb ulceration. vi) Peripheral sensory neuropathy. vii) Regional pain. viii) Vascular insufficiency. The cause of which can be related to: i) Arterial disease. ii) Connective tissue disorders. iii) Developmental disorders. iv) Genetic and hereditary disorders. v) Lower limb oedema. vi) Lower limb skin conditions/Dermatology. vii) Neuropathy. viii) Pressure. ix) Venous disease. d) Instigate appropriate investigative tests to aid diagnosis and assessment, including radiological imaging.

The ACP must be able to:	ACP knowledge and understanding:
	e) Critically evaluate indications and limitations of different tests to inform decision-making and interpret test results.
A3. Condition management, treatment/therapy and care	
a) Evaluate all treatment plan options including no treatment, non-pharmacological and other interventions to agree, individualised management plans ensuring the rationale for any treatment option risks are understood. b) Formulate and inform lower limb interventions and long-term management of conditions based on local policies and procedures using appropriate inter-professional service delivery models. c) Appraise and discuss with individuals the implications of their underlying disease diagnosis and personal treatment planning, in relation to healing potential, morbidity, disease management, modifiable risks to life and limb, and non-surgical and surgical interventions. d) Initiate and review the impact of key interventions such as medicines, exercise, weight reduction, smoking cessation, compression therapy and associated wound care; provide advice to individuals on the benefits of healthy lifestyle choices, including when this necessitates difficult or challenging conversations. e) Use understanding of medical and non-medical management of lower limb conditions to advise individuals on the management of their condition, the expected benefits and limitations, and inform them impartially on the advantages and disadvantages in the context of other management options. f) Develop and evaluate complex wound healing management solutions, showing consideration of any potential complications, underlying disease pathology and the psychological aspects of wound healing.	a) Evaluate how to support the development of a management plan: i) Conditions where an early referral and diagnosis may be particularly important for optimising individuals' long-term outcomes e.g. nerve or vascular compromise. ii) Management strategies / models of care for common lower limb viability problems that include support, self-management and consider prevention, symptom control, disease control and restoration of function. b) Analyse the impact and value of supported self-management and behaviour change for optimising physical activity, mobility, fulfilment of personal goals and independence. This includes the principles of: i) Behaviour change. ii) Care and support planning. iii) Health coaching techniques. iv) Lifestyle advice. v) Patient activation models. vi) Shared decision making. vii) Supported self-management. c) Demonstrate critical understanding of pharmacotherapy and prescribing: i) The role of common medications, the expected benefits and limitations. ii) Common medication errors and medication error-prevention strategies. iii) Current legislation on prescribing practice at local and national levels.

The ACP must be able to:	ACP knowledge and understanding:
g) Develop frameworks for management of tissue mechanics and the effect of shear, pressure and non-linear forces. h) Maintain an up to date knowledge of adjunct therapies and their impact in optimising healing and reducing risk of foot or lower limb amputation. i) Develop and explore strategies to deliver interventions which minimise health inequalities by enabling people to understand and cope with their disease or disability, its treatment and its consequences, drawing on an appropriate range of multi-agency and inter-professional resources to optimise patient care. j) Develop pathways to support long term lower limb conditions, symptoms and reduced mental well-being, referring individuals to sources of mental health services where appropriate. k) Advise on, instigate and oversee management plans for lower limb conditions and symptoms, within own service or in collaboration with other agencies and the wider MDT, providing counselling and advice to individual patients and colleagues as required. l) Provide advice and formulate evidence based therapeutic interventions for high risk foot and lower limb conditions, with a particular focus on expected benefits and limitations. m) Play a leading role in care planning practice development; devise and deliver training and support the development of others in relation to wound management, including compression bandaging, topical negative pressure, blade debridement and other advanced wound management treatments and interventions. n) Formulate and develop guidance delivering training where needed in relation to the use of interventional devices for pressure redistribution, load sharing and axial offloading. o) Identify, advise and refer as appropriate to local non-clinical services which are of benefit in the holistic management of the	d) Demonstrate critical understanding of wound care: i) The wound healing process and its potential complications. ii) The psychological impact of active diabetic foot disease on the patient. iii) Classification of active lower limb ulceration, including advanced investigations of vascular insufficiency (e.g. ankle–brachial pressure index, Doppler ultrasound), neurological deficit, foot deformity, trauma, increased pressures, extent and degree of infection. iv) National guidance related to diabetic wound management, leg ulcer management and pressure ulcer management. v) Advanced wound management techniques (e.g. topical negative pressure systems, wound biopsy, blade debridement, sharp incision and drainage). vi) Advanced wound bed preparation knowledge including: Dressing product choices based on consideration of clinical indications, wound type, patient needs, and formulary and budgetary directives. vii) Recognising the need for surgical debridement. viii) Recognising infection and sepsis, and the need for treatment including in those unable to communicate. e) Demonstrate critical understanding of Post-Ulcer Care: i) Available topical products and their role in the prevention of ulceration. ii) Biomechanical load distributing strategies to minimise the risk of foot ulceration. iii) Need for prescription of footwear and orthotic principles. iv) Need for pressure redistribution devices.

The ACP must be able to:	ACP knowledge and understanding:
high risk foot or lower limb condition and its impact, such as Social Prescribers and including those relating to employment, voluntary activities, counselling services and leisure facilities.	v) Need for ongoing compression therapy. f) Critically evaluate prescription of pressure redistribution, load sharing and axial offloading: i) Advanced and customised load distribution, load sharing and axial offloading strategies. ii) Technologies used in the assessment of foot pressure and gait analysis. g) Critically evaluate the role of common surgical interventions used in managing high risk foot and lower limb viability conditions, the expected benefits and limitations.

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Area B. Core Capabilities in Advanced Clinical Practice

The ACP must be able to:	ACP knowledge and understanding:
B1. Personalised and collaborative working	
Communication and consultation skills a) Autonomously adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to people's communication and language needs, preferences and abilities (including levels of spoken English and health literacy). b) Adapt communication approaches based on contextual demands, drawing on a broad range of approaches to broaden and deepen their influence on others. c) Demonstrate effective active listening skills. d) Communicate effectively with individuals who require additional assistance to ensure an effective interface with a practitioner, including the use of accessible information. e) Recognise when the person and their family/carer may have competing agendas and be able to facilitate shared agenda setting using a triadic consultation approach. f) Consult in a highly organised and structured way, with professional curiosity as required. g) Elicit psychosocial history/factors to provide some context for people's problems/situation.	**Communication and consultation skills** a) 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. Knowledge of consultation models the ability to be able to appraise what is required in each situation. b) Reflect on advanced communication strategies and skilfully adapt those employed to ensure communication strategies foster an environment of person empowerment. c) Communicate in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate people's care. d) Evaluate and remedy situations, circumstances or places which make it difficult to communicate effectively and have strategies in place to overcome these barriers. e) Enable effective communication approaches to non-face to face situational environments e.g. phone, video, email or remote consultation. f) Contextualise communication approaches to use in group situations. g) 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. h) Manage and enable people effectively, respectfully and professionally (including where applicable, carers and families) especially at times of conflicting priorities and opinions.

The ACP must be able to:	ACP knowledge and understanding:
Practising holistically to personalise care and promote public and person health a) Actively 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'[9] and signpost additional resources. b) Actively explore implement and evaluate approaches/strategies that positively influence health outcomes for individuals, populations and systems. c) Actively engage people in shared decision making about their care by: ➢ supporting them to express their own ideas, concerns and expectations and encouraging them in asking questions ➢ explaining in non-technical language all available options (including doing nothing) ➢ exploring with them the risks and benefits of each available option, discussing the implications, how it relates to them and promoting their understanding as much as possible ➢ supporting them to decide on their preferred way forward ➢ supporting them to explore the consequences of their actions and inactions on their health status and the fulfilment of their personal health goals. ➢ supporting them to self-manage their care where at all possible and where appropriate. d) Develop and promote shared management / personalised care/support	**Practising holistically to personalise care and promote public and person health** a) 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. b) Recognise the wider determinates of health, including (but not limited to) the impact of psychosocial factors on the presenting problems or general health such as housing issues, work issues, family/carer issues, lack of support, social isolation and loneliness. c) Recognise the importance of focusing on people as individuals and the focus of care and how to respect the diversity and values of individuals. d) Effectively employ the Public Health England "All Our Health" framework in own and wider community of practice[10] e) Evaluate how a person's preferences and experience, including their individual cultural and religious background, can offer insight into their priorities, wellbeing and managing their own care. f) Evaluate how the vulnerabilities in some areas of a person's life might be overcome by promoting resilience in other areas. g) Recognise and foster the importance of social networks and communities for people and where applicable their carers/families in managing long-term health conditions, such as linking with statutory and voluntary organisations and support groups. h) 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).

[9] https://www.makingeverycontactcount.co.uk/

[10] Public Health England (2019) All Our Health: personalised care and population health https://www.gov.uk/government/collections/all-our-health-personalised-care-and-population-health

The ACP must be able to:	ACP knowledge and understanding:
plans with people individualised to meet their needs in partnership, where appropriate, with other health and social care providers and with carers / family members and voluntary organisations where applicable. e) Work collaboratively across agencies and boundaries to improve health outcomes and reduce health inequalities at a personal level for individuals but also at to improve health outcomes at a population/system level. f) Advise on and refer people appropriately to (including but not limited to) psychological / occupational therapies and counselling services, in line with their needs and wishes, taking account of local service provision. g) Advise on sources of relevant local or national self-help guidance, information and support including coaching.	i) Advocate for and contribute to personalised approaches in the management and development of services.
Working with colleagues and in teams a) Ensure own work is within professional and personal scope of advanced practice and access advice when appropriate. b) Advocate and utilise the expertise and contribution to peoples' care of other allied health and social care professionals and work collaboratively within the multi-professional team to optimise assessment, diagnosis and integrated management and care for people. c) Work effectively within and across teams, managing the complexity of transition from one team to another or membership of multiple teams. d) Communicate effectively with colleagues using a variety of media (e.g. verbal, written and digital) to serve peoples' best interests. e) Make direct referrals in a timely manner as indicated by peoples' needs with regard for referral criteria e.g. 2-week wait cancer pathway, urgent or routine referrals.	**Working with colleagues and in teams** a) Synthesise a deep and systematic knowledge and understanding of the wider health and social care, voluntary sector services and teams and refer independently using professional judgement. b) Take responsibility for one's own well-being and promote the well-being of colleagues, escalating any causes for concern appropriately.

The ACP must be able to:	ACP knowledge and understanding:
f) Initiate and lead effective multi-disciplinary teams 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.	
Maintaining an ethical approach and fitness to practice a) Demonstrate the application of professional practice in one's own day to day advanced clinical practice. b) Lead and advocate for practice that promotes the rights, responsibilities, equalities and diversity of individuals, including, (but not limited to) acting as a role model in promoting individuals' rights and responsibilities and ensuring others do the same. c) Keep up to date with mandatory training and revalidation requirements, encompassing those requiring evidence for an advanced role. d) Demonstrate insight into any personal health issues and take effective steps to address any health issue or habit that is impacting on own performance as an ACP.	**Maintaining an ethical approach and fitness to practice** a) Critically reflect on how own values, attitudes and beliefs might influence one's professional behaviour. b) Identify and act appropriately when own or others' behaviour undermines equality, diversity and human rights. c) Reflect on and address appropriately ethical/moral dilemmas encountered during one's own work which may impact on care. Advocate equality, fairness and respect for people and colleagues in one's day to day practice. d) 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. e) React promptly and impartially when there are concerns about self or colleagues; take advice from appropriate people and, if necessary, engage in a referral procedure. f) Promote mechanisms such as complaints, significant events and performance management processes in order to improve peoples' care. g) Promote mechanisms such as compliments and letters of thanks to acknowledge and promote good practice.
B2. Assessment, investigations and diagnosis	
Information gathering and interpretation a) Structure consultations so that the person and/or their carer/family (where applicable) is encouraged to express	**Information gathering and interpretation** a) Apply a range of primary care consultation models appropriate to the clinical situation and appropriately across physical, mental and psychological

The ACP must be able to:	ACP knowledge and understanding:
their ideas, concerns, expectations and understanding. b) Use active listening skills and open questions to effectively engage and facilitate shared agenda setting. c) Undertake general history-taking, and focused history-taking to elicit and assess 'red flags'. d) Deliver diagnosis and test/investigation results, (including bad news) sensitively and appropriately in line with local or national guidance, using a range of mediums including spoken word and diagrams for example to ensure the person has understanding about what has been communicated.	presentations in line with the ACP scope of practice. b) Explore and appraise peoples' ideas, concerns and expectations about their symptoms and condition and whether these may act as a driver or form a barrier. c) Synthesise information, taking account of factors which may include the presenting complaint, condition or circumstance, existing factors, past medical history, genetic predisposition, medications, allergies, risk factors and other determinants of health to establish differential diagnoses. d) Incorporate information on the nature of the person's needs preferences and priorities from various other appropriate sources e.g. third parties, previous histories and investigations. e) 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.
Examination and procedural skills a) Recognise the need for a systematic approach to clinical/functional examination and assessment. b) Ensure the person understands the purpose of any physical examination (including intimate examinations), mental health assessment, and/or other form of assessment; describe what will happen and the role of the chaperone where applicable. c) Obtain informed consent and arrange the place of examination to give the person privacy and to respect their dignity (and comfort as far as practicable).	**Examination and procedural skills** a) 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[11]), working with chaperones, where appropriate in line with the advanced practitioner's scope of practice. b) Apply a range of assessment and/or clinical examination techniques appropriately, systematically and effectively as clinically indicated within the context of the situation, managing

[11] Health Education England and Skills for Health (2019), Advanced Clinical Practice: Capabilities framework when working with people who have a learning disability and/or autism: www.skillsforhealth.org.uk/learningdisabilityandautismframeworks

The ACP must be able to:	ACP knowledge and understanding:
d) Record the information gathered through assessments concisely and accurately, for clinical management and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance.	any risk factors such as suicidal ideation promptly and appropriately. c) Use nationally recognised tools, where appropriate to assess peoples' condition.
Making a diagnosis a) Consider all the relevant evidence from the individual's history, baseline observations and tests, and clinical examination. b) Make use of clinical interpretations and reports to make justifiable assessment of the nature, likely causes and prognosis of the individual's health condition/health status. c) Formulate a differential diagnosis based on subjective and where available objective data. d) Revise hypotheses in the light of additional information and think flexibly around problems, generating functional and safe solutions. e) Discuss the diagnosis with the individual to enable them to think through the implications and how these can be managed. f) Recognise when information/data may be incomplete and take mitigating actions to manage risk appropriately. g) 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.	**Making a diagnosis** a) Extrapolate, interpret and synthesise evidence from an individual's history, baseline observations, assessments, tests, and investigations in order to make a diagnosis. b) Synthesise the expertise of multi-professional teams to aid in diagnosis where needed. c) 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. d) Exercise clinical judgement and select the most likely diagnosis in relation to all information obtained. This may include the use of time as a diagnostic tool where appropriate.
B3. Condition management, treatment/therapy and care	
Clinical management a) Consider a 'wait and see' approach where appropriate.	**Clinical management** a) Vary the management options responsively according to the circumstances, priorities, needs,

The ACP must be able to:	ACP knowledge and understanding:
b) Safely prioritise problems in situations using shared agenda setting where the person presents with multiple issues. c) Implement shared management/personalised care/therapeutic intervention/support plans in collaboration with people, and where appropriate carers, families and other healthcare professionals, ensuring the absolute focus on being person-centred and promoting health outcomes. d) Arrange appropriate follow up that is safe and timely to monitor changes in the person's condition in response to treatment and advice, recognising the indications for a changing clinical picture and the need for escalation or alternative treatment as appropriate. e) Identify when interventions have been successful and complete episodes of care with the person, offering appropriate follow-on advice to ensure people understand what to do if situations/circumstances change. f) Promote continuity of care as appropriate to the person. g) Suggest a variety of follow-up arrangements that are safe and appropriate, whilst also enhancing the person's autonomy.	preferences, risks and benefits for those involved with an understanding of local service availability and relevant guidelines and resources. b) Evidence and evaluate outcomes of care against existing standards and patient outcomes and manage/adjust plans appropriately in line with best available evidence. Utilise such evidence gathered to inform practice of self and to work across teams/organisations/systems to use such outcome evidence to effect positive changes in practice. c) Ensure safety netting advice is appropriate and the person understands when and how to seek urgent or routine review. d) Support people who might be classed as frail[12] and work with them utilising best practice.
Managing complexity a) Simultaneously manage acute and chronic problems, including for people with multiple morbidities and those who are frail[13]. b) Manage both practitioner and peoples' uncertainty. c) Communicate risk effectively to people and involve them appropriately in management strategies.	**Managing complexity** a) Apply the complexities of working with people who have multiple health conditions both physical, mental, and psychosocial. b) Prioritise appropriately & safely in the context of your advanced practice. c) Recognise the inevitable conflicts that arise when managing people with multiple problems and take steps to adjust care appropriately.

[12] Health Education England, NHS England and Skills for Health (2018), Frailty: A Framework of Core Capabilities: www.skillsforhealth.org.uk/frailty-framework

[13] Health Education England, NHS England and Skills for Health (2018), Frailty: A Framework of Core Capabilities: www.skillsforhealth.org.uk/frailty-framework

The ACP must be able to:	ACP knowledge and understanding:
d) Consistently encourage improvement and rehabilitation and, where appropriate, recovery. e) Manage situations where care is needed out of hours and understand how to enable the necessary arrangements. f) Support people appropriately and with regard for other care providers involved in their care.	
Prescribing treatment, administering drugs/medication, pharmacotherapy a) Safely prescribe and/or administer therapeutic medications, treatments and therapies 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. b) Facilitate and or prescribe non-medicinal therapies such as psychotherapy or lifestyle changes (social prescribing). c) Maintain accurate, legible and contemporaneous records of medication prescribed and/or administered and advice given in relation to medicines or treatments/advice. d) Where a Non-Medical Prescriber (NMP) critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental well-being and healthcare provision. e) Where a NMP, practice in line with the principles of antibiotic stewardship and antimicrobial resistance using available national resources. f) Where a NMP, appropriately review response to medication, recognising the balance of risks and benefits which may occur. Take account of context including what matters to the person and their experience and impact for them and preferences in the context of their life as well as polypharmacy, multimorbidity,	**Prescribing treatment, administering drugs/medication, pharmacotherapy** a) Advocate personalised shared decision making to support adherence leading to concordance. b) 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). c) Apply a range of options available other than drug prescribing (e.g. not prescribing, promoting self-care, advising on the purchase of over-the-counter medicines). d) Prescribe/promote non-medicinal treatments which may include talking therapies, exercise, dietary changes, lifestyle workplace/home changes/adaptations.

The ACP must be able to:	ACP knowledge and understanding:
frailty[14], existing medical issues such as kidney or liver issues and cognitive impairment. g) Where a NMP, confidently explain and discuss risk and benefit of medication with people using appropriate tools to assist, as necessary. h) Where a NMP, 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. i) Where a NMP, support people to only take medications, they require and deprescribe where appropriate.	

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[14] Health Education England, NHS England and Skills for Health (2018), Frailty: A Framework of Core Capabilities: www.skillsforhealth.org.uk/frailty-framework

Leadership and Management in Advanced Clinical Practice

The ACP must be able to:	ACP knowledge and understanding:
a) Work within practice and across multi-organisational and multi-professional teams, care pathways and systems. b) Respond positively when services are under pressure, acting in a responsible and considered way to ensure safe practice. c) Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working and to positively influence practice. d) Lead on and work in partnership with others to plan how to put strategies for improving health and wellbeing into effect to ensure one's own role is impactful and such impact can be measured. e) Critically apply advanced clinical expertise in appropriate faciliatory ways to provide consultancy across professional and service boundaries, influencing clinical practice to enhance quality, reduce unwarranted variation and promote the sharing and adoption of best practice. f) Demonstrate advanced team leadership, resilience and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others. g) Demonstrate the impact of advanced clinical practice on service function and effectiveness, and quality (i.e. outcomes of care, experience and safety). h) Critically and strategically apply advanced clinical expertise across professional and service boundaries to enhance quality, reduce unwarranted	a) Influence how multi-organisational and multi-professional teams, care pathways and systems function. b) Be well organised with due 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 nature of service provision. c) Critically and strategically apply advanced clinical expertise across professional and service boundaries to enhance knowledge and understanding of the health and care system. d) Internalise and disseminate an in-depth, critical knowledge of relevant and appropriate strategic drivers from a local and national level. e) Inform and influence change at a system level that builds on clinical excellence and outcomes for individuals across the system. f) Identify the clinical and corporate context of their role and scope of practice. g) Continually develop practice in response to changing population health need, engaging in horizon scanning for future developments (e.g. impacts of genomics, new treatments and changing social challenges). h) Actively enable, facilitate and support change across care pathways and traditional boundaries. i) Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit). j) Role model the values of being an Advanced Practitioner and their place of

The ACP must be able to:	ACP knowledge and understanding:
variation and promote the sharing and adoption of best practice. i) Demonstrate leadership, resilience and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others. j) 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). k) Demonstrate receptiveness to challenge and preparedness to constructively challenge others, escalating concerns that affect people, families, carers, communities and colleagues' safety and well-being when necessary. l) Negotiate an individual's scope of practice within legal, ethical, professional and organisational policies, governance and procedures, with a focus on managing risk and upholding safety.	work, demonstrating a personalised approach to service delivery and development. k) Actively engage in peer review to inform own and other's practice, formulating and implementing strategies to act on learning and make improvements. l) 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. m) Deal with compliments and complaints appropriately, following professional standards and applicable local policy. n) Lead multi-professional teams, including those working as a first contact practitioner or in an advanced role, understanding the various profession specific frameworks.

Other relevant national standards or frameworks

NHS Leadership Academy: Healthcare Leadership Model

NHS Leadership Framework Scotland

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Education in Advanced Clinical Practice

The ACP must be able to:	ACP knowledge and understanding:
a) 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. b) Actively seek and be open to feedback on own practice by colleagues to promote ongoing development. c) Embed a culture of clinical audit into one's own and others practice, ensuring a culture of continual learning and reflection which is based on research gained from one's own and others practice. d) Facilitate collaboration of the wider team and support peer review processes to identify individual and team learning and support them to address these. e) 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. f) Actively seek to share best practice, knowledge and skills with other members of the team, for example through educational sessions and presentations at meetings g) Work with HEIs to support advanced practitioner development.	a) Critically assess and address own and others learning needs, negotiating a personal development plan that reflects the breadth of ongoing professional development across the four pillars of advanced clinical practice. b) Promote and utilise supervision for self and other members of the healthcare team to support and facilitate advanced professional development. c) Supervise a multi-professional teams, including those working as a first contact practitioner or in an advanced role, understanding the various profession specific frameworks and the portfolios of evidence of capability required. d) Advocate for and contribute to a culture of organisational learning to inspire future and existing staff. e) Enable the wider team to build capacity and capability through work-based and interprofessional learning, and the application of learning to practice. f) Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities. g) Lead education in their area of expertise.

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Research in Advanced Clinical Practice

The ACP must be able to:	ACP knowledge and understanding:
a) Critically engage in research/quality improvement activity, adhering to good, ethical research practice guidance, so that evidence-based strategies are developed and applied to enhance quality, safety, productivity and value for money. b) Lead on Quality Improvement initiatives/projects – sharing outcomes and leading change. c) Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review. d) Disseminate best practice research findings and quality improvement projects through appropriate media and fora (e.g. presentations and peer review research publications). e) Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical and other active researchers.	a) Evaluate and audit own and others' clinical practice, selecting and applying valid, reliable methods, then act on the findings by critically appraising and synthesising the outcome and using the results to underpin own practice and to inform that of others. b) Utilise the evidence of best practice to inform own practice. c) 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. d) Work in partnership with others in leading research which may include HEI's.

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Appendix 1. Competences and capabilities

The terms ‘competences’ and ‘capabilities’ are both widely used in educational and workforce development literature.

The Oxford English Dictionary definitions for both terms include; ‘the ability to do something’.

Due to the similarity of these terms, they have often been used interchangeably, with little clear distinction between the two. Both require knowledge, skills and behaviours.

However, in recent years there has been a move towards making a distinction which can be summarised as follows:

To be competent is to consistently perform to the standards required in the workplace.

Competences are therefore defined standards of performance, focused on the outputs of work and observable performance. Competences include the ability to transfer and apply skills and knowledge to a range of situations/contexts – although tend to describe practice in stable environments with familiar problems.

Capabilities are the attributes (skills, knowledge and behaviours) which individuals bring to the workplace. This includes the ability to be competent and beyond this, to manage change, be flexible, deal with situations which may be unpredictable and continue to improve performance.

There is inevitably a great deal of overlap between Competences and Capabilities. Both Competences and Capabilities:

- are about ‘what people can do’
- describe knowledge, skills and behaviours
- can be the outcome of education, training or experience.

For the purposes of this framework we have used the term ‘Capabilities’ as this describes the minimum threshold standards which lead to increasing competence and allow for further self-development.

> *Capability development… requires practitioners to be able to recognise what level of competence is required within any given situation and apply this successfully, recognising the limits of their competence. Capability also requires the practitioner to have the ability to extend these limits when required and flexibly adapt to unfamiliar professional environments* (HEE, 2017 p15).

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Appendix 2. Key principles for the implementation of advanced clinical practice

Key principles for the implementation of advanced clinical practice are presented in the Multi-professional framework for advanced clinical practice in England (HEE, 2017). These key principles are described under the following headings:

2.1 Planning the workforce and governance

In identifying the need for ACP roles and their potential impact, employers need to:

1. Consider where advanced clinical practice roles can best be placed within health and care pathways to maximise their impact.
2. Define a clear purpose and objectives for advanced clinical practice roles.

   …The capabilities which reflect the area of work or specialty will be required to be clearly defined.
3. Consider and evaluate the impact of advanced clinical practice roles on service user experience and outcomes and on service delivery and improvement objectives.
4. Ensure clarity about the service area the individuals will work within.

   Understanding the level of advanced clinical practice relative to the wider team, requires the roles of all team members, i.e. those above, below and surrounding this level, to be understood…
5. Ensure clear and unambiguous support for the role from the organisation/ employer at all levels.

   The employer must recognise the responsibilities and capabilities of someone working in these roles…
6. Develop a succession plan for future workforce.

2.2 Accountability

1. Individual practitioners, as registered professionals, continue to hold professional responsibility and accountability for their practice.
2. Employers recognise and accept potential new responsibilities and greater accountability in relation to governance and support for these roles and associated level of practice.
3. Professional support arrangements, which recognise the nature of the role and the responsibilities involved must be explicit and developed.

4. Employers must ensure regular review and supervision is carried out by those who are appropriately qualified to do so.

2.3 Education and development

This section outlines the principles to support the development of the workforce to work at the level of advanced clinical practice. The document recognises and respects that there are many ways to gain and develop these capabilities. It aims to ensure that there are robust and clear routes to evidencing achievement of the capabilities…

In order to meet the diverse and ever-changing workforce needs, it is essential that an outcome driven approach to developing the workforce is utilised, using the capabilities to ensure underpinning consistency and rigor. Therefore, the focus must be on the outcome, i.e. of the capabilities being met at the required level, as opposed to the developmental input or the educational process undertaken…

The development of health and care professionals to enable them to operate at the level of advanced clinical practice, requires three elements within the workplace:

- development of competence and capability
- supervision and support in the workplace
- assessment of competence and capability

Ref: Health Education England (2017), Multi-professional framework for advanced clinical practice in England: https://www.hee.nhs.uk/our-work/advanced-clinical-practice/multi-professional-framework

HEE Centre for Advancing Practice

This framework is structured to be consistent with the emerging model of ACP Credentials being developed by Health Education England (HEE).

Developing and retaining the Advanced Practice workforce is a strategic priority for the NHS. The NHS Long-Term People Plan recognises the potential of advanced level practitioners meeting short term and long-term workforce demands; whilst the NHS People Plan is heavily supportive of scaling up and delivering new roles and models of advanced level practice. HEE is leading this agenda by working collaboratively across the health and care system, to develop safe and effective advanced level practitioners which the system can learn to recognise and utilise within new models of care. A clinical career pathway and targeted continuing professional development have the potential to support the retention of highly valued and skilled staff and facilitate workforce transformation.

To create transferable, recognisable ongoing Advanced Practice education and training, there is a need to create, for each specialty, a standardised ‘credential’ framework of learning outcomes and assessment methods, to be delivered by education providers working in partnership with service. Often, this will be as part of

approved level 7 (Master's level) learning but this may not be the only model of learning. Each 'credential' articulates learning an individual is required to successfully complete in order to be awarded that credential in that speciality.

Achievement of credentials will be evidenced by a range of methods including qualifications or awards which are aligned to the credentials, evidence of prior learning and/or demonstration of current competency to carry out specific professional related activities. This combined clinical and academic delivery will better meet the needs of service, offering standardised and nationally transferable training routes for the workforce, recognisable to employers, employees and patients.

A key component of this work is the development by HEE of a Centre for Advancing Practice, which will accredit Advanced Practice programmes. Successful completion of a HEE accredited Advanced Practice programme will enable recognition as being educated to the national standard of advanced level of practice.

Appendix 3. How the framework was developed

Development of the framework was guided by a project steering group representing key stakeholders, including Health Education England, College of Podiatrists, Skills for Health and practitioners from a range of NHS Trusts and other key stakeholders in England; there was also representation from healthcare organisations in other parts of the UK (see Appendix 4). A wider stakeholder list was established to include a more diverse range of organisations and individuals that wished to be updated on development of the framework and to provide comments or feedback as part of the consultation process. Individuals were able to register their interest from a project web page.

Initial desk research was undertaken to identify key references, resources and significant themes or issues for consideration – further references and resources continued to be identified during the project (see Appendix 6: References and Resources). Initial iterations of the framework were developed based on the findings of the desk research and consultation with the project steering group. Subsequently, in June 2019, a wider online consultation survey was conducted, with a total of 224 respondents. Based on analysis of these survey outcomes, further amendments and refinements were undertaken, leading to a final meeting of the project steering group in August 2019.

Subsequently the framework was structured to be consistent with the emerging model of ACP Credentials being developed by Health Education England (HEE).

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Appendix 4. The project steering group

Name	Role	Organisation
Ahmad, Naseer	Consultant Vascular Surgeon	Manchester University NHS Foundation Trust
Atkin, Leanne (Dr.)	Vascular Nurse Consultant & Lecturer Practitioner Division of Podiatry and Clinical Sciences	Mid Yorkshire Hospitals NHS Trust & The University of Huddersfield
Cawley, Scott	National Diabetes Foot Co-ordinator Wales	NHS Wales
Chadwick, Paul (Dr.)	Clinical Director	The College of Podiatry
Coughtrey, James	Head of Education & Professional Development	The College of Podiatry
Game, Frances (Prof.)	Consultant Diabetologist and Director of Research & Development	University Hospitals of Derby and, Burton NHS Foundation Trust
Gohil, Krishna	High Risk and Diabetes Specialist Podiatrist	The College of Podiatry
Gosling, Sally	Assistant Director	The Chartered Society of Physiotherapy
Harden, Beverley	Associate Director of Education & Quality, South	Health Education England
Killough, Denise	Professional Head of Podiatry Service	Belfast Health and Social Care Trust
Pankhurst, Christian	British Association of Prosthetists and Orthotists	Guy's and St Thomas' NHS Trust
Wright, Colin	Development Manager (Frameworks)	Skills for Health
Wyles, Hilary	Senior Consultant	Skills for Health
Wylie, David	Head of Podiatry	NHS Greater Glasgow & Clyde
Yates, Ben	Podiatric Surgeon & Regional Dean	Great Western NHS Trust

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Appendix 5. Glossary of terms

Term	Definition
Acute	Acute conditions are sudden and severe in onset.
Advanced clinical practice	Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.
Capability	Capabilities are the attributes (skills, knowledge and behaviours) which individuals bring to the workplace. This includes having the potential to be competent and beyond this, to manage change, be flexible, deal with situations which may be unpredictable and continue to improve performance.
Competence	A defined standard of performance focused on the outputs of work and observable performance. Competence includes the ability to transfer and apply skills and knowledge to a range of situations/contexts although tends to describe practice in stable environments with familiar problems.
Chronic	Chronic conditions are of long-term duration.
Differential diagnosis	Developing a working diagnosis by systematic consideration of the various possibilities
Frailty	A long-term condition particularly related to the ageing process in which multiple body systems gradually lose their in-built reserves. It is now widely recognised as a state of reduced resilience and increased vulnerability, which results in some people becoming more vulnerable to relatively minor changes in their circumstances which can lead to a deterioration in their health and/or ability to live independently.
Health inequalities	Differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes (WHO).
Health literacy	The personal characteristic and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health (WHO).
High Risk	High risk conditions are those which involve difficult healing and the risk of losing a foot or lower limb as a result of their underlying condition(s).

Term	Definition
Multi-professional	Multi-professional care is an integrated team approach to healthcare. The evaluation of treatment options and treatment planning are collaborative processes involving medical and allied healthcare professionals in partnership with the patient and the patient's family. Individual, patient-specific treatment plans are developed, and delivery of care becomes a shared responsibility. The principles of multi-professional care identify five key elements: • A team approach, involving specialists, the general practitioner and allied healthcare professionals including a supportive care provider, who deals with the psychosocial aspects of care. • Regular communication among team members. • Access to a full range of therapeutic options, irrespective of geographical remoteness, rural or urban healthcare service. • Provision of care in line with national standards, and treatment decisions based on adequate information. • Patients are involved in their care discussions and management and receive timely and appropriate information from the healthcare professionals.
Personalised care	Care that takes account of and actively promotes individuality, rights, choices, privacy, independence, dignity, respect and partnership.
Shared decision making	Putting people at the centre of decisions about their own treatment and care by: • exploring care or treatment options and their risks and benefits • discussing choices available • reaching a decision about care or treatment, together with their health or social care professional or support worker.
Self-management support	When health professionals, teams and services (both within and beyond the NHS) work in ways that ensure that individuals with long-term conditions have the knowledge, skills, confidence and support they need to manage their condition(s) effectively in the context of their everyday life.
Supporting behaviour change	Encouraging individuals to adopt a healthier lifestyle by, for example, stopping smoking, adopting a healthy diet, being more physically active, better blood sugar control or adherence to medicines.

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Multi-Professional Advanced Capabilities Framework for Lower Limb Viability

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