

GPwER in MSK Medicine Framework

Guidance to the role, competencies, and accreditation for GPs
with an Extended role in Musculoskeletal Medicine and
Rheumatology



The Primary Care
Rheumatology and
Musculoskeletal
Medicine Society



Faculty of Sport
and Exercise
Medicine UK



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1. Introduction

This document outlines a standardised pathway for clinicians to follow in supporting their work as a GP with an Extended Role in Musculoskeletal Medicine and/or Rheumatology, including the competencies required, the pathways to accreditation, and the requirements for maintaining good practice in the role. This relates to roles within NHS England and does not cover the devolved nations. In such cases, we recommend referring to the appropriate local or national guidelines.

This has been developed during a significant period of change for musculoskeletal services within the NHS, including the development of a new breed of clinicians working within and across the traditional boundaries of primary and secondary care. This framework has been designed to align with those for other allied health professionals working in extended roles, ensuring equity and facilitating the interprofessional working that these settings require.

The intention is that this will support and entrench the vital addition that a GP with an extended role makes as a core member of a multidisciplinary team in a community musculoskeletal setting.

1.1 Evolving MSK Services – setting the scene

Back in 2000, recognising significant difficulties with the cost of, and access to, specialist advice, there was a plan to reform the NHS workforce¹ and create a new breed of GPs termed 'GPs with a Specialist Interest (GPwSI)'. These roles evolved from historical posts such as Clinical Assistants, where GPs often worked alongside consultants in a range of specialities. These roles enabled the development of specialist skills and knowledge to allow them to take referrals from their GP colleagues to deal with issues such as rheumatological presentations, drug addiction, women's health, and dermatology. The principle of the GPwSI title usefully identified the need for these roles to be based in primary care, driving changes to pathways to promote more community-based care.

In 2006, the Department of Health published the Musculoskeletal Services Framework² that identified a series of problems in existing musculoskeletal care, including long waiting times, inconsistency in pathways and variable outcomes of care. It made a strong case for community MSK services staffed with multidisciplinary teams. This led to a revolution in the workforce, with the development of extended role practitioners drawn from physiotherapy services, as well as the recognition of the input of GPs with a Specialist Interest and other allied health professions. The 2019 NHS Long Term Plan³ further emphasised these changes in the workforce, including the more recent development of First Contact Practitioners. It was recognised that the advent of these advanced practice roles required nationally recognised, standardised frameworks to support governance around these roles.

Historically, these roles relied on locally designed competency frameworks and appraisal, leading to a potential variance in standards of practice. In response to this, NHS England commissioned Health Education England to develop standardised pathways to advanced practice, which were formally launched in 2020⁴ with the intention that clinicians working in these settings would need to provide robust evidence of competency and governance around the role.

¹ Department of Health. The NHS plan: a plan for investment, a plan for reform. London: HMSO; 2000.

² Department of Health, 2006. The Musculoskeletal Services Framework—A Joint Responsibility: Doing it Differently.

³ [NHS Long Term Plan](#)

⁴ [HEE Multiprofessional framework for advanced clinical practice in England](#)

1.2 The RCGP Framework to support the governance of GPwERs

The Royal College of General Practitioners (RCGP) recognised a similar need to standardise training and accreditation and provide evidence of a level of sufficient competency for GPs working in several specialist areas. This led to the publication of a generic framework⁵ for clinicians working in an extended role with the following goals:

- (To create an) authoritative GPwER guide. Being relevant to all specialisms, the framework describes a set of principles in relation to GPwER and explains how competence is demonstrated, both initially and on an ongoing basis.
- (To) create a generic format for specialism specific GPwER frameworks and criteria to inform their development.
- (To) establish criteria for processes that accredit the individual GPwER, with the expectation that GPs will value accreditation in some specialisms, but not all

The subtle, but significant, shift in terminology from being a GP with a ‘Specialist Interest’ to a GP with an “Extended role” has helped redefine what such an extended role means. The term GPwER exemplifies the professionalisation of this role and that this exists outside of the usual GP scope of practice, requiring additional evidence of competency and ongoing professional development.

The RCGP definition of a GPwER is one who maintains a role in primary care but undertakes:

- an activity that is beyond the scope of GP training and requires further training
- an activity undertaken within a contract or setting that distinguishes it from standard general practice
- an activity offered for a fee outside the care provided to the registered practice population (e.g. teaching, training, research, occupational medical examinations, medico-legal reports and cosmetic procedures).
- (management of) referrals for assessment and treatment from outside their immediate practice and undertake work that attracts an additional or separate medical indemnity fee.

ROYAL COLLEGE OF GENERAL PRACTITIONERS 2020

In June 2018, a successful pilot of accreditation for GPs working in an extended role in dermatology was conducted, paving the way for other organisations and specialities. The British Association of Dermatologists now provides routes to accreditation for Dermatology GPwERs as a result⁶. This highlighted how speciality organisations can work alongside the RCGP and provide a more comprehensive approach to accreditation and training of GPwERs.

Building on this example, the Faculty of Sports and Exercise Medicine has collaborated with The Primary Care Rheumatology & Musculoskeletal Medicine Society and the British Association of Sports and Exercise Medicine to support a standardised national framework that enables clear demonstration of competencies and accreditation around the roles of a GP with an extended role in Musculoskeletal Medicine and a GP with an extended role in Rheumatology.

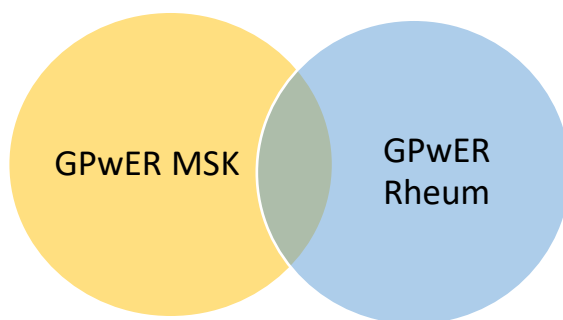
⁵ [RCGP framework for GPwER](#)

⁶ [GPwER Dermatology Pathway](#)

2. Defining the roles of the GPwER in MSK Medicine & Rheumatology

The activities of the GPwER in MSK medicine will vary depending on the clinic setting, local needs, and available resources. Importantly, a GPwER is not simply a 'mini-consultant', the ability to provide holistic assessment and management of the patient, including managing multiple comorbidities, complexity and uncertainty, is based on the generalist skill set of a GP that provides a unique and valued addition to any community MSK team.

This pathway relates to two discrete sub-categories for an individual GPwER to work in, namely a GP with an extended role in Musculoskeletal Medicine and a GP with an extended role in Rheumatology. The accreditation of GPs working in Team sport or Exercise medicine is not covered within this document, but guidance on this and information regarding the relevant diploma exams may be found on the faculty website (www.fsem.ac.uk).



Both categories of GPwER can be thought of as sharing the same core skill set, including the importance of identifying patients with possible autoimmune or inflammatory conditions, as these may be encountered in any MSK setting; however there are additional capabilities required to work in a community rheumatology setting that can be described as follows:

1. **GP with an extended role in Musculoskeletal Medicine** – may work within existing community pathways with a focus on the non-surgical management of musculoskeletal problems, including within hip, knee, shoulder, hand & wrist, foot & ankle, chronic pain, and spinal pathways.
2. **GP with extended role in Rheumatology** – will work alongside rheumatology colleagues in secondary care settings with specialist knowledge of the diagnosis and management of inflammatory/autoimmune conditions, metabolic bone disease, vasculitis, and connective tissue disease.

3. Curriculum

3.1 Curriculum: Competencies

Clinicians working in extended roles are expected to maintain the generic competencies introduced by the GMC in 2017, in which the patient is at the centre of any consultation and decision-making⁷ outlined across nine domains.

- Domain 1: Professional values and behaviours
- Domain 2: Professional skills
- Domain 3: Professional knowledge
- Domain 4: Capabilities in health promotion and illness prevention
- Domain 5: Capabilities in leadership and team working
- Domain 6: Capabilities in patient safety and quality improvement
- Domain 7: Capabilities in safeguarding vulnerable groups
- Domain 8: Capabilities in education and training
- Domain 9: Capabilities in research and scholarship

⁷ [Generic Professional Competencies](#)

Proof of having satisfactorily evidenced these competencies is provided by having attained a certificate of completion of training (CCT) as either a GP or a speciality doctor in the UK. The 2019 GP curriculum maps directly to these core competencies with the essential capabilities as outlined below:



Essential capabilities in practice, 2019 GP Curriculum

In addition to these core competencies, additional, speciality-specific competencies are required to enable the practitioner to work in an extended role. These have been drawn from the Sports and Exercise Medicine speciality guidance and the Joint Royal Colleges of Physicians Training Board curriculum for rheumatology speciality capabilities in practice (CiPs) and practical procedures, adapted for the proposed GPwER in MSK and rheumatology accreditation. They align in large part to the clinical standards identified by the Centre for Advanced Practice, which set out the core competencies for clinicians from a range of specialities to work across a range of clinical settings in musculoskeletal practice.

Evidencing these competencies is demonstrated using triangulation between multiple sources, including senior clinical supervisor structured reports, passing the Faculty of Sports and Exercise Medicine MSK Diploma exam, workplace-based assessments (DOPs/CEX/CBDs) and audit gathered during a GPwERs training, including elements contributing to annual appraisal.

3.2 Curriculum: Capabilities in practice (CiPs)

3.2.1 Speciality Specific CIPS – Musculoskeletal Medicine

The GPwER curriculum is structured into three separate high-level learning outcomes, known as Capabilities in Practice (CiPs). The CiPs are split into musculoskeletal and rheumatology-specific capabilities, as outlined below.

Applicants must demonstrate that they are currently practising at the level of 'entrusted to act independently' in all speciality CiPs.

Speciality CiP 1: Working effectively as part of a multi-disciplinary team

- 1.1 Understands the principles of, and uses, effective inter-professional collaboration to optimise patient and population care across all care settings
- 1.2 Understands the features of good team dynamics

- 1.3 Demonstrates ability to synthesise complex clinical and psychosocial information, leading to patient-centred clinical decision making
- 1.4 Demonstrates involvement in audit, quality improvement activity and/or research
- 1.5 Demonstrates ability to support, educate, influence, and develop members of the wider multi-professional team to deliver high-quality musculoskeletal medicine care across all care settings for all patients
- 1.6 Shows an ability to coordinate care across multiple agencies to address physical, psychological, and social needs in the community
- 1.7 Demonstrates attitudes and behaviours that assist the dissemination of good practice
- 1.8 Understands personal and team resilience and its impact on team effectiveness
- 1.9 Supports an open and transparent approach to incident and complaint investigation, management, and resolution

Speciality CiP 2: Ability to deliver comprehensive, community-based management of musculoskeletal problems

Key skills:

- 2.1 Understand the burden of musculoskeletal problems across socio-economic and ethnic minority groups, those with disabilities and co-morbidities
- 2.2 Demonstrates the ability to help develop clinical services and pathways that meet local needs alongside community, primary and secondary care colleagues
- 2.3 Demonstrates the ability to assess, appropriately investigate and diagnose patients with a wide range of acute and chronic musculoskeletal conditions
- 2.4 Demonstrates the ability to formulate a multi-disciplinary management plan to optimally treat patients across the spectrum of musculoskeletal problems, following the latest guidelines and best practices
- 2.5 Demonstrates effective consultation, time management and prioritisation skills within a busy outpatient setting
- 2.6 Understands the pathophysiology of tissue injury and repair and its relevance to management and rehabilitation decisions
- 2.7 Demonstrates the knowledge and understanding of working with a multidisciplinary team to support the rehabilitation and treatment of people with musculoskeletal problems
- 2.8 Identify and re-direct management of malignancy, infection, and inflammatory pathologies
- 2.9 Can identify risk factors and contributors to musculoskeletal injury
- 2.10 Demonstrates knowledge and utilisation of pharmacological and non-pharmacological approaches to the management of musculoskeletal pain
- 2.11 Safely and appropriately perform intra-articular and soft tissue injections for musculoskeletal conditions using, or referring on for image guidance where appropriate
- 2.12 Has full knowledge of different imaging techniques, including safe practice and limitations

3.2.2 Speciality Specific CIPS – Rheumatology

For accreditation with the FSEM a GPwER in Rheumatology would be expected to meet the MSK competencies in 3.2.1 as well as additional capabilities below.

Understands and can apply in practice the following:

- 3.1 Aetiology and pathophysiology of musculoskeletal and rheumatological conditions, including inflammatory arthritis, connective tissue diseases, vasculitis, metabolic bone disease and paediatric and adolescent rheumatological disease.
- 3.2 The diagnostic criteria for rheumatological and musculoskeletal conditions, differential diagnoses, and risk factors.
- 3.3 The relevant treatment pathways for these conditions including taking a shared decision-making approach with patients, their families, and carers where relevant

- 3.4 Appropriately requesting investigations such as blood tests, radiological investigations, X-rays, US, CT, and MRI.
- 3.5 Coordinates multidisciplinary, multi-agency patient management and follow-up, including the knowledge of when and where to refer a patient to other clinicians within the team and to other specialities.
- 3.6 Age-appropriate scoring and measurement tools relevant to disease monitoring
- 3.7 Aware of the distinctions between paediatric and adult-onset disease and the natural history of rheumatological conditions.
- 3.8 Able to distinguish between normal, osteopenia and osteoporosis dual energy-ray absorptiometry (DXA) results and resulting treatment options.
- 3.9 The individual and national health burden of rheumatological conditions and their impact on patients and services.
- 3.10 The differences between delivery of care in a paediatric, adolescent, young person, and adult care setting.
- 3.11 The main drug therapies available including analgesia, non-steroidal anti-inflammatory drugs (NSAIDs), disease-modifying anti-rheumatic drugs (DMARDs), immune modulatory drugs and corticosteroids.
- 3.12 Able to counsel a patient and identify the impact of combination therapies, and the risks related to immunosuppression
- 3.13 Problems with bone health, including the relevance of diet, vitamin D, micronutrients, exercise, and associated risk factors.
- 3.14 Safe and accurate prescribing of medication, joint aspiration, and injection.

3.3 Curriculum: Syllabus content

For each condition/presentation within the syllabus, GPwERs wishing to work within their specific area of interest will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management, and prognosis.

Although the exact treatment care and strategy approach adopted by the GPwER will depend on the service and tier in which the GPwER is working, as a requirement for GPwER accreditation, the individual will need to demonstrate an awareness of these conditions, the basis on which diagnosis is made and basic first-line management. It is also expected that the GPwER will understand when and to whom to refer, as well as the urgency of referral.

3.3.1 GPwER Musculoskeletal Medicine – Presentations and conditions

To establish a formal applied knowledge test for a practitioner in an extended role in MSK Medicine, a committee was convened, including members of the Primary Care Rheumatology and Musculoskeletal Medicine Society and the Faculty of Sports and Exercise Medicine to create a syllabus (Appendix 1). This syllabus forms the basis of a new applied knowledge test in the form of the FSEM MSK Diploma exam, intending to set a benchmark of the entry-level knowledge required to work in an advanced role in community MSK and primary care settings.

This syllabus covers the most encountered musculoskeletal health issues in primary care, including:

MSK Conditions & Principles	Acute and chronic pain neurophysiology Tendinopathy Osteoarthritis Rheumatoid Arthritis Erosive OA Spondyloarthropathies Connective Tissue disorders Vasculitis
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	Gout/Pseudogout Infection Malignancy Chronic pain states including fibromyalgia, CRPS, Regional pain syndromes Polymyalgia Rheumatica (+/- Temporal Arteritis) Osteoporosis (including fracture risk assessment tools)
Paediatric MSK Conditions	Apophysitis Scheuermann's Disease Juvenile Degenerative Disc Disease Pars interarticularis injury Slipped Upper Femoral Epiphysis (SUFE) Perthes Osgood-Schlatter's disease Severs Disease Juvenile Inflammatory Arthritis
Regional disorders	
Shoulder	Frozen shoulder Subacromial pain syndrome Osteoarthritis Instability
Elbow	Extensor & Flexor Origin Tendinopathy Cubital Tunnel Syndrome Olecranon bursitis Degenerative & Inflammatory Arthropathy
Hand & Wrist	Carpal Tunnel Syndrome Trigger Digit/Finger Degenerative & Inflammatory conditions Ganglion Cyst Dupuytren's Disease Tenosynovitis TFCC injury
Spine	Serious Pathologies – Cauda Equina Syndrome, Malignancy, Infection, Trauma, Inflammatory disease Radiculopathy Lumbar pain Cervical pain Thoracic pain
Hip	Osteoarthritis Groin pain and Femoro-acetabular Impingement Greater Trochanteric Pain Syndrome Buttock pain
Knee	Osteoarthritis Patello-femoral pain Tendinopathy Bursitis Meniscal injury Ligament injury Popliteal cyst
Foot & ankle	Achilles Tendinopathy

	Posterior Tibialis Tendon Dysfunction (PTTD) Neural impingement Plantar Fasciitis Lateral Ankle Problems following sprain injury Ankle OA Mid-foot OA 1st MTPJ OA Metatarsalgia (including Morton's neuroma)
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3.3.2 GPwER Rheumatology syllabus

This additional syllabus is based on the Joint Royal Colleges of Physicians Training Board curriculum for rheumatology training draft speciality capabilities in practice (CiP)⁸ adapted for the proposed GPwER in MSK and rheumatology accreditation (further details can be seen within Appendix 4)

Clinical area	Presentations	Conditions/Issues
Inflammatory arthritis	Monoarthritis Polyarthritis	Septic arthritis Gout/Pseudogout Chronic infectious arthritis – Mycobacterial arthritis, Lyme disease Viral arthritis – Parvo, Hepatitis and HIV-associated arthritis Reactive arthritis Psoriatic arthritis Rheumatoid arthritis Unclassified inflammatory arthritis Arthritis associated with immunodeficiency Sarcoidosis – Lofgren's syndrome Palindromic arthritis
Spondyloarthropathy	Inflammatory back pain Oligoarthritis Enthesitis Dactylitis	Axial Spondyloarthropathy (AxSpA) (Radiographic/Non-radiographic) Peripheral manifestations of AxSpA IBD associated arthropathy/SpA Reactive arthritis Undifferentiated Spondyloarthropathy
Connective tissue diseases	Facial rashes Discoid rash Renal disorders Scleroderma and Raynaud's Haematological disorder Neurological disorders including peripheral and central syndromes Thrombophilia Sicca syndrome Salivary/Lacrimal gland swelling Lymphadenopathy	SLE Cutaneous LE SLE-associated nephritis Sjogren's syndrome Systemic sclerosis and associated conditions Inflammatory myopathies Overlap syndromes Antiphospholipid antibody syndrome

⁸ [Curriculum for Rheumatology Training](#)

	Muscle weakness with or without rash Serositis	
Vasculitis	Pulmonary-renal syndromes Systemic illness with multiorgan disease Rash and arthritis/nephritis/lung disease Uveitis Scleritis Deafness – sensorineural External ear disease	ANCA-associated vasculitis Granulomatosis with Polyangiitis (GPA), Eosinophilic Granulomatosis with Polyangiitis (EGPA), Microscopic Polyangiitis (MPA) Non-ANCA Vasculitis – Polyarteritis Nodosa (PAN) Behcet's disease Large Vessel Vasculitis -Takayasu's arteritis, Giant Cell Arteritis Leukocytoclastic vasculitis Vasculitis Cryoglobulinemia Relapsing polychondritis
Auto-inflammatory disorders	Pyrexia of unknown origin Fever and rash Fever with multi-organ dysfunction Serositis	Periodic fever syndromes Familial Mediterranean fever Adult-onset Still's disease Macrophage activation syndrome Amyloidosis Sweet's syndrome
Multi system disease – others	Lymphadenopathy Granulomatous diseases Retroperitoneal fibrosis Immunodeficiency Inflammatory eye disease	Sarcoidosis Castleman's disease/Histiocytic syndromes IgG4 disease Uveitis Scleritis
Bone disease	Pathological fracture Insufficiency fracture Stress fracture Bone pain Laboratory abnormalities of calcium, phosphate, alkaline phosphatase Incidental radiographic abnormalities	Osteoporosis Osteomalacia Postmenopausal osteoporosis Male osteoporosis Paget's disease of the bone Osteonecrosis Atypical femoral fractures Transient regional osteoporosis

3.2.4 Practical skills & procedures

There are several procedural skills in which a trainee must become proficient as a GPwER.

Trainees must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting help when appropriate. For all practical procedures the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

Trainees should receive training in procedural skills in a clinical skills lab if required. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool. The table below sets out the minimum competency level expected for each of the practical procedures. When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct).

Required

- Large joint injections: Knee/shoulder
- Medium joint injections: Wrist, elbow, and ankle
- Small joint injections: MCPJ, MTPJ, PIPJ
- Soft tissue injections: Bursa, tendon sheath, plantar fascia, epicondylitis, carpal tunnel

Additional (desirable but not essential)

- Ultrasound-guided joint or soft tissue injections
- Fluoroscopy-guided injections

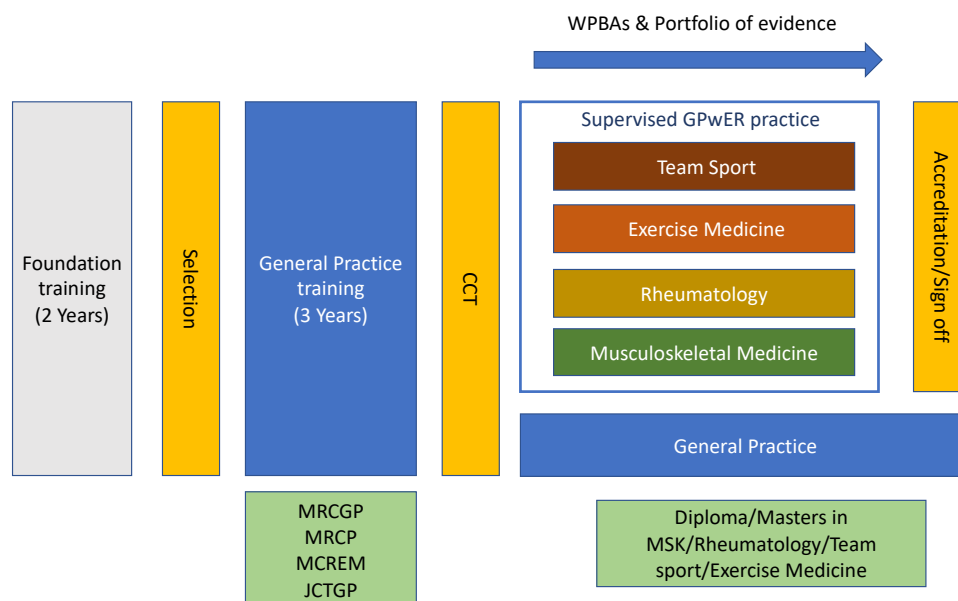
3.4 Curriculum: Teaching & Learning

Pathways to Practice

The clinicians that this career pathway would be relevant include;

- Clinicians already working in an extended role (traditionally known as GPs with a specialist Interest (GPwSIs))
- Clinicians who have transferred to General Practice from other speciality areas, wishing to work in an extended role
- Clinicians who have gained a CCT in General Practice and who wish to develop an extended role in the future.

Irrespective of experience or current role, any GP aspiring to be accredited with the FSEM would need to submit evidence to satisfy the same capabilities in practice. Accreditation in other GPwER roles with the faculty of sports and exercise medicine in the future will include Team sport as well as Exercise Medicine; these are not covered within this pathway.



The prerequisites for initial accreditation as a GPwER, as laid out by the RCGP include:

- Evidence of a CCT or equivalent in General Practice
- Evidence of being currently registered, licensed and in good standing with the GMC
- Continuing to work in a primary care role, be on a performer's list for General practice and have evidence of annual appraisal as a GP (not just in the extended role)

Theoretical training

There is a range of institutions and organisations that provide theoretical training for those wishing to become GPwERs or for existing GPwERs wishing to explore continuing professional development. A list of resources outlining many of these can be found in Appendix 5. This is not exhaustive, and new courses and university programmes are continually evolving. Postgraduate courses and qualifications should be of a suitable level of learning (ideally at QAA HE level 7) and appropriately accredited for them to be included in a portfolio of evidence.

Opportunities to acquire relevant knowledge are manifold and not limited to the postgraduate period, and could include:

- Hospital and community MSK clinics
- Postgraduate qualifications in MSK Medicine, Rheumatology or SEM.
- Attendance at recognised meetings, lectures, conferences, and courses
- Online learning via suitably recognised portals with evidence of completion.

Clinical training

It is expected that any clinician working towards accreditation in an extended role will continue to work as a general practitioner regularly, providing evidence that they are working to a high standard with ongoing appraisal and revalidation.

From this foundation, the aim would be to accrue enough clinical experience and additional learning to meet the definition of a GPwER as a 'Specialist Generalist', someone who can work as an autonomous practitioner in primary care and other community-based clinic settings, providing a high standard of care for musculoskeletal conditions.

It is expected that any individual will have a named supervisor of practice who will support the trainee and guide them in this process. The supervisor should be appropriately qualified for their role and be familiar with the accreditation process.

Evidence of competency may be compiled within existing practice. It would recognise prior experience and competency frameworks that may have been worked towards for existing roles as part of the submission. There are several ways evidence could be compiled, including:

- During training posts within a vocational training scheme, e.g., integrated training posts (ITPs), which present an ideal opportunity to gain role-specific learning and supervised practice.
- As a GP speciality trainee with a GP Speciality training attachment (during ST1 year)
- As a speciality or hospital doctor working under the supervision of a consultant (e.g., in Rheumatology, Orthopaedics, Pain medicine, or SEM)
- Working with an existing GPwER in a community specialist clinic.
- Working with a specialist in a clinical placement under local arrangements

3.4 Curriculum: Assessment

The Faculty of Sport and Exercise Medicine sets the standard for those working, or wanting to work, as a GPwER in musculoskeletal medicine and rheumatology. This process of assessment and accreditation provides a clear, standardised pathway to accrue the relevant knowledge and experience to work

autonomously as a GPwER. By working to the standards already set by specialist groups it provides a 'gold standard' of assessment and further professionalises the role that can facilitate, promote, and protect employment in the role.

3.4.1 Assessment as a new GPwER

During a period, likely to be not less than 18-24 months, a clinician who has not previously been through any assessment of competence in the role as a GPwER will need to gather evidence of competency using the range of learning approaches and assessments relating to activity within 5 years before submission. They can formally submit their portfolio of evidence alongside the senior clinical supervisors' structured reference to an accreditation panel under the remit of the FSEM. This panel would meet at least annually to assess submissions and provide feedback, as well as formal accreditation where acceptable.

An electronic record should be kept of evidence to demonstrate competence for the role that should include:

- Form 1: Portfolio of evidence
- Form 2: Injection logbook
- Form 3: DOPS template
- Form 4: Learning diary
- Forms 5a&b: Patient feedback and analysis (minimum 25 returns)
- Form 6: Multi-source feedback forms (minimum 5 returns)
- Form 7: Audit - guidance
- Form 8: Senior clinical supervisor report
- Evidence of successfully passing the FSEM Diploma in MSK medicine (and any other qualifications relevant to the role)
- Summary of the last core GP appraisal summary and copies of BLS, Safeguarding training.
- Any other relevant information

Should the evidence meet the requisite standards, then the candidate would be accredited by the Faculty of Sport and Exercise Medicine and their name entered onto a register of accredited GPwERs. Further support and guidance for GPwERs is available for Diplomate members of the FSEM and allied organisations.

Candidates whose portfolio is found lacking in the required evidence would be given feedback on what is needed and invited to resubmit when they have addressed any deficits in their submission.

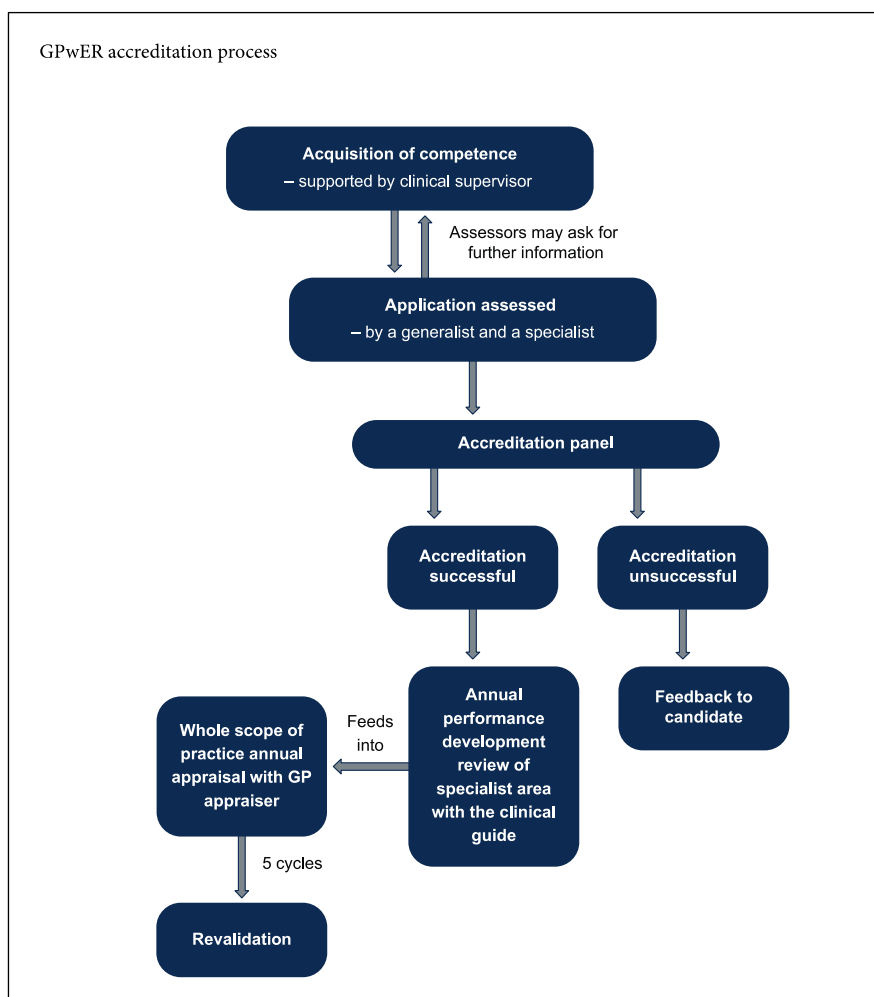
3.4.2 Assessment as an existing GPwER

There is a single pathway to accreditation irrespective of point of origin. This means that individuals already working in an extended role would be invited to submit the same evidence; however, they would also be invited to submit any previous local assessments of competency alongside recent audits, PSQs, MSFs, etc., as evidence provided that this was gathered within the last 5 years before accreditation.

Role-specific appraisal and professional development, and evidence of audit, QI in the service would be encouraged.

Candidates would be expected to submit the senior clinicians' structured supervisor's report, which must relate to regular and long-standing clinical interaction with the candidate. The senior clinical supervisor is usually expected to be a consultant or an associate specialist supervising within their scope of practice; however, senior clinicians in other specialities (e.g., physiotherapy) working at consultant grade would be acceptable.

This would sit within the suggested framework as set by the RCGP, as outlined below.



4. Maintaining practice: Continued professional development & Appraisal

To maintain competency in a specialist role and ensure adequate exposure to sufficient cases and exposure to colleagues, the GPwER would undertake a minimum of 40 sessions in a year, which relates to the RCGP, BMA, and NHS England agreed threshold for a low volume of work.

It is expected that the GPwER will undertake an annual appraisal in their specialist role, which will then inform their broader appraisal covering their entire scope of practice, as per the RCGP guidance. This would mirror the evolving GP appraisal process and be adapted to recognise workforce development and national guidance (for example, this would be reduced to mirror requirements during the COVID-19 pandemic).

Within the annual appraisal, there would need to be evidence of a personalised development plan (PDP) for the year. To aid with this process, the GPwER should expect to establish regular managerial and clinical supervision that should be with relevant named individuals with appropriate experience and roles (this may include supervision from clinicians outside the employing organisation).

Further evidence of continued professional development can take the form of quality improvement activities, including:

- Relevant courses and seminars attended
- Significant event reviews
- Reflections on case discussions
- Clinical audit and research

- Feedback from patients and colleagues
- Service design and development activities
- Reflection on teaching and training undertaken for peers/colleagues

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