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ROYAL COLLEGE of PODIATRY

First Contact Podiatrists
Growing the profession

Who we are:

The Royal College of Podiatry is the academic authority for podiatry in the UK and the professional body and trade union for the UK's registered podiatrists. We provide information to the public, media and health organisations; we also give professional and employment support to podiatrists in the UK.

Further foot health information:

The Royal College of Podiatry website **www.rcpod.org.uk** provides a wealth of information on common foot conditions and general foot health advice.

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First Contact Podiatrists - Growing the profession

Overview and Background

With the 2019 publication of - Advancing our health: prevention in the 2020s[1], the vision was:

'The 2020s will be the decade of proactive, predictive and personalised prevention.'

To help deliver care closer to home, in primary care, the Additional Roles Reimbursement Scheme (ARRS) resource became available for band 7/8a first contact practitioners (FCPs) to be utilised by GPs within Primary Care Networks (PCNs) to support local population need.

This began with physiotherapy in 2014 to help the GP shortfall and more recently Paramedic, Podiatry, Occupational Therapy and Dietetics have joined this group. To support these new roles, road maps were published for each profession, directing the scope, training, and competencies.

What were the drivers for Podiatry involvement:

A survey of 2,500 people were asked: 'Would you like to see other health professionals in the primary care team without going through your GP?'

Over 85% of respondents indicated that they would wish to see a podiatrist working as a FCP. This was the highest score amongst the fifteen professions who were listed, which demonstrates the need and demand for podiatrists to be working as FCPs in Primary Care.[2]

According to the Podiatry FCP roadmap[3] podiatrists are experts in the diagnosis of conditions affecting the foot and ankle. Within primary care, the FCP podiatrist will apply their specialist knowledge of foot health across a broad range of clinical presentations spanning: musculoskeletal, cardiovascular, neurological, dermatological, as well as a focus on conditions that present in the older adults, and children and young people.

First Contact Podiatrists working in Primary Care are trained to request and interpret a range of diagnostic tests, such as x-rays or blood tests, to help inform a diagnosis. Upon diagnosis, First Contact Podiatrists can provide personalised self-management advice, formulate treatment plans, or refer to other services.

First Contact Podiatry Goals

- Prevent or delay the onset of long-term conditions affecting the foot and ankle
- Preserve foot and ankle health, reducing the risk of wounds, infection, or amputation
- Preserve foot and ankle function, reducing the risk of immobility, or secondary consequences of reduced physical activity
- Reduce foot and ankle pain and support people living with long-term pain
- Reduce hospital admissions and secondary care referrals
- Lead medicine management for conditions primarily affecting the foot and ankle, saving GP time and resource.[3]

8% of GP consultations for MSK are for foot and ankle pain. Enabling people who have foot pain to self-refer to a podiatrist working as a FCP has the potential to significantly reduce the burden of foot and/or ankle pain on GPs, improve patients' quality of life and prevent work-related absence.[1]

20% of people aged 60+ in the UK are affected by Peripheral Arterial Disease, this is about 9% of the total population. Podiatrists specialise in the early detection and management of this condition preventing avoidable heart attacks, strokes, amputation and early death.[4]

To support these roles, GP mentorship alongside core skills and additional competencies, such as non-medical prescribing, injection therapy, minor surgery and wound care alongside health screening have the potential to reduce GP time within the scope of the following areas:

- Older adults
- Children and Young People
- Neurology
- Cardiovascular
- Musculoskeletal
- Dermatology

Survey Data Results and supporting FCP audit data

Current Position

In 2022 there were approximately 30-35 podiatrists in England working as FCPs. Podiatrists are generally recruited by the PCN. There was only one NHS community provider (that we know of), providing FCP podiatrists via secondment.

To support the emerging roles, the Royal College of Podiatry supported Dr Jill Halstead and Usamah Khalid to begin the FCP project. In May 2021 the National Primary Care FCP Podiatry Network was established. Currently this group has 19 practicing members in England. Over 18 months, we have seen a fluctuation in these roles, and know of 5 podiatrists who are no longer in post and have sought roles elsewhere. The emerging themes from the Podiatrists were the lack of support for the set-up of the new roles and lack of FCP training. At time of publication there were 59 podiatrists employed in FCP roles.

For the next step of the project, May 2022, we launched the FCP primary care Podiatrist survey, this was sent to all the network members and advertised on Twitter. We had 14 responses, summarised below (see appendix for more detail).

Current FCP Roles

- These posts are recognised as Primary Care Podiatrists, once they have completed the portfolio they can refer to themselves at First Contact Practitioners
- The first FCP posts were reported in January 2021, with new roles being advertised across the country
- Most are working in substantive permanent roles, with one person reporting a secondment from the NHS community trust
- FCP Primary Care podiatrists are located across all areas of England (see appendix for details), more commonly in smaller rural areas or areas where the NHS may have recruitment difficulties
- The FCP model either, has podiatrists working across multiple GP sites (average 6 sites from a possible PCN size of 10-21 GPs), or they work across 1 to 3 GP sites with patients travelling from a wider primary care GP catchment area. Estates is noted to be a barrier to set up
- It was noted there was a variation in the types of appointments offered, some reporting only face to face, while 2 reported a case mix of digital appointments, 1 reported home visits and outreach into nursing homes and homeless communities
- The number of clinical sessions per week varied between contracts from 2 to 10. The number of patients seen also varied, according to the time given per patient. Some were given 30 mins (6 per session) others were given 10 mins (18 per session). We noted this may be a mix of clinical and digital appointments.

Training

- FCP Primary care roles attracts a younger podiatry demographic, age range 24 to 54 (42% aged 24-34 years old)
- Only 2 (out of 14) have completed their FCP portfolio so far and 1 is in progress
- Just over half have a BSc as their highest qualification (57%); the remainder reported education levels to post graduate level; with one reporting having an MSc and one with a PhD. Only one FCP has a non-medical prescribing qualification
- FCPs were asked to identify their training needs - The top 4 reported were:
  - Non-medical prescribing
  - Non-medical requesting rights for bloods and tissue
  - Non-medical requesting rights for imaging
  - Clinical decision making and red flags.

Scope and Impact

The FCP clinical scope of practice most commonly reported:- MSK, dermatology and older adult in keeping with wider Podiatry and NHS practice (see appendix for more details).

This is supported by FCP Audit from Northamptonshire which shows 56% consultations were for MSK and 35% were for dermatology conditions.

This is supported by FCP Audit from South Shields which shows 42% consultations were for MSK and 52% were for dermatology conditions.

The clinical management reflected in the surveys shows:

- Of the 13 sites reported in the survey (one in set-up), FCPs have an average of 8 sessions a week and see an average of 10 patients per session - **An average of 80 appointments per week.**
- From the survey estimates we can show the average number of internal GP, PCN and external referrals (outlined below).

Mean referrals rates			
FCP GP referrals* per session	FCP GP referrals per week	FCP primary care clinical referrals** per week	FCP secondary / community referrals*** per week
1.2 per session (12%)	4.5 per week (5%)	3 per week (4%)	12 per week (15%)

* not every session
**PCN referrals dietician, FCP physiotherapist, pharmacists, social prescribers
*** Podiatry for high-risk podiatry team, toenail surgery, Orthotics for more durable offloading insoles. MSK team for steroid injection and or surgical opinion, occasional 2week skin cancer clinic referral.

Survey and PCN FCP Podiatry Audits suggest a PCN podiatrist can save time for GPs and Primary care staff an average of 80 appointments per week with 5% patients returning for within 2 to 6 weeks for GP or nurse management.

Survey data reports PCN, First Contact Podiatrists can manage around three quarters (76%) of the caseload. Onward referral can be broken down into 5% to GP, 4% to PCN clinical team and 15% to community and secondary care NHS providers.

This is supported by PCN audits that report 23% to 32% require onward referral.

72% Audit data from Blackpool FCP Podiatry showed that after initial set-up 72% of appointments were managed and 28% were referred on.

Reasons: onward referrals included Orthotics service accounting for 14%, followed by nail surgery 7%. While referral for foot surgery, wound care MDT, vascular services and community nurses only accounted for 2%, 2%, 1% and 1% respectively. With referral to physiotherapy just 1%.

77% Audit data from Northamptonshire FCP podiatry showed that 77% of appointments were managed and 23% were referred on.

Reasons: onward referrals included Orthotics services accounting for 10%, followed by 10% for foot surgery and 3% for podiatry. There were no nail surgery or injection onward referrals as the FCP podiatrist could undertake both in the general practice.

68% Audit data from South Shield's FCP Podiatry showed that after initial set-up 68% of appointments were managed and 32% were referred on.

Reasons: for onward referrals were nail surgery 9%, Podiatry at 7%, ultrasound +/- guided injection 7% and referral for wound care 6%. While referral for foot surgery, vascular services and orthotics only accounted for 1%, 1%, and 1% respectively.

Return rates using the prospective audit data shows:

5% Audit data from Northamptonshire FCP Podiatry showed that within 2 to 6 weeks of being seen only 5% returned for the same concern seeking help from the GP or practice nurse (notably infection, gout and MSK foot pain management while waiting for further care).

5% Audit data from South Shields FCP Podiatry showed that within 2 to 6 weeks of being seen only 5% returned for the same concern seeking help from the GP or practice nurse (notably dermatology flare up and MSK foot pain management while waiting further care).

Prescribing support

Most podiatry FCPs report seeking GP or pharmacist support 0 to 3 times a session. Interestingly where the podiatrist was a non-medical prescriber, the number of prescriptions was reported as 4 to 5 per session.

- Many FCPs in the survey reported requiring GP support for request of bloods, imaging and prescriptions. This is reflected in the training needs identified. It was also noted with more established FCP posts, they relied less on GPs support, as time went on.

3% Audit data from Northamptonshire FCP Podiatry showed that GP input for prescribing was 3% over 1 week.

6% Audit data from South Shields FCP Podiatry showed that GP input for prescribing was 6% over 2 weeks.

Outcomes

Out of the 13 FCP posts established, six are collecting audit data on outcomes. Three have shared the results and these are incorporated into this report, one is in progress, two have are currently publishing their findings.

Challenges and Recommendations

Themes from the Survey

1. **Training support is needed for these new roles**
   This was a strong theme from the FCP survey results. Many podiatrists are not trained to a Masters level prior to taking on the roles and many do not have extended scope skills (e.g. prescribing or injections).

This is a different picture to the physiotherapy model, which attracted very senior therapists with an MSc or postgraduate training when the FCP roles were first rolled-out. This is also reflected in the pay bands where many of the FCP physiotherapists are paid between band 7 and band 8a under a secondment NHS agreement.

In the last 6 months, we now have podiatrists being accepted onto general FCP training MSc modules. We also have podiatry schools supporting the FCP training with a programme being developed.

Recommendation

A framework around what courses to attend- an FCP podiatry toolkit- would also be beneficial.

2. **Care navigation**
   This is the key to reducing PCN burden and promoting FCP roles with admin staff directing self-presenting patients to the Podiatrist first. This can be a big problem initially and referrals may at first come from healthcare professionals internally.

54% Audit data from Blackpool shows at initial set-up, admin staff were responsible for directing 54% of referrals to FCP podiatry instead of a GP or PCN care staff (e.g. practice nurse, etc).

51% Audit data from Northamptonshire shows admin staff were responsible for directing 51% of referrals to FCP podiatry instead of a GP or PCN care staff.

80% Audit data from South Shields showed that with an established service, admin staff were responsible for directing 80% of referrals to FCP podiatry instead of a GP or PCN care staff.

Creating a standard care navigation approach/guide that new sites can adopt will likely improve success of the FCP roles. This would need to include promotional materials for admin to understand and book the correct patients.

3. **Onward referrals**
   The survey showeds the need for MSK and Dermatology skills to be prioritised for those wanting to succeed in these posts. To reduce onward referrals, an FCP would require joint injection skills, non-medical imaging requesting rights, and non-medical prescribing rights. Since the Direct Enhanced Services guidance for primary care 2022/23 was produced, PCNs have been given resourcemonies to support podiatrists with an orthotics budget and nail surgery budget to support care closer to home. This would also enable services to be delivered in the practice.

Long-term considerations

These primary care reimbursement roles are required to be set up in primary care and in place by 2024. If the roles are set up, they will be permanently funded. If not, then the resources will be withdrawn and there is uncertainty about the long-term future of the FCP Podiatry roles in primary care.

Acknowledgements

We would like to acknowledge all the pioneering members of the Podiatry Primary Care FCP Network for their support with the survey and their ongoing tenacity to make strides into this new way of working. We would like to acknowledge the support from Samantha Bell, Richard Keating and Victoria Johnson for allowing us to use their FCP Audits in this report.

We would like to thank Lawrence Ambrose from the RCPod for championing this project and supporting the FCP network. Dr Lindsey Cherry who co-wrote the Podiatry FCP roadmap and for taking the time to support this FCP project and the FCP Podiatry network in her role as Regional Head of Allied Health Professions (AHPs) for the South East Health Education England Hub. We would like to thank Andrea Gledhill for supporting the FCP project as part of her Health Education England RCPod project officer role.

We would like to acknowledge the work of Dr Jill Halstead and Usamah Khalid in setting up the FCP network, creating data collection tool, creating the FCP survey, collecting the survey data, analysing the audit data and preparing this report. Finally, we would like to acknowledge the work of Dr Jill Halstead who has authored this report.

Appendix

Demographics and Roles

FCP Locations and Sites - total = 14 responses:

Location of Role	Number of GP sites care is provided
Greenwich, London	5
Hampshire	5
Calderdale, West Yorkshire	7
North	1
Doncaster	11
Portsmouth	6
Southend, Essex	9
Bristol	7
Warwick	1 (has patients from 12 practices)
South Tyneside	3 (has patients from 21 practices)
Bexhill, East Sussex	1 (difficulty with GP estates)
South Tyneside	3 (has patients from 21 practices)
Northamptonshire	5
Blackpool	4

FCP clinics - total 14 respondents

No of sessions per week	No of patients per session
5 (20-25 patients per week)	5
1	8
10	20
10	6
9	10
10	6 clinic, 10 digital (30 appointments, 50 telephone/ week)
4	10
8	6 clinic, 5 home visits, 5 homeless
5	3-6
9	18
10	13
10	10
8	8
TBC, just set-up	TBC
Mean=7.6 sessions/week	Mean=10.3 patients per session

Appendix

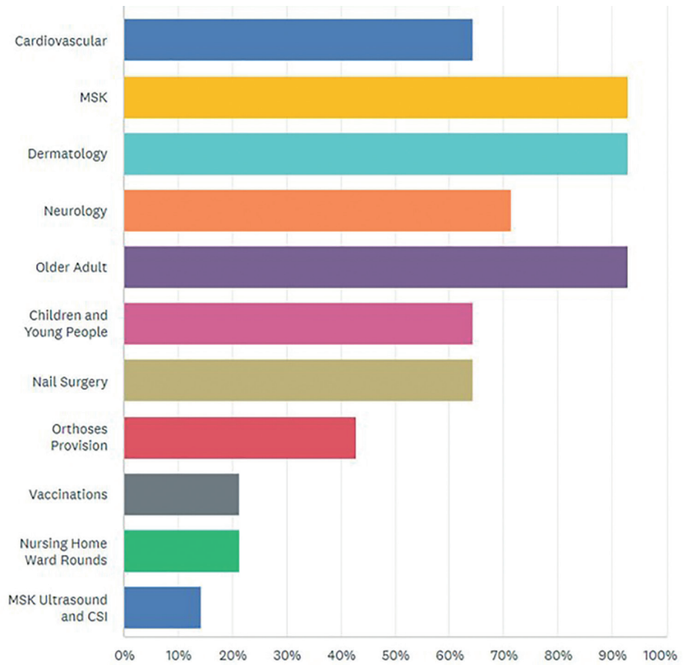
Training

FCP - Training identified for the post - Ranked according to total responses
- note multiple responses (14 respondents).

Training	Responses
Non-medical prescribing	10
Non-medical requesting rights (Bloods and tissue)	7
Non-medical requesting rights (imaging)	5
Clinical decision making and Red Flags	3
Leadership and Policies in Primary care	2
First contact practitioner MSc module	2
Primary care consultation skills	2
Primary care pathways	1
MSK injection therapy	1
MSK and Biomechanics assessment	1

Scope and Impact

FCP Scope of practice



Appendix

FCP number of referrals – 14 respondents unless indicated

GP referrals per session	GP referrals per week	Other primary care clinical referrals per week**	Other secondary / community care clinical referrals per week ***
1	3-4	3	6
0	0	3	4
8	4	10	20
2	29	2	13
0-1	1	1	7
1	4-5	8	20-25
?	?	2	8
0-1	0-1	3	6
1	0	0	5-10
*	4	4	20
0-1	2	1-2	10-12
0-3	3	2	10
0-1	2-3	1	12
N/A	N/A	N/A	N/A
Mean=1.2/session	Mean=4.5 / week	Mean=3/week	Mean=12/week

*Skipped
**PCN referrals dietician, physio PCN pharmacists, social prescribers
***Other referrals: high risk podiatry team, toenail surgery, Orthotics for more durable offloading insoles – MSK team for steroid injection and or surgical opinion, occasionally undertaken 2 week skin cancer clinic referrals.

Appendix

Recommendations

What would help PCNs and FCP Podiatry – 12 respondents (note some responses are summarised).

Better first contact triage to encourage referrals straight to Podiatry and reduce burden on PCN
GP templates to capture robust dates on impact and evidence
Models for pathway planning
Short infographic/media clip about FCP Podiatry clinics (EG scope of practice)
Better referral pathways/criteria
More training
Increasing ease and awareness of the inclusion criteria, ease of booking and referring to them
Supervision from GP and Advanced Nurses, feedback about complex cases to reinforce skills and knowledge. Develop working relationships with wider primary care team (reception, HCA, NP, paramedics etc)
Independent Non-medical prescribing
Requesting of X-rays, USS, MRI and none medical prescribing
Independent Non-medical prescribing
Onward CPD, supportive groups. Prescribing. Requesting bloods, X-rays to avoid going through GP
Not much, I think the role adequately addresses the PCN needs as expected
More integration with team training and updates.

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