

Musculoskeletal Clinical Fellowship - Final Report.

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Supporting the Development of Our Future Primary Care Workforce

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Background:

The increase in demands due to an ageing population, often with multiple co-morbidities, has placed additional pressure on the NHS's ability to meet patient's complex needs. In response to these demands, the Primary Care Workforce Commissions report, *The Future of Primary Care – Creating Teams for Tomorrow* (2015), prioritised development of staff, with appropriate training, to support primary care provision, through workforce redesign. The GP Forward View (2016) proposed pilots in musculoskeletal (MSK) first contact practitioners (FCP), as a recommendation.

New care models (NHSE, 2016) were introduced as a way of providing and scaling up these transformations, with the development of an advanced clinical practice (ACP) framework (HEE, 2017), to support non-medical professions, to take on roles traditionally performed by doctors. Data from the Royal College of General Practitioners (2007) found that musculoskeletal health issues made up approximately 20% of the GP caseload. Vanguard sites, where patients with MSK symptoms opted to see an MSK FCP, instead of a GP, to assess, diagnose, advise and, when required, carry out further investigations and refer on, have been shown to enhance patient care, reduce GP workload and demonstrate efficiencies (CSP, 2017).

In May 2018, NHS England identified FCP's treating MSK conditions, as a high impact intervention and developed commissioning guidance to the system to facilitate expansion of these roles. To further support the clinical pillar of advanced practice, the MSK Core Capabilities Framework was published, in July 2018, which aimed to ensure that the range of health professionals who provided care for people with MSK problems, were appropriately equipped to consistently deliver person-centred care, play a full role in helping to manage

problems appropriately, at the first point of contact and help towards achieving better outcomes across the system.

HEE Wessex MSK Fellowship Role:

The aims of the role were outlined as follows:

1. Develop a network of MSK FCP's
2. Identify the learning needs specific to practitioners working in these roles
3. Developing work and thinking related to MSK FCP's in primary care
4. Establish how the MSK Core Competency Framework could be applied in practice
5. Understand how FCP's working in or seeking to work in primary care could be supported
6. Support the development of these roles

In addition, HEE Wessex had set aside a sum of money to develop and deliver an advanced practice module, to support AHP's working as FCP's in primary care. A significant part of the role therefore also included understanding the requirements and developing a module to address the need.

I have outlined my reflections on how the above aims were accomplished below.

1. Develop a network of MSK FCP's

This was initiated through my existing clinical network and developed further; as the fellowship facilitated an expansion of my personal network; in addition to an increase in the number of AHP's carrying out the roles. Identifying and developing links with key individuals and organisations working nationally, particularly via Twitter and attending national HEE meetings and conferences, was crucial in the success of network development and, once a critical mass

Musculoskeletal Clinical Fellowship - 2018 – Final Report

was established, expansion of a network and access to ideas and new developments, was easily obtained and updated.

Outside the obvious clinical network, relationships were built with key stakeholders including HEI's, AHP professional bodies, HEE Wessex fellows, specifically working to support AHP's in primary care, national HEE MSK fellows from other areas, the Dorset primary care workforce centre, as well as primary and secondary care providers with Wessex.

2. Identify the learning needs specific to practitioners working in these roles

Following network development, I was able to meet directly with individuals, who were already established MSK FCP's and gain a deeper understanding of the diversity of roles, with an explicit aim to ascertain what they had learned 'on the job' and asked "what would you teach your former self, prior to starting the role?" Themes were generated from the various discussions and I was initially surprised that the concerns were not directly related to MSK clinical scenarios, but instead more associated with the culture and workings of primary care, the additional burden of risk shouldered in the primary care setting, working with ambiguity and uncertainty and, following publication of the MSK core capabilities framework, issues around person centred care, shared decision making and social prescribing.

Once these themes were identified, significant parallels were identified, when compared against the GP registrar training and Paramedics working in primary care course content (HEE GP Fellow - Sarnia Ward).

3. Developing work and thinking related to MSK FCP's in primary care

Identifying parallels with the learning needs related to MSK FCP's, as well as paramedics and GP's, led me to explore the options of considering learning related to all FCP's in primary care, as opposed to limiting it to the MSK clinicians'. I also considered that it would be more appealing to the HEI's and HEE, if course content was designed to meet the needs of larger populations of clinicians and foster greater understanding, networking and teamwork within a wider range of clinicians working within primary care.

Relationships built with those working in similar roles to mine, in different regions or nationally, were crucial, in gaining a rich understanding of the national picture and emerging developments within a rapidly evolving landscape. I was pleasantly surprised by the generosity of individuals sharing their work and their keenness for this to be disseminated to different regions. Also the consistency in identification of barriers to developing the roles and challenges associated with scaling up the projects, particularly with regards to lack of financial support and workforce challenges, in particular, backfilling short term vacancies, following a pilot or secondment, was a valuable insight.

A key relationship, established early in the fellowship, was with Richard Collier and we worked together to consider the contents of the MSK CCF and develop the thinking on how individuals could demonstrate that they met the requirements of the framework.

As a clinician, when your concept of a successful days work involves a full list of patients, with a number of overbooks, and little opportunity for reflection, the idea of developing the 'thinking' initially feels luxurious. However it is fundamental to the role to develop this tacit knowledge and use it to underpin your thinking on decision making. I found attending HEE events was a

Musculoskeletal Clinical Fellowship - 2018 – Final Report

valuable way to gain a multitude of perspectives and a deeper understanding of the challenges involved.

4. Establish how the MSK Core Capabilities Framework could be applied in practice

This was a significant challenge within this role. The MSK Core Capabilities framework was developed using the Delphi technique, which is a method used to systematically combine expert opinion, in order to arrive at an informed group consensus, on a complex problem (Donohoe et al, 2011). Dealing with issues of complexity, by their nature, they are not compatible with linear analytical techniques and it is not possible to distil them down to linear, right or wrong answers. Consequently, identifying simple solutions, as evidence of competency, to demonstrate that the individual met the requirements of a complex framework, was particularly challenging.

Multiple conversations with clinicians, supervisors and facilitating an event at the Chartered Society of Physiotherapy; involving representatives from all professional bodies involved in FCP; were carried out, in an attempt to understand opinions, gain consensus and 'tame' a wicked problem. However, as complexity theory suggests, a simple solution remained elusive. Clinicians in the roles ask for clarity to identify 'what is good enough' to demonstrate that they meet the requirements of the framework and providing and articulating this continues to be challenging.

5. Understand how FCP's working in or seeking to work in primary care could be supported

Traditionally, individuals carrying out these roles have been supported with formal, face to face training. Developing new and advanced practice skills, via Masters Modules (such as injection

Musculoskeletal Clinical Fellowship - 2018 – Final Report

therapy or non-medical prescribing), have been primarily taught and are essential criteria for gaining advanced practice roles. Consequently this is the expectation of most individuals looking to demonstrate advanced practice and is also evident in advanced practice routes for nursing staff (RCN, Advanced Practice Standards, 2018).

Even within MSK FCP roles in primary care, there is significant diversity of requirements; due, for example, to the population demographics; therefore some flexibility will need to be offered that ensures that each module remains flexible and adaptable to apply to the individuals' working environment, in addition to allowing it to evolve, depending on the changing landscape of Advanced Practice thinking and national policy. A smorgasbord approach may be a way that individuals can tailor the content of their training to their role, rather than have a rigid set of predefined modules to complete, as a tick box exercise.

Utilising new technologies, such as e-learning or virtual campus modules, with submitted work that is applicable to a multitude of clinical situations; yet with a values-based 'thread' linking clinicians together with a common aim (for example, providing a patient centred approach); would be a practical and efficient method to scale up and ensure consistency of quality nationally.

Mapping the content to Advanced Practice Frameworks and e-portfolios, so that the advanced practice academy and clinicians could clearly demonstrate competency, and identify their outstanding learning and developmental needs, would be beneficial.

6. Support the development of these roles

Throughout the fellowship, I was able to support the development of MSK FCP roles confidently, due to developing a deeper understanding of the diversity and complexity what the

Musculoskeletal Clinical Fellowship - 2018 – Final Report

role could offer to commissioners, providers, HEI's, primary care teams and prospective clinicians.

Clinicians' were supported directly through signposting towards training opportunities, in particular appropriate HEE e-learning modules, linking them to their peers, advising on content for training days, advice and guidance regarding demonstrating competency of the MSK Core Capabilities framework and national developments with regards to advanced practice thinking, for individuals in existing roles, as well as the future workforce going into FCP.

I have played an active role in supporting the content development of HEE National e-learning modules supporting the Musculoskeletal Core Capabilities Framework for first point of contact practitioners. This enabled me to become an integral part of the National team developing these modules, learn from them and feed in the learning that I had gained to the module development. Linking with this team also ensured that the taught element complemented and built upon the foundations laid by the e-learning modules and therefore presented a co-ordinated and seamless transition from e-learning to masters' module.

One area where I was keen to provide a significant impact was developing a person-centred approach. Initially this was considered as a stand-alone module, however taking this approach does not integrate it to all levels of interaction and I was able to influence a change, where the person-centred consideration was woven into all modules, therefore making it a fundamental value of the role and not an added extra when the situation allowed it. I believe that this is essential to support these changes and would be keen to weave a similar thread throughout the masters' module.

Musculoskeletal Clinical Fellowship - 2018 – Final Report

Clinicians considering moving into these roles could be first directed to the e-learning modules. This would give them an understanding of what the role entailed, as well as developing some underpinning skills, which would map to an advanced practice framework. They could subsequently use this as a pre-requisite to complete a relevant module in advanced practice. It is vital that there is co-ordination between national e-learning programmes and local masters' modules to provide a logical, seamless transition, avoid duplication and efficiently support the building of a portfolio for advanced practice, that maps to the appropriate framework to support advanced practice and provide quality assurance.

Feedback and learning was fed into the discussions regarding the development of a module for FCP in Primary Care. Initially this was designed to map to the MSK core capabilities framework, however, as previously described, as my learning matured, I could see the significant parallels with other advanced practice opportunities within primary care (including paramedics and frailty).

In addition, the MSK core capabilities framework was not restricted to primary care clinicians, but was developed to support all FCP's (for example those with the emergency department or secondary care physiotherapy), therefore a bias towards primary care would not be relevant, to all clinicians in MSK FCP roles.

Networks were developed with Bournemouth University (who had been commissioned to deliver the module), the Dorset Primary Care Workforce Centre, National HEE representatives; associated with Advanced Practice, the MSK Core Capabilities framework and FCP work within primary care; and Wessex clinicians' currently in the role, to understand and inform the content of the module.

Musculoskeletal Clinical Fellowship - 2018 – Final Report

Appropriate content for a masters module for FCP's in primary care, considered the needs of the following stakeholders...

- a. Colleagues in primary care
- b. Potential providers within secondary care
- c. AHP's currently in FCP roles
- d. AHP's considering future MSK FCP roles
- e. HEE National Programme for FCP (e-learning modules and M level modules)
- f. HEI's
- g. Associated professional bodies
- h. HEE Advanced Practice Framework
- i. Musculoskeletal Core Capabilities Framework
- j. Evolving thinking of the National Academy for ACP
- k. Dorset Primary Care Workforce Centre
- l. E-portfolio development
- m. HEE MSK Fellows nationally
- n. NHS England and NHS Digital High Impact Intervention
- o. CCG's

Currently the content of the module covers the following aspects:

- a. Clinical assessment skills
- b. Critical appraisal of evidence
- c. Wider determinants of health
- d. Risk assessment, clinical safety and quality
- e. Effective team working
- f. Shared decision making and delivering person-centred care
- g. Patient experiences and involvement

Musculoskeletal Clinical Fellowship - 2018 – Final Report

- h. FCP Policy
- i. Legal and ethical issues
- j. Professional development planning
- k. Professional values, scope of practice and autonomy
- l. Service improvement

Further discussion is required, with BU and Wessex FCP's, to enable the current content (30 masters' credits) to fit with the BU Advanced Practice module size, which are either 20 or 40 credits. One option would be to incorporate aspects of the BU, evidencing professional learning, course, which allows the flexibility to differing perspectives of role, which will enable the student to tailor it to both their role, as well as their gaps in learning relating to the four pillars of advanced practice, yet still provide academic rigour in the form of masters accreditation.

<https://www1.bournemouth.ac.uk/study/courses/evidencing-professional-learning-and-or-management-level-6-or-7-credits>

Learning for the system:

As a clinician with 25 years' experience within an acute trust, moving away from providing direct patient care, to an organisation with different role has been both challenging and very rewarding.

Conversations, early in my tenure, around working with a rapidly evolving landscape and the associated requirements to be flexible and adaptable to this, were invaluable in relieving my concerns regarding working with intangibility. I have tried to relay this to any new fellows who have contacted me for advice.

Musculoskeletal Clinical Fellowship - 2018 – Final Report

Actively developing a new network requires support and signposting. I found that personal or email introductions were particularly helpful in expanding my network.

Utilising the benefits of technology to create a 'virtual campus' to support and scale up the four pillars of advanced practice, directly linked to an e-portfolio, would be an efficient, effective, consistent and scalable method of evidencing that clinicians are working at an advanced practice level.

Work based assignments, peer reviews, case studies and essays could be used to evidence level 7 working and developing modules that can be applied to the requirements of the individual, will be both efficient and effective.