NHS
Health Education England

A retrospective review of the influences, milestones, policies and practice developments in the First contact MSK model

Developing people for health and healthcare

www.hee.nhs.uk

THE NHS CONSTITUTION
the NHS belongs to us all

Contents

Introduction

Musculoskeletal (MSK) conditions present a significant challenge for the population, clinicians and commissioners of healthcare services. They are reported to affect 1 in 4 of the adult population (many being young and of working age) which is around 9.6 million adults and 12,000 children in the UK (PHE 2019). Differing reports suggest they may account for up to 30% of GP consultations in England (Department of Health 2006).

In terms of impact MSK pain and disability may have significant negative effects on the quality of life of millions of people in the UK; 10.8 million working days are lost as a consequence of musculoskeletal conditions (PHE 2019) and they are associated with a large number of co-morbidities, including diabetes, depression and obesity. Over 25 per cent of all surgical interventions in the NHS are MSK related, and this is set to rise significantly over the next ten years (Arthritis Research UK 2013) and therefore from a cost perspective £4.76 billion of NHS spending each year (Department of Health (2011) will continue to be required to manage MSK pain and disability, and is likely to increase.

The development of practice across many areas of health care has historically moved at different paces dependent on the internal progression of the professions, research knowledge, external factors such as the economy and of course, the needs of the population. Many key progressions in MSK service development have concentrated on improvement of the patient experience, cost effectiveness and benefits to the wider clinical communities. This document looks to present a review of one such progression in practice. The First Contact Practitioner (FCP) in MSK practice is an advanced practice clinician who provides a musculoskeletal service within primary care. This model of practice was set out to achieve some vital and specific aims. The proposed outcomes included creating greater capacity in primary care, sign-posting patients more effectively enabling improved “down-stream” referrals, and ultimately enhanced self-management strategies in delivering person-centred MSK care at the first point of contact.

Health Education England has developed a number of short video clips that give greater context if required. Using advanced clinical reasoning skills with knowledge of multi-morbidities and advanced skills such as injection therapies, diagnostic requests and independent prescribing, the FCP through shared decision making can improve patient experience and promote self-care at the front end of the pathway. This will also provide cost savings within the pathway and reduce GP work-load.

The development of these roles is still in a fast-moving phase and has attained national exposure as part of numerous national policies and plans outlining transformation across the health sectors.

Advanced clinical practice (ACP) is also a rapidly developing model of practice that has gained much recognition. In doing so has also supported the future projects around gaining an advanced practice workforce that is well-supported, well governed and appropriately educated.

The multi-professional advanced practice framework (2017) was a vital publication as it standardises the level of practice at this high level of advanced clinical skill incorporating clinical skills, leadership, education and research pillars. FCP as an area of practice has the capacity to add to the ACP model and in doing so FCP may well be recognised as part of ACP level of practice for the future. Much has happened in the last five years, in particular the last 12 months has seen significant movement to integrate FCP within primary care.

MSK allied health professionals (AHPs) have a history in advanced levels of practice particularly across orthopaedics, rheumatology and pain-management. Historically these roles were named *Extended* and it was these early roles that saw the MSK AHP advance their reasoning and diagnostic skills across different elements of the MSK pathway. The professions saw a rapid change in the clinical offer that physiotherapists could make, such as injections therapies and independent prescribing. Whilst this support occurred advanced MSc level 7 courses continued to thrive and individuals in these roles gained their level of practice through clinically based local competencies and externally validated M-level programmes. As these secondary and community care clinicians developed further, primary care practice was identified to be in crisis, and an urgency to transform, support and collaborate with general practice began to rapidly emerge.

AHPs were soon to be called upon to realise their potential and utilise their wide-ranging person-centred skills to enhance care across all sectors. The NHSE publication "*AHPs into Action*" (2017) clearly gave a supportive offer across numerous fields of healthcare that allowed the wider health community to soon realise the art of the possible with this collective of health care clinicians.

This current document seeks to take the reader through the policy developments of one element of the multiple AHP offers, FCP in primary care. It will determine the timeline for the policies, the influences they had on each other and some of the strategic uni and multi-professional work that contributed to its current position. It will also provide the reader with a history surrounding the research, evaluation, education and competency of FCP as well as the identified future proposals.

Recent history

The NHS England business plan 2014/15 to 2016/17 “Putting Patients First” set out 7 key components based on the NHS change model which effectively set out a systematic approach to improving the quality of care of all patients accessing NHS services in England. The key components identified were

- leadership for change
- engagement to mobilise
- spread of innovation
- improvement methodology
- rigorous delivery
- transparent measurement
- system drivers.

Each of these elements had a specific task -these are set out in table 1 below.

Delivery model	
Leadership for change	Research & evidence, communicating intent and clinical leadership
Engagement to mobilise	Patient & public participation, identifying interdependencies and alignment with partners.
Spread of innovation	Identifying & championing innovation
Improvement methodology	Commissioning support & development. Issuing guidance.
Rigorous delivery	Funding & resourcing. Commissioning assurance & system oversight.
Transparent measurement	Transparency. Data & monitoring. Milestones.
System drivers	Setting standards. Incentives (including finance, competition)

An early driver that helped set the scene for FCP was the third key component “Spread of innovation” that in many ways opened the door to the possibility of how the multi-professional workforce could be used differently and more effectively across boundaries of care.
The “*Five Year Forward View*” published in 2014 set out a clear message surrounding the importance but also crisis that General Practice was facing at that time. The publication made clear references for a “new deal” for general practice in supporting a vision for improving prevention and managing ill health closer to patients’ homes and away from the hospital environment.

In May 2015 the RCGP document "*Blue-print for building the new deal for General Practice in England*" was published. This clearly highlighted the share of NHS spending allocated to General Practice had fallen from 11% in 2004/05 to 8.5% in 2012/13 whilst spending on secondary care had risen. The publication suggested a shift in investment to enable GPs to improve care, tackle waiting times and improve the continuity of care within the community and it clearly proposed that improved General Practice resources would inevitably help place the NHS in a more sustainable position by reducing secondary care costs. Calculations presented in the paper proposed that increasing spending on General Practice by £72m per year would lead to savings projected to be up to £708m by the end of 2019/20.

The further clear challenge recognised within General Practice was the statistic surrounding GP recruitment and retention. At this time it was noted that the numbers of GPs in 2015 were lower than they were in 2009, the growth between 2006-2013 was just 4% as compared to hospital doctors at 27% and that the RCGP predicted that the GP workforce would need to increase by 8000 (FTE) in 5 years to meet the existing shortfall. There were clear calls for innovation, new models of care, and funding requests for additional clinicians such as pharmacists.

Therefore, it was clear that the development of primary care had to be focussed around the re-direction of funding but also the widening of the primary care team to aid with innovation, service readiness and improvements in the patient experience. Several proposals began to emerge that identified professions that would in partnership be able to answer the call concerning how primary care could be developed to deal with the clearly highlighted need for clinical as well as financial investment. The Primary Care Workforce Commission published "*The future of primary care: Creating teams for tomorrow*" (2015) and here was a clear recommendation where Allied Health Professionals were proposed as part of a possible solution. Physiotherapists particularly were mentioned in roles providing services such as self-referral, falls prevention, and musculoskeletal practice without the need to see a GP. Physiotherapists with prescribing rights since 2014 were proposed in parallel to paramedics as options in reducing the first contact waiting times for GPs by utilising core and extended skills in managing a particular patient cohort. This proved somewhat of a green light for AHPs and particularly physiotherapists and paramedics to begin considering innovations, and how each profession could make an offer that would work towards the NHSE business plan surrounding the particular components of engagement to mobilise and spread innovation.

Clear innovative practice was needed, and the model by which NHS practice and individual new models could be developed was offered via the NHSE Vanguards programme (2015). In March 2015 29 Vanguards were chosen nationally to pilot innovative practice. There were three vanguard types; integrated primary and acute care systems, enhanced health in care homes, and multispecialty community providers offering differing solutions to health and social care challenges. These new models were well supported by the lobbying and underpinning by ARMA (Arthritis and Musculoskeletal Alliance) who in a number of papers clearly advocated the importance of FCP in the wider MSK context (http://arma.uk.net/wp-content/uploads/2019/12/local-nhs-plans-core-offer-final.pdf). An influential document supported by ARMA written by Peter Kay (At that time National Clinical Director for MSK) laid the foundations to underpin evidence for MSK FCP in primary care http://arma.uk.net/wp-content/uploads/2016/05/developing-MSK-networks-resource-pack.pdf and demonstrated how an integrated network provides coordinated person care and sustainable outcomes. A series of webinars also set the scene and clearly gave further offer in support of the proposed model (https://www.youtube.com/watch?v=rh_TAmNBjuw; https://www.youtube.com/watch?v=Jft5u-DzZpg).

Integrated primary and acute care systems were proposed to join up GP, hospital, community and mental health services, whilst multispecialty community providers were designed to move specialist care out of hospitals into the community. Enhanced health in care homes offered older people better, joined up health, care and rehabilitation services.

One of the multispecialty community providers within the identified vanguard sites known as "Better Local Care" was located in Hampshire and within this programme a "Musculoskeletal Practitioner" model was the first development within this site. A physiotherapist providing first-contact musculoskeletal assessment, diagnosis, investigations, injections and referrals was set up as part of a new model of care within this vanguard team. This paralleled a number of other similar services being rapidly developed across the UK, such as Nottingham and Windermere. These new models led to a number of local evaluations that developed a data set to improve the knowledge base around physiotherapists working in primary care as First-Contact practitioners. It began to aid in answering the hypotheses that placing certain clinicians at the front of the pathway, directly in primary care would lead to improved patient experience, savings throughout the patient pathway and increased release of GP capacity.

At this time a number of national responses to the Five Year Forward view and RCGP report were being published. The "*GP Forward View*" and the Kings Fund report "*Understanding pressures in general practice*" both from 2016 offered a deeper insight into the particular pressures that primary care was under. The Kings Fund report provided a deep dive into the complexity of general practice, workforce and patient demographics and explored some of the causative factors underpinning the current changes that GPs were facing and made recommendations regarding workforce re-design such as the use of paramedics and pharmacists in providing part of the solutions as clear contributions to the new Models of Care programme. The GP Forward view identified as part of NHSE and HEE commitments a pilot programme to utilise the role of primary care physiotherapy services, this was part of the wider development of nursing, pharmacists and paramedics.

In response to these new, exciting developments in practice the Chartered Society of Physiotherapy (CSP) could see clearly see the unrealised potential benefit for the profession to support the new developments in General Practice and the proposals of gaining care closer to home, in the community and reducing secondary care activity for musculoskeletal conditions. "*Think Physio*" was a published policy briefing document from the CSP (July 2017). It clearly created the case for physiotherapy in primary care and wished to build upon the GP Forward View and Vanguard sites in providing a model of care to support GP services. It articulated that although self-referral to physiotherapy had been shown to be effective, the take up of this was still low (31% of all CCGs commission self-referral at time of publication) and it then further utilised a FCP case study from Cheshire that through audit demonstrated clear reductions in physiotherapy and orthopaedic referrals, decreased use of imaging and costs-savings for GPs in terms of appointments saved. This model of FCP was clearly different from self-referral as the clinician was embedded as part of the primary care team.

The CSP through effective promotion and work to inform the development of the future policy documents that further developed the pilot proposals of the GP Forward View into something more collected, rounded and robust.

NHSE published in 2017 the "*Transforming MSK and Orthopaedic Care Services"* handbook which looked at describing a number of innovations and developments across the MSK pathway. It took the term "First Contact Practitioner" and established it as the utilised phrase for describing the new proposed model of MSK primary care practice. It was at this point that a clear definition was nationally published; "First Contact Practitioner is usually an Advanced

Practice Physiotherapist who has the advanced skills necessary to assess, diagnose and manage musculoskeletal problems", and additionally within this document implementation guidelines were available in the commissioning and provision of such care. Another influential document at this time was published in May 2017 "*Transforming the MSK Landscape with Physiotherapists as a first point of contact, A Commissioning Guide"* This paper provided some high-level guidance regarding a system model, the role and the potential benefits of investing in Physiotherapy as a first point of contact and made recommendations regarding the opportunity for Commissioners. In May 2019 NHS England and Improvement co-produced the "*Elective High-Impact interventions: First Contact practitioner for MSK Services*" which is a comprehensive document supported by case studies that outlines the need for change, the implementation plans and data to support the process. Its rationale for publication was secured on the previous work outlined and the NHS Long Term Plan which summarises a national mobilisation plan for local systems to roll out this service for patients across the country as part of the transformation of care. They concluded as an aim that the whole NHS England patient population will have direct access to MSK First Contact Practitioners by 2023/24, across all Primary Care Networks. Finally, the pathway to the FCP process has currently led to a firm offer within the "*A Five year framework for GP contract reform to implement the NHS Long term plan*" p99, 2019. Advanced practice physiotherapist as part of the MSK pathway (FCP) was reported as of April 2020 to have 70% of costs funded to implement a service within primary care. This was proposed to support a national roll-out of the program enhancing the pathway and supporting primary care clinical practice. A very recent development has seen the reimbursement offer for a range of clinicians in primary care including FCP rise from the initial 70% to 100%.

Research / Evaluation

First contact practice and physiotherapy in primary care has history of evaluation in several fields. As far back as 1995 Physiotherapist as part of the primary care team have been considered and evaluated. O' Cathain et al (1995) looked to evaluate a transfer of hospital based physiotherapy into a primary care setting. This pilot study concluded that direct access physiotherapy in this setting can lead to reduction in referrals for secondary care Rheumatology and Orthopaedic services, therefore setting the scene for the future changes in design and models. The direct access model which reviewed the outcomes, satisfaction and clinical practice of physiotherapists receiving a direct referral from the patients rather than the GP or consultant was extensively researched in Scotland. In a review of GPs and Physiotherapists views around self-referral a large survey highlighted that 78% of clinician asked felt that there were possible and definite benefits for patient's if Physiotherapists were involved in drug management, sick certificates and requesting X-Rays.

There were smaller levels of concern regarding the level of experience required and levels of training needed (Holdsworth et al 2008). This research group had already demonstrated cost savings with self-referral models (Holdsworth et al 2007) and so this underpinned the first contact development into primary care.

FCP in different formats have been assessed internationally. Three Swedish primary care clinics were assessed in the integration of Physiotherapists in terms of the potential health and societal benefits (Bornhoft et al 2019). Although not purely first contact (the patients seen were initially triaged by a Nurse) the study compared GP to physiotherapy management of MSK conditions. The study concluded that the use of a Physiotherapist in this context was more cost effective, reduced referrals to specialist services and highlighted a reduction in radiological requests.

In the UK important work was published that compared the management of patient care in terms of clinical effectiveness, patient satisfaction and economic efficacy (Goodwin and Hendrick 2016). The study reviewed the practice of two GP practices (Inner city and University). Patients reported high satisfaction with the Physiotherapy service and no adverse events were reported. Clinically significant improvements were observed (EQ-5D-5L, Global Rating of Change). Comparison of costs saw examples such as in the University practice £56.51/patient for the physiotherapy and £366.44/patient for the GP cohort. These differences were attributed in the main to salary, however the physiotherapy cohort had double the time with the patients in clinic, and yet also supporting the economic value was the highlighted differentials in referrals for diagnostics and secondary care assessment, which were significantly lower in physiotherapy patient groups in both sites.

A number of UK based clinical audits have been published that have further echoed the economic benefits from FCP and one of the recent studies evaluated over 2 years primary care data from 2 GP practices in the Forth valley (UK) (Downie et al 2019). 8417 patient contacts were made and outcomes including capacity, referral rates to orthopaedics and physiotherapy, number of steroid injections and outcomes from Orthopaedic referrals were evaluated. The results highlighted that both practices saw a reduction in referrals to Orthopaedics. Referrals to Orthopaedics were substantially reduced in both practices. Practice A from 1.1 to 0.7 per 1000 patients; practice B from 2.4 to 0.8 per 1000 patients and from GP capacity perspective only 15 from the 8417 of patients needed to see a GP for a review after the physiotherapy assessment.

In a review of an urban GP practice of 16,000 patients over a 12-month period, 150 patients were assessed each month (20 minute appointments) with 87% of these self-referring and the remainder triaged by a GP (Wigglesworth and Greenwood 2019). Over 70% of patients were managed with self-care advice or a home exercise programme. Referral rates to physiotherapy were 13% and to an Orthopaedic Consultant, 1%. The need for GP review within 4 weeks of presentation to the physiotherapist was 1%. The use of resources was found to be low such as X-rays and blood tests which were requested by the physiotherapist in only 2% of cases respectively. Morley and Kerr (2019) in a further service evaluation revealed that 16% patients seen in the FCP clinic were referred to physiotherapy, 13% required a review via the GP for blood tests, medications and sick notes, whilst referral for imaging was at 3% and Orthopedics at 9%. Whilst within the NHSE document "*AHPs into Action*" (2017) three case studies were cited all able to clearly identify the cost and pathway benefits for patients when accessing a First Contact Practitioner (in these cases a Physiotherapist).

Work continues at Keele University who are leading a study that is evaluating data collection from across numerous localities in England, and a qualitative evaluation of patient, clinicians and stakeholders such as GPs via workshops across the UK. This will provide robust data to help understand and underpin the challenges of implementation, the potential benefits and the support potentially required for teams within the primary care and extended health networks.

Data tools

Standardised Data Collection

In 2014 early implementation of First Contact Services were set up showing promising results both within primary care and to the wider healthcare system. The data collected was similar and demonstrated the same benefits such as in Hampshire 64% of patients were managed without the need for any onward referrals, in Nottingham the figure was 71%. Orthopaedic referrals in Cumbria and Nottingham were at 6% and Cumbria reported a 90% conversion rate.

Physiotherapy referral rates were reported to be at 20% and 27% in Hampshire and Nottingham respectively (AHPs into Action 2017). Other pilots across England started to emerge based on this information and again, the results showed that despite demographics, there was a pattern that highlighted First Contact roles are able to achieve their aims. However, extrapolating data that was transferable was a challenge due to differing methods of data sets and collection. Although there were a good number of service examples demonstrating the worth of the model, the outcomes collected although similar were not the same. This meant that each could not be directly compared. A large amount of collective comparative data was needed to move the role forward from local success to gaining national recognition for a national roll out. Based on this, a national standardised minimum data set was created funded by Health Education England and in collaboration with NHSE digital using background SNOMED coding which is a universal digital language underpinning all NHS computer systems. The significance of using the same coding meant that a First Contact MSK template could be developed for all GP computer systems ensuring that standardised data outcomes could be collected at scale.

NHSE identified five parameters needed to evaluate the service: cost of service delivery, patient safety, patient experience, clinical effectiveness and productivity. From these parameters, outcome measures that could demonstrate were agreed nationally and templates built ready to use for the national pilot https://www.csp.org.uk/publications/first-contact-physiotherapists-fcps-standardised-data-collection

Once the templates had been developed, the Chartered Society of Physiotherapy worked with the NHSE elective care transformation programme to support FCP pilots across every Sustainability and Transformation Partnership (STP) across England based on the First Contact Physiotherapy High Intervention specification. The national evaluation was developed to track metrics which were proposed to aid in the improved understanding of the impact of FCP on the system which ultimately would build and provide robust standardised evidence for the service.

National Evaluation

Three phases of evaluation were agreed. Phase 1 and 2 funded and managed by NHSE, and phase 3 by the CSP. All three phases were to be overseen by one steering group to ensure

alignment of the evaluation. (https://www.csp.org.uk/system/files/?file=001404_fcp_guidance_england_2018.pdf). In summary the plans were;

Phase 1: To set up information around delivery plans: structure, costs, location, governance, competencies, incidence reporting and notes auditing systems.

Phase 2: Baseline performing metrics and collection of standardised data. Pilots were asked to comply with the standardised data collection templates around the key metrics. This information was to be collected monthly and sent to a central point of contact. Search and report templates were developed to collect this information for all 3 GP systems https://www.csp.org.uk/icsp/resource/fcp-searchreport-templates-emis-systmone-vision so that the correct metrics were taken from the standardised data templates for monthly reporting.

Phase 3: Qualitative metrics: To support the objective metrics, phase 3 focused on: the impact on the patient experience, GP and GP services and other stakeholders, quantitative data in terms of PROMS and evaluation of services to see if FCP achieved objectives set to benchmark service effectiveness. This phase currently is part of the multi-methods evaluation of the FCP model of care led by a collaboration of Keele University and the University of Nottingham.

Education and Competency

One of the significant challenges to the integration of FCP within primary care is the assurance of capability. The minimum standard of capability within this environment has been formally addressed by the "*MSK Core Capabilities Framework"* (2018) https://www.skillsforhealth.org.uk/services/item/574-musculoskeletal-core-skills-framework which was a joint collaborative project involving Skills for Health, Health Education England, NHS England, Public Health England and the Arthritis and Musculoskeletal Alliance (ARMA) who launched the framework aimed at practitioners who will be the first point of contact for people with musculoskeletal conditions. The work was built around clear research principles (Delphi Consensus) and the methods/methodology and this work has been published (Chance-Larsen et al 2019). This was aimed at any practitioner who with the suitable professional skills and knowledge was able to provide a First Point of Contact MSK assessment and management plan within a primary care environment. It sets out a number of clear domains of practice. 14 capabilities are housed within the 4 domains (Person-Centred Approaches, Assessment, Investigation and Diagnosis, Condition Management, Interventions and Prevention and Service and Professional Development). This level 7 framework (Masters) allows clinicians and relevant stakeholders to understand the clinical requirements of the role, and further cements the governance in terms of competence and capability.

What became acutely obvious is that this framework required effective training models and opportunities to develop clinical practice and that learning needs were becoming clear. One clear example of this was a course procured by Health Education England (North West) which through a tender process was offered to the University of Central Lancashire (https://www.uclan.ac.uk/courses/ahp-first-contact-practice-in-primary-care.php). The University team developed a single MSc module that looked to address the clinical capability elements of the core capabilities framework including a period of supervised practice. Further to this HEE also commissioned an e-learning set of modules based on a person-centred approach to support clinicians gaining skills and knowledge around areas such as complexity, mental and public health, illness identification and red flags (https://www.e-lfh.org.uk/programmes/musculoskeletal-primary-care). The development of this programme was led a by a number of experts in the field and utilised what was described by the team as a "Particular to primary care model" to really broaden the education for MSK across a multi-professional group .This work has now gained international recognition and is being accessed by a range of clinicians world-wide. A further thematic analysis after semi-structured interviews and subsequent focus groups of FCPs, aspiring FCPs and a GP trainer surrounding the skills knowledge and attributes that a FCP may require was also published further enhancing the requirement of these roles (Langridge 2019). It was found that a number of themes emerged that underpin the competency of these clinicians; medical assessment and systems knowledge; speed of thought in an uncertain environment; breadth of knowledge; people and communication skills; common sense/simplify; and responsibility and experience were all identified.

Ongoing work is planned to aid with operationalising national frameworks and competency, local career development and progression from qualified to advanced level. The aim of this will be to support from graduate level an “in-practice” clinical portfolio, with mentorship, supervision and clinical sign-off documentation that will ultimately match against the core-capabilities framework.

Future Developments

Development of an MSK educational roadmap from graduate to Level 7

To address the need of clarity of how to develop educationally along an MSK pathway to work to the top of a clinical licence, a “Roadmap” is being developed to support this. It will give clear guidance of what competencies need to be achieved at each level, and ways in which clinicians can evidence this. Central to the roadmap will be:

- The Musculoskeletal (MSK) core capability framework
- The mulita professional framework for Advanced Clinical Practice (ACP)
- The International Federation of Orthopaedics Manipulative Physiotherapists (IFOMPT) standards

The IFOMPT standards have been demonstrated to cross reference against both the two frameworks (Rushton, Noblet and Heneghan 2020 *in press*) and are used in Higher Education Institutions (HEIs) as the standard along with the HCPC standards to examine clinicians against a level 7 framework.

The Roadmap will be developed as an educational support that will aid clinicians in identifying learning opportunities, gaining advanced skills and knowledge, whilst generating knowledge from reflective practice. Ultimately this will support an equivalence route to Advanced Clinical Practice from graduation and development in any MSK speciality and in any healthcare sector; primary care, secondary care or community care to reach level 7 advanced clinical practice status i.e. to demonstrate learning at level 7 across the four pillars of clinical, research, leadership and education. Once a clinician has reached ACP level 7, their skills will be transferable across all 3 sectors as by nature of working at that level, their skill set will enable working multi-professionally, integrated and cross sector.

The roadmap will have two documents; Firstly, a clear explanation of the educational journey via competency/capability and standards, and secondly a document that highlights underpinning the pathway with clear guidance regarding how to evidence the competencies/ standards via clinical sign off. There will be a number of suggested options of how to evidence learning for example; educational course, e-learning, case studies, reflective learning etc.

Also to be considered is expanding the roles for all MSK clinicians and building the work-force for professions such as podiatry and osteopathy. Building in the capabilities around agreed scopes of practice will involve multi-stakeholder involvement and agreement.

Digital ACP portal

A digital ACP portfolio is in development for clinicians to use from graduate level to level 7 sign off so that evidence can be stored and monitored over the course of the clinical journey. The portal will cross reference to the MSK core capability framework and the ACP framework so that

any learning needs can be easily identified. This portal will be used to support the roadmap to store learning as the clinician progresses through their clinical journey.

Supervision

Core supervision training is also being developed. This will aim to set a base level of how to facilitate clinicians learning to draw out CPD needs, and how to find the relevant information or courses to help progress skill sets.

A second training module is being developed to support supervisors to guide a clinician through the educational Roadmap and the digital ACP portal and provide clinical sign off at level 7. This bolt on to a core supervisors training will require some experience of supervision prior to supporting this pathway.

Workforce

There is a need to expand the MSK workforce to meet the needs in primary care ongoing, but also to redesign how the wider MSK workforce is utilised to support the wider system to prevent destabilisation in the community and secondary care sectors.

With regard to the former, an increase of 41% of physiotherapy graduates will help toward this project moving forward, but there is work going on with developing both osteopaths and podiatrists into First Contact roles. These roles will be known as MSK First Contact Practitioner roles with the profession stated in brackets afterward to maintain professional identity.

The two aforementioned professions will be introduced into the system once the clinical skills been cross referenced against the MSK Core Capability Framework and clinical pilots have been evaluated to therefore reference against the previous physiotherapy pilots using the same job description, and the same set of national standardised metrics so that the system can be assured of the same quality of outcomes, and the robustness of the conclusions.

From national data collection it is appears that by putting an MSK First Contact Practitioner at the front of the care pathway reduces demand to the whole MSK system by 20%, so this suggests that it is unlikely to cause any imminent destabilisation by honouring the Directed Enhanced Service (DES) agreement in the 5 year general practice contract https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf , but some thought will need to be taken projecting into the future around how to utilise existing workforce in a different way, how to use a different MSK workforce including other MSK roles such as sports therapists and how to redevelop the whole MSK system efficiently to honour the NHS 10 year plan.

The MSK FCP has provided the foundation for other professions to sit in primary care in similar roles. NHSE, NHSE/I and the British Medical Association (BMA) have supported this development and further additional FCP roles are being introduced roles into primary care adding them via the DES https://www.england.nhs.uk/wp-content/uploads/2020/02/update-to-the-gp-contract-agreement-2021-2324.pdf with 100% reimbursement for primary care.

To support the incoming workforce , Health Education England have developed an Allied Health Professions Primary (AHP) Care Ambassador role (previously named Advisors) https://www.ahpnw.nhs.uk/latest-news/405-primary-care-ahp-advisers-call-for-expressions-of-interest that currently sit in the North West and the South East of England, with the vision for national coverage. The role is designed to:

- Advise a range of stakeholders on high quality care and sustainable workforce supply, training and education in primary care in relation to AHPs.
- Support a coordinated approach across primary, community and secondary care within STPs/ICSs and across the North West.
- Support the development of practical implementation resources.
- Support PCNs in recruiting, training and retaining AHPs.

Education

A number of ventures are being supported by Health Education England to support the MSK workforce:

- Apprenticeship opportunities into ACP and therefore FCP roles (https://www.nhsemployers.org/news/2019/02/acp-apprenticeship-procurement).
- First Contact Physiotherapy University modules suitable to upskill band 6s to band 7 roles and to bridge the gap for band 7 moving into primary care from other sectors.
- ACP courses with additional overarching ACP FCP content to support band 8a roles.
- The development of key relationships between multi-professional MSK special interest groups in driving a common national standard.

Key engagements with HEIs, professional bodies and other national and international (IFOMPT) MSK stakeholders are taking place to inform the national picture around MSK, MSK FCP roles and ACP so practice can develop to meet the wider MSK future ask, and to support co-production and collaboration.

Governance

Governance has been an area that has needed to be addressed with the national roll out of FCP. With the future MSK workforce comprising of three different professions (physiotherapists, osteopaths and podiatrists) and with different potential implementation models from both the NHS and private sectors there is a need to ensure that the right clinicians are being employed with the correct capabilities (which underpin the recognised roles and responsibilities associated with this role). It is recognised how imperative the governance is that supports these roles in assuring quality and standardisation to the system.

Governance of the FCP roles has currently been divided into internal and external perspectives:

Internal:

- Clinician responsibility to their registration body to maintain professional standards (HCPC / The General Osteopathic Society), and also to report other clinicians that they may have concerns to be working outside the competencies of the role that they are employed in.
- For physiotherapists being employed by the FCP DES, the role must match the job description and core competencies for Band 7/band 8a FCP before any funding can be released to the Primary Care Network (PCN).

- For the DES, it is required that the clinician uses the minimum data set metrics set by NHSE to pull data remotely from the primary care computer systems to monitor outcomes.
- Implementation guidance has been developed for PCNs to follow to ensure safe employment of the correct clinicians for the purpose of the DES (https://www.hee.nhs.uk/sites/default/files/documents/FCP%20How%20to%20Guide%20v21%20040919%20-%202.pdf) and a second document is being developed for release in late spring 2020 from NHSE/I with all possible ways of implementation, the pros, cons and mitigation of each. This will include NHS, private MSK providers, individual practitioners, osteopaths and podiatrists.
  A further overarching implementation document will also be released by NHSE/I in late spring that will include the existing MSK FCP role and all the other FCP roles that are incoming into primary care.

External:

- The HCPC and the General Osteopathic Society registration standards require that if a clinician breaches their professional conduct, they will be taken through the referral pathway if there is a concern around capability and to offer guidance and support.
- Work is ongoing in collaboration the Care Quality Commission (CQC) to ensure that MSK FCP roles are quality assured externally through CQC inspections to ensure that the right clinicians are being employed into the roles, and that competency and supervision needs are being met.

References

Allied Health Professions Network Primary care AHP Advisors – call for expressions of interest https://www.ahpnw.nhs.uk/latest-news/405-primary-care-ahp-advisers-call-for-expressions-of-interest

Arthritis Research UK (2013) Musculoskeletal Health: A public health approach.

Bornhoft L, Larsson M et al (2019) Health effects of direct triaging to physiotherapy in primary care for patients with musculoskeletal disorders: A pragmatic randomised controlled trial. Feb https://journals.sagepub.com/doi/10.1177/1759720X19827504

Chance-Larsen K, Backhouse M, Collier R, Wright C, Gosling S, Harden B et al (2019) Developing a national musculoskeletal core capabilities framework for first point of contact practitioners. Rheumatology Advances in Practice 3 (2).

Chartered Society of Physiotherapy (July 2017) Think Physio for Primary care. https://www.csp.org.uk/system/files/001455_thinkphysio_primary_care_engld._mob1st_high.res__0.pdf

Davis C (2017) Transforming the MSK Landscape with Physiotherapists as a first point of contact, A Commissioning Guide. HEE

Department of Health (2011) Programme Budget Plan 2009/10 June.

Downie F, McRitchie C, Monteith W and Turner H. (2019) Physiotherapy as an alternative to a GP for Musculoskeletal conditions: A 2 Year service evaluation of UK Primary Care data. Br J General Practice. 69 (682) e314-e320.

Goodwin RW & Hendrick PA (2016) Physiotherapy as a first point of contact in general practice: a solution to a growing problem?, Primary Health Care Research Development 17, 5: 489-502.

Global Burden Disease (2016) Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016.

Holdsworth L, Webster V, McFadyen A (2007) What are the costs to NHSScotland of self-referral to physiotherapy? Physiotherapy 93:3

Holdsworth L, Webster V, McFadyen A (2008) Physiotherapists and general practitioners views of self-referral and physiotherapy scope of practice. Physiotherapy 94: 236-243.

Kay P Developing MSK Networks http://arma.uk.net/wp-content/uploads/2016/05/developing-MSK-networks-resource-pack.pdf

Kings Fund. (2016) Understanding pressures in General Practice. Accessed 17/12/17 https://www.kingsfund.org.uk/topics/general-practice

Langridge N (2019) The skills, knowledge and attributes needed as a first contact physiotherapist in musculoskeletal healthcare. Musculoskeletal care 17 (2): 253-260.

Moffatt F, Goodwin R, & Hendrick P (2017) Physiotherapy-as-first-point-of-contact-service for patients with musculoskeletal complaints: understanding the challenges of implementation. Primary Health Care Research.Develeopment.:1-10.

Morley H and Ker K. (2019) Patient satisfaction and outcomes of musculoskeletal pain patients accessing advanced physiotherapy practice in primary care; a service evaluation. Physiotherapy 105 (1); e164-e165.

NHS England (2014) Putting Patients First : NHS England Business Plan for 2014/15 – 2016/17 https://www.england.nhs.uk/publication/putting-patients-first-nhs-england-business-plan-for-201415-201617/

NHS England (2014) Five Year Forward View. Accessed 17/12/19 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf.

NHS England (2016) Allied Health Professions Into Action. Accessed 07/08/2019 https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf

NHS England (2016) GP Practice Forward View April Accessed 7/08/19 https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

NHS England (2017) Transforming Musculoskeletal and Orthopaedic Elective Care services. Accessed 7/08/19 https://www.england.nhs.uk/publication/transforming-musculoskeletal-and-orthopaedic-elective-care-services/

NHS England (2019) Elective care high impact interventions: First Contact Practitioner for MSK services. Accessed 9/11/2019 https://www.england.nhs.uk/publication/elective-care-high-impact-interventions-first-contact-practitioner-for-msk-services/

NHS England (2019) A Five Year Framework for GP contract reform to implement The NHS Long Term plan. Accessed 9/11/2019 https://www.england.nhs.uk/publication/gp-contract-five-year-framework/

NHE England Models of Care Accessed 7/08/19 https://www.england.nhs.uk/new-care-models/about/

O'Cathain A, Froggett M, and Taylor M P. (1995) General practice based physiotherapy: Its use and effect on referrals to hospital orthopaedics and rheumatology outpatient departments. Br J GP 45 (396): 352-354.

Primary Care Workforce Commission (2015) Accessed 7/08/19 https://www.hee.nhs.uk/sites/default/files/documents/The%20Future%20of%20Primary%20Care%20report.pdf

Public health England (2019) Musculoskeletal health: 5 Strategic Framework for prevention across a life course. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810348/Musculoskeletal_Health_5_year_strategy.pdf

RCGP (May 2015) A Blueprint for building the new deal for general practice in England. Accessed 07/08/2019 https://www.rcgp.org.uk/-/media/Files/PPF/A-Blueprint-for-building-the-new-deal-for-general-practice-in-England.ashx?la=en