

First Contact Physiotherapy posts in General Practice

A guide for implementation in England

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1 Forewords



Dr Arvind Madan

General Practice is one of the great strengths of the NHS, valued greatly by patients for its access, versatility and effectiveness.

However, we have an increasingly ageing population, with more people living with more long-term conditions. These population trends, combined with GP shortages, are placing the sector under ever-greater pressure. We therefore need to consider how we can use and target resources more effectively. This includes enabling more patients' care to be managed by a wider range of practitioners within the practice-based team.

Initiatives already show how a broad range of professions, including physiotherapists, can contribute to providing safe, effective, timely care. This includes being able to address some of the needs of the rising number of people living with muscular and joint pain. Musculoskeletal (MSK) conditions are characterised by pain, loss of movement and function. In turn, this impacts on individuals' quality of life, family and social relationships, and capacity to work. Delayed treatment risks patients developing a range of significant co-morbidities. The challenge – and need – is to seek new and innovative ways to deal with MSK problems effectively, efficiently and in a location close to home, so that patients receive convenient, early care.

Many GPs are already seeing the benefits of drawing in the expertise of experienced physiotherapists to work alongside them as the first point of contact for their MSK patients. Physiotherapists are able to advise on self-management, and initiate further investigations and referrals, when needed. This approach to service delivery puts physiotherapy expertise at the start of the pathway, where patients can most benefit from prompt specialist attention, in the place where they are most likely to seek help first.

I am pleased to support this CSP guidance. Endorsed by the BMA and the RCGP, it provides practical advice and recommendations on implementation and evaluation.

This is a real opportunity for physiotherapists and physiotherapy services to support GPs, enhance how patient care is delivered, and to build capacity, sustainability and diversity in the primary care work.

Dr Arvind Madan is the Director of Primary Care, NHS England



Dr Krishna Kasaraneni

In the context of ever rising GP workload and staff shortages, and the combined efforts of the BMA, NHS England and Health Education England to expand primary care workforce numbers and skill mix, the BMA welcomes this workforce initiative. It has the potential to reduce workload pressures for GPs and their practice staff, as well as improve patient access to skilled general practice musculoskeletal services.

The Chartered Society of Physiotherapy has produced this guidance for physiotherapists, GP practices and commissioners, in collaboration with the BMA GP Committee. We anticipate that this will help to ensure patients get swift diagnosis and treatment for musculoskeletal conditions through the increased commissioning and delivery of physiotherapy services in primary and community care settings. The accompanying cost calculator, which enables practices and commissioners to determine how much could be saved in both cost and GP time through direct patient access to a physiotherapist, also offers an additional tool to enable local determination as to whether this would benefit patient populations across groups of GP practices. Where appropriate, GP time freed up by initiatives such as these will allow them to spend more time with those patients who have complex and, often, multiple care requirements. [The GP Forward View](#), published in April 2016, contains a range of commitments to increase GP and primary care staff numbers. The BMA believes each initiative can have a positive incremental impact on the path to bringing intense workload pressures down to manageable levels. At the same time, this will ensure GP practices can maintain and improve high quality care for patients.

Dr Krishna Kasaraneni is the BMA UK GP Committee Policy Lead for Education, Training and Workforce



Karen Middleton

General Practice is under immense pressure and the existing workforce and resources in the NHS need to be used in new ways to meet this effectively. The physiotherapy profession has been rising to this challenge, working with GPs to develop new physiotherapy roles and service models in general practice. First contact physiotherapists have been shown to safely and effectively manage a musculoskeletal (MSK) caseload; enhancing the patient experience and freeing up GP time to lead, manage and spend with other patients.

As part of the primary care team physiotherapists can promote and implement the practice's approach to health promotion, early intervention, avoiding unnecessary medication, referrals and hospital admissions, and supporting patient self-management. The feedback from GPs and patients affirms that this is working in practice.

While this guidance is focused specifically on MSK, physiotherapists have expertise to offer in many clinical areas to improve the health of the population, and I look forward to working with our partners in exploring how this can be utilised to better support general practice. I am delighted to introduce this practical guidance for GPs, commissioners and physiotherapists to support implementation and thank colleagues at the BMA for working in partnership with the CSP on this.

Karen Middleton is Chief Executive of the CSP

2 Introduction

The BMA, *Urgent prescription for General Practice*⁽¹⁾ makes clear its recommendations that an 'expanded workforce in and around the practice' includes physiotherapists.

NHS England is launching a First Contact Practitioner High Impact Intervention (FCP HII) specification and guidance. NHS England has co-produced this with the CSP, other professional bodies, patient groups and Health Education England.

At the time of writing this is due for imminent publication. It has already been issued to STPs who are required to identify sites for implementation before the end of June 2018.

The purpose of the guidance here is to support implementation of the FCP HII specification, both by emerging services and those already delivering the First Contact Physiotherapy model.

It is a revised version of the implementation guidance published by the CSP with the BMA and the RCGP first in 2016. It is relevant to physiotherapists, GPs and those involved in funding and commissioning MSK services.

With an ageing population and increase in the numbers of people with multiple morbidities, the pressure and demands on primary care will continue to rise. GP surgeries now provide 370 million consultations every year; 70 million more than five years ago. Despite this, GP numbers have remained relatively static during that time, if not decreased.⁽²⁾

Physiotherapists providing a first point of contact service means that patients presenting with a musculoskeletal (MSK) problem for a GP appointment are offered an appointment with a physiotherapist instead. Physiotherapists working in general practice are able to address the needs of a large proportion of the patient population.⁽³⁾ They have the clinical expertise and autonomy to assess, diagnose and treat patients with a range of conditions, including MSK, neurological and respiratory conditions. To access a range of case study examples which showcase how the physiotherapy role is working in General Practice go to: www.csp.org.uk/casestudies

It has been estimated that MSK conditions alone account for around one in five GP appointments.⁽⁴⁻⁶⁾ This is therefore an opportunity for physiotherapy services to support GPs and to build capacity and diversity in the primary care workforce through increasing physiotherapy roles in general practice settings

3 MSK pathway redesign

The introduction of First Contact Physiotherapist (FCPs) should be part of a review and redesign of the MSK pathway.

It should not add further steps in the pathway, but rather reduce the steps and speed up the time it takes for a patient to receive the services they require.

The diagram below presents an example of the timescales with an FCP as part of the pathway, compared to a traditional MSK pathway. It is based on case studies of FCP early pilots.

Traditional MSK pathway
Patient has an MSK problem
▼
Patient visits GP who offers analgesia and advice
▼
Patient returns to GP with unresolved problem
▼
Patient referred to physiotherapy, 6 week wait. Then undertakes 4 weeks of treatment
▼
Problem unresolved, patient referred to Interface service, 6 week waiting time.
▼
Patient referred for diagnostic imaging and informed of results 5 weeks + 1 week
▼
Referred for surgical opinion. Total waiting time for patient 22 weeks

Pathway with first contact physiotherapists
Patient has an MSK problem
▼
Patient contacts GP surgery who offer appointment with a first contact physiotherapist
▼
Patient receives advice, analgesia, and 4 week exercise prescription. At the same time is referred for imaging and informed of results
▼
Referred for surgical opinion. Total waiting time for patient 6 weeks

4 Benefits

Where first contact physiotherapy posts have been implemented in general practice as part of the MSK pathway, they have generated a range of benefits that enable patients to get the most out of one contact. Key benefits are outlined below.

For patients

- Quick access to expert MSK assessment, diagnosis, treatment & advice
- Prevention of short-term problems becoming long-term conditions⁽⁷⁾
- Improved patient experience⁽⁷⁾
- A shorter pathway, so patients have fewer appointments to attend
- Simple logistics, so patients are less likely to miss appointments, or to suffer administrative errors
- Opportunity to gain lifestyle/physical activity advice
- Longer appointment times, meaning patients feel listened to, cared for and reassured

For GPs

- Release of GP time through re-allocating appointments for patients with MSK problems
- Reduced prescription costs⁽⁸⁾
- In-house MSK expertise gained
- Increased clinical leadership and service development capacity
- Support in meeting practice targets

For the local health economy

- Reduced number of MSK referrals into secondary care; this includes reduced demand and waiting times for orthopaedics, pain services, rheumatology, community physiotherapy and CMATS (Clinical Musculoskeletal Assessment and Treatment Services)⁽⁹⁾
- Improved use of imaging
- Improved conversion rate to surgery when referrals are required
- Improved links with local voluntary sector and patient groups to ensure the continued support of individuals with MSK conditions

For physiotherapists

- Professionally stimulating and rewarding role and use of their professional knowledge and skills, including through stronger links with the multi-disciplinary team⁽³⁾
- Opportunities to develop and make use of their scope of practice and skills, including those relating to independent prescribing, injection therapy and imaging referral rights
- Opportunities to develop experience, learning and skills in service development, quality improvement and implementation science.

Calculating the benefits

- Health Education England and the SCW Commissioning Support Unit have developed a model to calculate cost and resource savings. <http://arma.uk.net/musculoskeletal-networks/network-resources/#MSK-First>

5 Evaluation

Contributing to the national evaluation

NHS England will be working with The Chartered Society of Physiotherapy (CSP) and other partners to support national evaluation of FCP pilots as part of the NHS England Elective Care Transformation Programme. This will report at the end of March 2019.

Every Sustainability and Transformation Partnership (STP) will identify a pilot site based on a system readiness checklist within the FCP HII specification (at GP federation or CCG level) to establish an FCP service in line with the specification and to engage with the national evaluation process.

The purpose of the national evaluation is to build a robust evidence base for

FCP. It will track metrics to understand the impact of the FCP pilot on activity including financial costs, secondary care referrals, GP workload, MSK physiotherapy services and patients' experience/outcome. It will also help define FCP practice and prove impact on others' services.

The evaluation is critical for providing evidence to support a full scale roll out and for individual services to be continued beyond the period receiving initial funding.

There are three phases of the evaluation, and phases 2 and 3 run concurrently. Phase 1 and 2 are funded and managed by NHS England. Phase 3 is funded and managed by the CSP. All three phases will be overseen by one steering group, to ensure alignment of all aspects of the evaluation.

Phase 1 – set up information

Pilots will be asked to complete an implementation pro forma to collect information on delivery plans. This is likely to include information on:

- Structure
- Finance /costs (direct and associated)
- Location
- Governance
- Competencies
- Incident reporting systems
- Notes auditing systems

Phase 2 – base line and performance metrics

Phase 2 of the evaluation includes an audit of baseline data and an on-going collection of standardised data.

Some of these are data that FCPs collect themselves, some is data collected by others that FCPs have direct access to (e.g. held in other parts of the primary care electronic system) or indirect access to (e.g. held by secondary care systems or by NHS Digital).

Developing a baseline

The baseline audit will include relevant GP practice and secondary care data.

Standardised data collection by FCPs

Pilots need to comply with a standardised data collection template against key metrics. These templates have been developed for EMIS, Vision and System One and will be available to download.

These data include outputs, activities and impact that FCPs need to record about each patient.

Much of these data will be collected throughout the pilot period by NHS England regional teams. They will also provide regular feedback from pilot sites to support learning across the system about what has and has not worked well.

Phase 3 – qualitative metrics

Phase 3 will focus on the impact of FCP on patient experience/outcome, GP and other stakeholders' experience, and on GP services.

All of these data will be collected by FCPs working with the CSP.

Data item	Activity	Output	Impact
Referral source (via GP appointment, GP receptionist, self-referral, other)	●		Efficiency of access to FCP service
Refer for FCP follow up		●	% requiring review/follow up appts (aim <30-50%)
Refer to GP / practice nurse		●	Limited increased resource for primary care
Waiting times	●		Efficiency of access to FCP service
Number of FCP appts	●		Define FCP service delivery
Time per contact	●		Efficiency of FCP service delivery
DNA rate	●		Efficiency of FCP service delivery
Referral for further investigation (XR, MRI etc.)		●	Efficiency of FCP service delivery, comparison with existing primary care,
Prescription (medication, exercise etc.)		●	Efficiency of FCP service delivery, access to holistic health and care services
% of GP appts related to MSK pre and post FCP		●	Efficiency of GP service
Diagnosis	●	●	Efficiency of FCP service delivery
Referral to other services		●	Efficiency of other services as result of FCP service
AHP Fitness for Work report issue (AHP Fit Note)		●	Efficiency of FCP service, efficiency of primary care, impact on length of time MSK patients signed off work
Exercise/self-management advice/ prescription		●	Patient experience (confidence, wellbeing, body image?)
Red flag warning	●		Efficiency of FCP service, safety of FCP service
Adverse event recording	●		Efficiency of FCP service, safety of FCP service

More details will be hosted on the CSP website about the national evaluation and what this means in terms of data collection requirements as it becomes available.

6 Funding

Pump-priming

The majority of physiotherapy services already within General Practice were set up through pump-priming; e.g. NHS Vanguard funding and the Prime Minister's Challenge Fund (GP Access Fund).

NHS England's FCP HII specification advises that CCGs and STPs are expected to pump-prime using transformation funding. Transformation funds are normally held with NHS England regions by a lead transformation officer, who a local CCG should be able to contact.

These funding sources are typically fixed-term and designed to foster and facilitate the adoption of innovative practice. It is expected that services funded via these routes evaluate their impact to show their value, which will then enable them to be funded through a 'business-as-usual' funding pathway.

Commissioning as part of an integrated MSK pathway

Taking an integrated approach by commissioning the whole MSK pathway via a prime provider model could mean every part of the system works together in the interest of patients. If this approach is taken, new money does not necessarily need to be found – rather, it just needs to be shifted and remodelled.

First contact physiotherapy roles linked to General Practice achieve savings across the pathway – for example, from reducing demand for orthopaedic services. STPs and Accountable Care Systems should make it possible to unlock these savings easier, to fund first contact physiotherapy roles.

Co-commissioning

From April 2016, half of all CCGs in England accepted full delegated responsibility for commissioning local primary care from NHS England. Co-commissioning aims to support the development of integrated out-

of-hospital services based around the needs of local people. It is part of a wider strategy to join up care in and out of hospital. So primary care-based physiotherapy services may well be commissioned by local CCGs via co-commissioning in the near future. This would be one way of enabling services that were initially funded through pump-priming to move to business-as-usual commissioning.

More detail on co-commissioning including which areas are involved can be found at: www.england.nhs.uk/commissioning/pc-co-comms/

GP practice-funded

Physiotherapists are able autonomously to manage a significant proportion of GP MSK appointments. GP practices therefore may consider funding their own physiotherapy services. This can be done in the following ways:

- Contracting – where the physiotherapist/s are paid at an hourly rate for their services
- Directly employing a physiotherapist and paying them a salary
- Inviting a physiotherapist to join the practice as a partner.

Income generation for practices

Physiotherapists within GP practices can also provide services that generate additional income. For example, the provision of steroid injections can often be funded by local CCGs whereby GP practices are paid per injection. Through providing these types of services, which decrease demand on more costly secondary care orthopaedic clinics, income can be generated. This, in turn, can fund the FCP roles.

Similarly, follow up appointments (for example, for hip fracture and hip and knee replacements) after orthopaedic operations could be dealt with by first contact physiotherapists, are paid for through a tariff which could come to the practice.

Funding and employment models

Type of funding / employment	Advantages	Considerations
GP-funded (contractor model)	<p>Contract for services model (not employment) so can agree flexible sessional rates.</p> <p>Insurance cover will be held by the self-employed physiotherapist, provided they are a fully practising CSP member.</p>	<p>Training needs to be met by practitioner.</p> <p>Lone-working and therefore can be isolating.</p> <p>Need to agree arrangements for annual leave and sick leave cover – these can be difficult to organise for self-employed physiotherapists.</p>
Employed by GP practice(s)	<p>Consistency of physiotherapist(s) in providing service.</p> <p>GP practice can invest in long-term training plan.</p> <p>Physiotherapist would be clearly defined as part of the practice team.</p>	<p>Employment terms should be comparable to AfC and should include access to NHS Pension Scheme.</p> <p>Isolated practitioner will require access to peer support network.</p> <p>Currently no CSP recognition as a Trade Union within GP practices.</p> <p>GP practice will need insurance in place to cover vicarious liabilities.</p> <p>No cover for annual leave/sickness/maternity leave unless sourced separately e.g. via an agency.</p> <p>All equipment will need to be provided by the practice.</p> <p>Recruitment and retention may be an issue.</p> <p>The practice would need employment policies and health and safety mechanisms in place.</p>
GP practice partner	<p>Physiotherapy integral to the GP practice and decision-making processes.</p>	<p>The physiotherapist would share the risks of the practice.</p> <p>Isolated from peer support.</p>
Contract with NHS provider as part of MSK pathway services	<p>Physiotherapists will be part of a wider service with established training, support and local policies.</p> <p>Peer support will be more readily available.</p> <p>The patient pathway may be more seamless.</p> <p>Cover for sickness and annual leave may be available.</p> <p>Some equipment may be shared and/or provided by the service provider.</p> <p>Insurance cover is provided by the NHS.</p>	<p>Continuity and consistency of physiotherapy staff should be considered to enable good working relationships to develop.</p>
GP Federation	<p>A physio service could be developed across a GP Federation, allowing for peer support, appropriate skill mix, training and support mechanisms.</p> <p>Cover for sickness and annual leave may be available.</p>	<p>Employment terms should be comparable to AfC and should include access to NHS Pension Scheme.</p> <p>CSP recognition could be sought with the Federation.</p> <p>GP Federation will need insurance in place to cover vicarious liabilities</p> <p>All equipment will need to be provided by the practice.</p> <p>The Federation would need employment policies and health and safety mechanisms in place.</p>

7 The FCP role

The role of the FCP in primary care is to assess patients with soft tissue, muscle and joint pain and to decide on the most appropriate management pathway.

The MSK core capabilities framework

Health Education England (HEE) and NHS England have developed a musculoskeletal (MSK) core capabilities framework. This framework sets out the core capabilities to deliver high quality, consistent and person-centred care, for MSK patients presenting to a first point of contact practitioner (FCP). Physiotherapists and GPs recognise the value of the framework and are also best placed to demonstrate fulfilment of the capabilities.

The framework provides a standard structure and language to enable greater consistency and portability in MSK core capabilities. Practitioners with expertise in the area, including physiotherapists, defined the capabilities.

The framework describes what an MSK FCP is able to do, not what they should simply know. It does not detail the underpinning knowledge and skills required, nor specifies the learning and development process that would enable practitioners to achieve the capabilities.

The capabilities reflect the demands of Master's level (level 7) learning, particularly in relation to managing complexity, uncertainty, ambiguity and risk. An individual can use the framework to identify and address their learning and development needs.

At the time of writing, the MSK core capabilities framework is due to be published imminently by HEE and NHS England.

National framework for multi-professional advanced clinical practice

HEE, in partnership with NHS Improvement and NHS England, have developed a National framework for multi-professional advanced clinical practice

FCP roles require advanced clinical practice skills, so this framework is applicable to the role. <https://hee.nhs.uk/our-work/advanced-clinical-practice/multi-professional-framework>

For further information about the MSK core capabilities framework and the National framework for multi-professional advanced clinical practice, see appendix 1.

Knowledge and skills acquisition

Physiotherapists able to fulfil high-level roles in primary care have typically completed the following post-registration professional development:

- Postgraduate level learning relating to MSK conditions (e.g. a full Master's degree, Master's level modules, or work-based learning at an equivalent level)
- Acquired and maintained competence in injection therapy
- Acquired and maintained competence and the right to practise independent prescribing, denoted by their annotation on the Health and Care Professions Council (HCPC) register as an independent prescriber.

This specialist knowledge and skills development will be in addition to a broader range of post-registration learning and development completed since qualification as a physiotherapist. In addition to clinical areas of practice, this is likely to include professional development relating to leadership, management, supporting others' learning, research and evidence-based practice.

Grading

Under the NHS Agenda for Change system, physiotherapy posts are graded from band 5 (at which a newly-qualified physiotherapist is appointed) through to band 9. The banding is used across specialisms and roles. The grade of a particular post is determined by the level of knowledge and skills that its fulfilment requires. The Agenda for Change system is well-established and well-known, and is frequently used outside the NHS. It is therefore recommended that any non-NHS employment models use the NHS grading and pay structure. This provides clarity around expectations and comparability of pay. It should therefore assist with recruitment and retention.

The grade of a specific role will need to be assessed, depending on the service need and skill mix requirements. The greatest value and impact of FCP in general practice will be gained from those that demonstrate a high level of independence (without the day-to-day support of peers), the ability to order

further examinations, and to refer on to a range of different services and for the delivery of specialist treatments. The job role is likely to be either band 7 or 8.

As these roles are established in greater numbers it is likely that FCP teams with a greater mix of banding will be necessary, to support on-going workforce development.

Salary scales for Agenda for Change bandings can be found on the NHS Employers website. www.nhsemployers.org/your-workforce/pay-and-reward/agenda-for-change/pay-scales

Title

NHS England used the term 'First Contact Practitioner' which refers to a broad programme of work for the non-medical professions. The CSP recommends always using 'Physiotherapist' in a job title, including for roles that are new so that the title would be first contact physiotherapist (FCP). This ensures that patients are fully informed about who they are seeing. This means that there is no ambiguity, and not a need for a complex explanation of a practitioner's professional background.

Using 'physiotherapist' recognises and promotes the profession's value in contributing to a modern primary care team. It also gives a strong message that, by shifting services into primary care, the physiotherapy profession is actively responding to the needs of the whole population, including through advancing a preventative, early-intervention approach to meeting patients' needs.

'Physiotherapy' and 'physiotherapist' are both strong brands. Physiotherapist is a protected title. Its use therefore requires individuals to be registered and regulated by the HCPC. This safeguards patients' interests and safety, and upholds public protection.

8 Implementation

In this section, factors are outlined that need to be considered in making a range of decisions on practical arrangements.

Governance

Having an appropriate governance structure is key to the success and sustainability of physiotherapy posts. The design of these will be undertaken in conjunction with the local STP/CCG lead for MSK transformation. Governance structures need to provide first contact physiotherapists with:

- Access to support and advice on how they can best manage the needs of individual patients, including by referring an individual patient on to a colleague or other service to optimise the care delivered
- Access to structured, wide-ranging opportunities for their professional development, to consolidate existing knowledge and skills, acquire new knowledge and skills, and engage in peer-to-peer review and reflective learning and practice.

Sustainability

Early adopters of these physiotherapy posts in primary care have utilised advanced practice roles.⁽¹⁰⁾ As a result, the physiotherapists in these roles work independently and are able to manage high levels of complexity, uncertainty and risk. Once these advanced roles have become established and greater in number, there should be the opportunity to develop a wider skill mix. This includes with more junior physiotherapists and physiotherapy support workers contributing to general practice services and increasing the capacity for physiotherapy students to gain access to practice-based learning within general practice settings. This will help to achieve a sustainable approach to workforce development, and increase the number of patients who can benefit from direct access to physiotherapy services within primary care.

Indemnity

Physiotherapists have autonomous clinical responsibility for patients, and carry their own professional liability insurance.⁽¹¹⁾ If GPs employ

physiotherapists in their practice, then as employers they will need to cover the acts and omissions of their employees. If they are contracting with a physiotherapist, then the individual's PLI will cover their practice. From the PLI claims to date, there is no evidence of increased risk of claims against MSK physiotherapists in the primary care setting.

The following three examples describe the different insurance arrangements required for physiotherapists in General Practice. All the examples are predicated on the basis that the physiotherapist is a fully practicing member of the CSP:

- The physiotherapist is employed by the general practice – as the employer the practice would need additional insurance in place to cover vicarious liabilities including the PLI for the acts and omissions of their employees.
- The physiotherapist is contracted from another employer such as the NHS to work in general practice – insurance cover would be provided by the employer which in this case is the NHS or NHS provider
- The physiotherapist is self-employed (acting as a sole trader) and contracts with the GP would have PLI cover as part of their membership package. If the physiotherapist is not acting as a sole trader, then they should look at the specific guidance available on the CSP website or contact CSP insurers directly for further advice.

The CSP website provides more detailed information www.csp.org.uk/professional-union/practice/insurance/csp-pli-scheme

The GP team

Patients will need to be directed to the FCP service in a streamlined manner. As part of the setting up of these roles, the physiotherapist should provide frontline staff with training and ongoing advice. Practice staff have a key role in marketing the service effectively and offering patients appointments with the FCP.

The following algorithm and checklist of inclusion/exclusion criteria are helpful in delivering consistency in how questions are asked and how responses are delivered. It is important to invest time in this process, as patients may require some explanation from reception staff as to how their problem will be dealt with.

See Appendix 2 for examples of an algorithm and an inclusion/

System readiness checklist

The NHS England FCP HII specification sets out an expectation that each STP will develop a large scale pilot of the FCP model as part of the MSK pathway.

To accompany the specification they have produced a system readiness sustainability checklist, which includes high level criteria for STPs selecting pilots sites.

High level pilot site selection criteria:

- Desire to host a new FCP site or adaption of current site to adopt FCP HII specification requirements
- Commissioner able to adopt new commissioning model and develop service specification in Q1-2 2018/19
- Work with a minimum population of 50,000 (i.e. GP network) or full CCG
- Fully established physiotherapy workforce
- Stakeholder buy-in to transformation
- Identified executive sponsor and clinical champion(s)
- Ability to engage with evaluation, ideally through the standardised data collection requirements

Implementation checklist

The table below provides a check list for those implementing FCP roles in General Practice. While the checklist is by no means exhaustive, answering the majority of questions with a 'yes' should demonstrate that a service will be ready, safe, effective, patient-centred, integrated, and sustainable. Where the response is no and there is qualification in the comment column further support must be sought to explore what the blocks and barriers are to further progress.

	Yes	No	Comment
Need			
Can you identify the data that you will collect that will show the impact and benefit of the new model of service delivery? E.g., reduce GP waits, improve surgical conversion rates, reduce orthopaedic outpatient waits, reduce wastage of injections and investigations, improved patient experience and outcome. If you are an HII pilot site, data items will be collected as part of the NHS England /CSP led evaluation processes?			
Can you: <ul style="list-style-type: none"> identify all stakeholders who have an interest in the FCP, e.g., GPs, radiology, podiatry, orthopaedics, patient participation groups, MSK physio services, ICATS or similar triage services identify stakeholder support in working with the new role collect the views from stakeholders as to where benefits will be seen in the MSK pathway/system? 			
Funding			
Has funding for the FCP been arranged? Including options for redirecting existing physiotherapy resources (within MSK physio or ICATS or similar triage services)?			
Have you approached the CCG, LMC, Better Care Fund, GP Federation, NHSE regional transformation fund, or other source for pump-prime funds for initial set up/piloting of model?			
If seed funding or pump prime funds have been used is there an agreement with the CCG about a transition to funding from baseline CCG budget?			
Governance			
Has a format for clinic documentation, standardised examination tools, protocols for patient correspondence and communication with other services/stakeholders been agreed?			
Have you identified where clinical documentation will be aligned i.e. either GP records or trust records or both?			

	Yes	No	Comment
Can you identify the shared protocols agreed with the practices that support the safe management of red flags and other serious findings?			
Can you identify the procedures in place that ensure safety for all patients in respect of cover for annual, unexpected or sick leave, i.e., to action results or follow up on urgent matters?			
<p>Is there agreement and time allowed to attend:</p> <ul style="list-style-type: none"> • The regular GP meetings to discuss cases and share learning? • Multidisciplinary or MSK physiotherapy learning sessions to share and support system wide learning? • Appraisal and personal develop plan sessions to enable goal and performance monitoring. • Peer supervision/ including networks to enable shared learning (may be linked to other part of role if employed in physio or ICATs service)? 			
<p>Are agreed procedures in place? For example:</p> <ul style="list-style-type: none"> • Requesting imaging/haematology/biochemical investigations? • Interpretation and return of imaging/haematology/biochemical investigations • Acting on results of investigations • Injection therapy • Independent prescribing • Patient Group Directions or Patient Specific Directions • Management of serious findings • Cover when away to action results? 			
Evaluation			
Have adequate resources been made available to support service evaluation and audit for the new physiotherapy role to be delivered? (This includes service numbers, patient experience, referrals to secondary care, surgical conversion, referrals to physiotherapy & staff feedback.)			

	Yes	No	Comment
Have mechanisms been put in place to ensure analysis of the data from service evaluation of the role?			
Leadership			
Can you identify how the new physiotherapy service should align with: <ul style="list-style-type: none"> current policy drivers the organisations or local system's strategic plan and vision? Can you demonstrate how this alignment influenced the service design and delivery? 			
Can you identify how GPs and Practice staff have been involved in development of the role? Did this engagement influence the design and delivery of the service?			
Has the scope of the role been agreed by both the GPs and the physiotherapy service? Has the knowledge and skills required being matched with the local workforce? If no, can you identify the barrier or issue? How have the competencies for the role been signed off (physiotherapy and GP sign-off needed)?			
Have service users been involved in the development of the service? (e.g., local GP practice patient participation groups.) Can you identify their views and how these views have shaped the service design and delivery?			
Has the service been promoted to all potential users? If yes, can you identify how and how successful this process has been?			
Development			
Can you demonstrate compliance with the MSK capabilities framework?			
From the MSK capabilities framework, can you identify your specific development needs and the routes and resources to support appropriately matched CPD?			
Have you established rotations into primary care to support future workforce development?			
Has a GP been designated who is willing to undertake regular mentorship for the FCP?			

	Yes	No	Comment
Can you identify the workforce development plan that includes succession planning for future FCP roles in primary care?			
Digital support and integration with primary care systems			
Are your current data capture/recording systems integrated with Primary Care systems e.g. EMIS, System One, Vision?			
Are there data recording systems within the GP practice that you could use?			
Referral management			
Can the GP referral system be used by the physiotherapist to refer patients to all necessary care?			
Has the appointment length for the physiotherapist been agreed with the whole practice team?			
Have you agreed referral protocols with the radiography/imaging services?			
Clinic space			
Have you identified the minimal clinic time/sessions you would need based on the population of the GP surgery?			
If yes, Is there suitable clinic space for the physiotherapist in the general practice?			
Is there sufficient reception and administrative provision to ensure the smooth running of the physiotherapy service?			
Are there computer & printer facilities for the physiotherapist?			
Will the computer systems support all necessary programmes?			
Has an induction process been put in place for the physiotherapists?			
Have you identified what the clinical sessions will comprise of? i.e. how many F2F appointments, telephone reviews and admin time			
Support services			
Have the reception staff had suitable support and training to understand the role of the FCP and use the appropriate referral criteria?			
Where applicable, has support been arranged for the physiotherapist for services such as chaperoning, counselling, etc.?			
Have you established clear methods of communication & education, both formal and informal, with secondary care services e.g., orthopaedics, pain services, rheumatology, imaging, physiotherapy?			

9 Further information

- On physiotherapists' professionalism, see: www.csp.org.uk/publications/code-members-professional-values-behaviour
- On how physiotherapists are regulated in the UK, see the HCPC website: www.hcpc-uk.org/aboutregistration/
- On advanced practice physiotherapy roles, see: www.csp.org.uk/publications/advanced-practice-physiotherapy
- Think Physio for Primary Care England: <http://www.csp.org.uk/professional-union/practice/primary-care/physiotherapy-primary-care-summary-briefing>
- Physiotherapy Case Studies database: <http://www.csp.org.uk/professional-union/physiotherapy-works/resources/physiotherapy-case-studies>
- Health Education England, in partnership with NHS Improvement and NHS England, National Framework for Multi-Professional Advanced Clinical Practice: <https://hee.nhs.uk/our-work/advanced-clinical-practice/multi-professional-framework>
- Health Education England and the SCW Commissioning Support Unit First Point of Contact Model to calculate savings: <http://arma.uk.net/musculoskeletal-networks/network-resources/#MSK-First>
- Salary scales for Agenda for Change bandings can be found on the NHS Employers website. www.nhsemployers.org/your-workforce/pay-and-reward/agenda-for-change/pay-scales
- More detail on co-commissioning including which areas are involved can be found at: www.england.nhs.uk/commissioning/pc-co-comms/
- More details on private liability insurance: www.csp.org.uk/professional-union/practice/insurance/csp-pli-scheme

At the time of writing the following are due for imminent publication:

- NHS England First Contact Practitioner specification, implementation framework, FAQ
- Health Education England and NHS England MSK core capabilities framework

Once published this guidance will be updated to include and they will be featured on the CSP website: <http://www.csp.org.uk/professional-union/practice/primary-care>

10 References

1. British Medical Association. Responsive, safe and sustainable: our urgent prescription for general practice. London: British Medical Association; 2016. URL: <https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/urgent-prescription-for-general-practice>
2. Royal College of General Practitioners. A blueprint for building the new deal in general practice in England. London: Royal College of General Practitioners; 2015. <http://www.rcgp.org.uk/campaign-home/sign-up/building-the-new-deal-for-general-practice.aspx>
3. Landen Ludvigsson M, Enthoven P. Evaluation of physiotherapists as primary assessors of patients with musculoskeletal disorders seeking primary health care. *Physiotherapy*. 2012;98(2):131.
4. Arthritis Research UK National Primary Care Centre. What do general practitioners see? *Musculoskeletal Matters Bulletin* no1. 2009. <https://www.keele.ac.uk/media/keeleuniversity/ri/primarycare/bulletins/MusculoskeletalMatters1.pdf>
5. Jordan K, Clarke AM, Symmons DP, et al. Measuring disease prevalence: a comparison of musculoskeletal disease using four general practice consultation databases. *Br J Gen Pract*. 2007;57(534):7-14. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2032694/>
6. Royal College of General Practitioners Birmingham Research Unit. Weekly returns service annual prevalence report 2007. London: Royal College of General Practitioners 2007. <http://ghdx.healthdata.org/record/united-kingdom-england-and-wales-weekly-returns-service-annual-report-2007>
7. Bishop A, Ogollah RO, Jowett S, et al. STEMS pilot trial: a pilot cluster randomised controlled trial to investigate the addition of patient direct access to physiotherapy to usual GP-led primary care for adults with musculoskeletal pain. *BMJ Open*. 2017;7(3) <http://bmjopen.bmj.com/content/bmjopen/7/3/e012987.full.pdf>
8. Holdsworth LK, Webster VS, McFadyen AK. What are the costs to NHS Scotland of self-referral to physiotherapy? Results of a national trial. *Physiotherapy*. 2007;93(1):3-11.
9. Department of Health. The musculoskeletal services framework. A joint responsibility: doing things differently. London: Department of Health; 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf
10. The Chartered Society of Physiotherapy. Advanced practice in physiotherapy. London: The Chartered Society of Physiotherapy; 2016. URL: <http://www.csp.org.uk/publications/advanced-practice-physiotherapy>
11. The Chartered Society of Physiotherapy. CSP PLI scheme. London: The Chartered Society of Physiotherapy; 2016. <http://www.csp.org.uk/professional-union/practice/insurance/csp-pli-scheme>

11 Appendices

MSK and ACP frameworks – an explanation of their differences and links, CSP 18 May 2018

<p>Multi-professional capability framework for first point of contact musculoskeletal practitioners (June 2018)</p> <p>Accessible via the following link: [to be added when published]</p>	<p>Advanced clinical practice (ACP) framework (November 2017)</p> <p>Accessible via the following link: https://www.hee.nhs.uk/our-work/advanced-clinical-practice</p>
<p>Who is the framework for?</p> <p>The framework has been produced for use in England, but may have useful application in the other UK countries.</p> <p>The framework is multi-professional in its approach and relates to the medical and non-medical professions.</p> <p>It is feasible for registrants from any regulated healthcare profession to demonstrate how they meet the capabilities within their scope of practice.</p> <p>In reality, it is recognised that physiotherapists and GPs will be best-placed to demonstrate fulfilment of the capabilities (i.e. with the capabilities most naturally fitting with their scope of practice and personal competence, and implying the minimal amount of learning and development activity to demonstrate fulfilment).</p> <p>The particular relevance of the framework to physiotherapists and GPs is reflected in statements supplied by the CSP and the Royal College of General Practitioners (RCGP).</p> <p>The framework asserts the capabilities for roles with an MSK first point of contact focus.</p> <p>How was the framework developed?</p> <p>The capabilities were developed building on input from practitioners with expertise in the area. This included physiotherapists at each stage of the developmental process. The CSP was directly involved in the framework’s production.</p> <p>What is the framework designed to do?</p> <p>The framework is designed to assert what an MSK FCP is able to do, not what they should simply know. It does this across 14 domains of practice.</p>	<p>Who is the framework for?</p> <p>The framework has been produced for use in England. It has strong similarities with advanced practice frameworks produced in the other UK countries.</p> <p>The framework is multi-professional in its approach and relates to registered practitioners in the non-medical professions.</p> <p>It asserts the capabilities required for advanced clinical practice (ACP) as a level of practice, rather than for particular ACP roles.</p> <p>It is feasible for registrants from any regulated healthcare profession to demonstrate how they meet the capabilities within their scope of practice. It is not specific to any profession, specialty, sector, setting or job role.</p> <p>How was the framework developed?</p> <p>The capabilities were developed through HEE-led work, within which AHP engagement was secured.</p> <p>The CSP was directly involved in the framework’s production, including to ensure its inclusive approach and its responsiveness to changing workforce needs.</p> <p>What is the framework designed to do?</p> <p>The framework asserts ACP as a level of practice. It does this across four domains of capabilities. These relate to clinical activity, leadership and management, education and research.</p>

<p>The framework is intended to be used to:</p> <ul style="list-style-type: none"> • Identify and address learning and development needs at an individual level • Design learning and development programmes • Set out from a service delivery and patient care perspective the remit, responsibilities and approach of MSK FCP roles. 	<p>The framework is designed to be used to identify and address learning and development needs at an individual level and to design learning and development programmes.</p>
<p>The framework can be used to test/affirm that individual practitioners hold the capabilities to practise in an MSK FCP roles. This is likely to become increasingly significant in how it is applied.</p>	<p>The framework can be used to test/affirm that individual practitioners hold the capabilities for ACP roles. This is likely to become increasingly significant in how it is applied.</p>
<p>How does the framework define capabilities?</p> <p>The capabilities broadly and intentionally reflect the demands of Master’s level (level 7) learning, particularly in relation to managing complexity, uncertainty, ambiguity and risk.</p> <p>The framework does not detail the underpinning knowledge and skills required – beyond the indicative listing supplied as an appendix – nor specifies the learning and development process that should be enacted to enable practitioners to achieve the capabilities.</p> <p>The framework links with the clinical domain of the ACP framework.</p>	<p>How does the framework define capabilities?</p> <p>The capabilities broadly and intentionally reflect the demands of Master’s level (level 7) learning, particularly in relation to managing complexity, uncertainty, ambiguity and risk.</p> <p>The capabilities within the clinical domain of the framework broadly correlate with the MSK FCP framework capabilities.</p> <p>Physiotherapists wanting/needing to demonstrate their fulfilment of the ACP framework capabilities would do so through the prism of their particular role/clinical focus; e.g. this could be through demonstrating fulfilment of the MSK FCP framework capabilities.</p>
<p>How does the framework link with the ACP apprenticeship?</p> <p>The advanced clinical practitioner (ACP) apprenticeship could form an employer-funded route through which physiotherapists are enabled to progress into an MSK FCP role.</p>	<p>How does the framework link with the ACP apprenticeship?</p> <p>The capabilities of the ACP framework and the knowledge, skills and behaviours (KSBs) set out in the advanced clinical practitioner (Master’s level/level 7) apprenticeship broadly align (including in covering the same four domains).</p> <p>The ACP apprenticeship will now form an employer-funded route through which physiotherapists and other registered healthcare professionals are enabled to progress into ACP roles. this includes as FCP practitioners.</p>
<p>How can members use the framework?</p> <p>A physiotherapist in an MSK FCP role, as set out in the framework, wanting/needing to demonstrate their fulfilment of the framework would evidence how they meet the capabilities. A proportionate, enabling process for this is currently being piloted by Health Education England (HEE).</p> <p>A physiotherapist in an MSK FCP role wanting or needing to demonstrate fulfilment of the ACP framework would also need to demonstrate how they meet the capabilities across each of the framework domains (i.e. relating to management/leadership, education and research, as well as their clinical practice).</p>	<p>How can members use the framework?</p> <p>A physiotherapist in an MSK FCP role (or any other role) wanting or needing to demonstrate fulfilment of the ACP framework would also need to demonstrate how they have achieved the capabilities in the other three ACP domains (relating to management/leadership, supporting others learn and research).</p>
<p>What is being done to implement the framework?</p> <p>HEE is progressing work to test out possible (portfolio-based) approaches to implementing the framework. CSP members are involved in this, and the CSP is informing how the process is developed and evaluated.</p> <p>It will be useful for HEIs to review their education provision (at pre- and post-registration levels) against the capabilities and to consider how they can usefully map their curricula against them.</p> <p>Over time, it will be useful to more proactively consider how education provision can most usefully be designed and delivered overtly to enable learners (again, whether students or qualified practitioners) to demonstrate their fulfilment of the capabilities.</p> <p>Work is being funded by HEE to develop e-learning materials to support individuals’ engagement with/fulfilment of the capabilities.</p>	<p>What is being done to implement the framework?</p> <p>HEE is funding project activity via the Council of Deans of Health to support HEIs’ re-design of their post-registration Master’s provision to align with the ACP framework and apprenticeship. The CSP is directly involved in shaping and progressing this.</p> <p>Individual HEIs are reviewing their ACP Master’s provision to ensure that it is inclusive of all relevant level 7 learning opportunities. The CSP has alerted physiotherapy teams to the need for this and is providing advice at an institutional level where sought.</p> <p>HEE is progressing work to test out possible (portfolio-based) approaches to this, with CSP members involved.</p>

11 Appendices

Appendix 2: Examples of guidance for reception staff

Inclusion/exclusion criteria to guide reception staff when booking with the FCP

The role of the FCP in Primary Care is to assess patients with soft tissue, muscle and joint pain and to decide on the most appropriate management pathway. FCPs are physiotherapists with expertise in the assessment and management of Musculoskeletal (MSK) conditions.

If you are unsure if a patient is appropriate, please discuss with your FCP and they will be happy to advise you

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none">• All soft tissue injuries, sprains, strains or sports injuries – upper and lower limb• Arthritis – any joint• Possible problems with muscles, ligaments, tendons or bone eg tennis elbow, carpal tunnel syndrome, ankle sprains• Spinal pain including lower back pain, thoracic and neck pain• Spinal pain including arm / leg symptoms +/- neurological symptoms eg pins and needles• Mobility changes• Post orthopaedic surgery	<ul style="list-style-type: none">• Acutely unwell• Children under 16• Acute LBP if the APP is not available on that day• Medical management of rheumatoid conditions• Women’s health, Antenatal and Postnatal• House bound patients• Medication Reviews• Neurological and respiratory conditions• Headaches• Acute mental health crisis• Patients who do not want to see a FCP

Algorithm to guide reception staff when booking with FCP for patients 16+

