

Musculoskeletal First Contact Practitioner Services



Implementation guide

Developing people for health and healthcare

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Foreword

With the NHS Long Term Plan and the new GMS contract there is at long last promised significant investment in Primary and Community Care. A key aspect of this is the support to employ more than 20 000 healthcare professionals as part of the wider primary care multidisciplinary team. First contact MSK practitioners are a vital element of this new workforce. A significant proportion of patients present to general practice with musculoskeletal problems. This new workforce provides an opportunity to provide early intervention for patients with MSK conditions at the front of the care pathway by Advanced Practitioners improving patient care, and to work alongside GPs as part of the multi-disciplinary team allowing GPs to focus on patients that need their skills as expert generalists. This framework will support the implementation of this promised and welcome new workforce.

***Suzanne Rastrick
Chief Allied Health Professions Officer (England)
NHS England and NHS Improvement***

***Prof Simon Gregory DL
Deputy Medical Director, Primary and Integrated Care, Health
Education England***

Case study

More than one in five GP consultations are for MSK problems. There are over one million patients seen in general practice every year and this has increase significantly over the last five years. With a falling number of GPs to meet the demand, other ways of expanding the capacity is needed to help meet the patient demand. With an ageing population and more people with long term conditions this is becoming increasingly important as demand is going to increase significantly over the next 5 years.

NHS England published the Five-Year Forward View (FYFV) in 2014 which included the establishment of new model of delivering care. The Hampshire became one of the 'Vanguard' sites which were selected to test out these new models of care. One of our first initiatives was to explore how other healthcare professions could help with the capacity in general practice.

We decided that MSK was a good place to start. Our hypothesis was that if we had an experience physiotherapist, who would become part of the practice team, and was able to see patients who presented with MSK problem without having to see a GP first, we could improve access for patients and provide more capacity.

Our MSK practitioner had two surgeries booked a week based in a practice. When patients contacted the practice for an appointment, they were offered the option of seeing a GP or an



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MSK specialist. Over a 9-month period we showed a high level of patient satisfaction with the new MSK service.

Our pilot showed that the MSK specialist being present in the practice opened up lines of communications with the GPs who increased their understanding and knowledge. We showed that the cohort of patients who saw the MSK specialist were prescribed less medication, has fewer investigations and were referred less often to secondary care.

Our conclusion was that basing a first point of contact MSK practitioner in a general practice will help with expanding the capacity and it also helps the system by reducing costs.

Ultimately, I see Primary Care Networks not only having first point of contact MSK practitioners based in practices, I also believe that this could provide a focus for delivering a much more integrated MSK service incorporating community physiotherapists.

***Dr Nigel Watson
GP and Vanguard Lead in Hampshire
Chief executive Wessex Local Medical Committee.***



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Developed by the CSP with contributions from: College of Podiatry, Institute of Osteopathy, Royal College of Occupational Therapists and the British Medical Association, ARMA, NASS, Versus Arthritis NHSE/I, NHS Right Care/ HEE And many individual stakeholders from the iCSP network, Primary Care teams and healthcare organisations.



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Introduction to this guide

Musculoskeletal (MSK) First Contact Practitioner (FCP) services position highly skilled and regulated MSK practitioners at the first point of contact in primary care.

This means that a patient presenting to a GP practice with an MSK condition can see a FCP at their first appointment, accelerating their MSK assessment, treatment plan and (if appropriate) investigations and referral, along with saving both time and resources within primary care teams.

As regulated MSK practitioners, FCPs work at an Advanced Clinical Practice (ACP) level. This “is a level of practice characterised by a high degree of autonomy and complex decision making... It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people’s experience and improve outcomes”.¹ The skills and knowledge required for this role are attained through postgraduate-level MSK learning, which may include independent prescribing skills, injection therapy skills and imaging expertise.

Evidence demonstrating the value of FCP is growing with NHS England’s evaluation of over 25,000 consultations across more than 40 FCP services.² Common outcomes include fewer referrals into secondary care, fewer requests for imaging and improved conversion rates to surgery. Following its recent inclusion in the NHS Long Term Plan, more general practices are reaping the benefits of FCP.

The transformation of the MSK pathway requires key stakeholders to work together to plan and develop FCP services that address local patient needs and workforce challenges and maximise efficiency in the local system.

This guide is intended for GPs, Primary Care Networks (PCNs), integrated care system leads, providers of musculoskeletal services, all clinical and non-clinical staff within primary care teams, and those involved in funding and commissioning MSK services.

¹ Multi-professional framework for England (NHS HEE)

² NHSE 2019 evaluation report



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It sets out the key steps to consider when implementing FCP services with links to resources that can act as a starting point for local use. As there is no 'one size fits all', this guide highlights the importance of aligning your chosen approach with local objectives and needs.

The guidance, data and details within this toolkit are based on hundreds of conversations, survey responses and meetings with system stakeholders, as well as information gathered from over 40 FCP services taking part in the NHS England evaluation (2018-19). Informed by this learning and best practice, this guidance provides information to help you deliver an optimal FCP service.





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Principles of FCP

The core principle of an MSK First Contact Practitioner service is that the patient sees the most appropriately skilled healthcare professional, in a primary care setting, as their first point of contact. The FCP approach is most efficient when multi-disciplinary primary care teams work together to share knowledge and, expertise, and pool resources. This helps to build strong working relationships, develop more effective services, and avoid duplication and inappropriate referrals and interventions.

The Right person:

- FCPs are regulated, advanced and autonomous health professionals trained to provide expert MSK assessment, diagnosis and first-line treatment, self-care advice and if required, appropriate onward referral.
- Health Education England (HEE) and NHS England (NHSE) agree that FCP roles require advanced level skills to manage individuals with undifferentiated diagnoses at the start of the pathway recognising the uncertainty and potential complexity of patients.
- FCPs working at this level have the confidence and expertise to assess, diagnose and provide first-line treatments within the appointment time without increasing referrals into secondary care or back to the GP.
- A range of Health care professionals, such as podiatrists, osteopaths and occupational therapists, may meet the capabilities as detailed in the [Musculoskeletal Core Capabilities Framework](#) and so may be able to fulfil FCP roles as determined by local need. However, currently physiotherapists fill the majority of FCP roles in Primary Care.



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The Right place:

- FCPs are based in primary care and can be accessed in the same way as GPs (i.e. via the receptionist or the practice's online booking system) or through a local triage process.
- Most FCPs can be in a variety of primary care settings including general practices, hubs, and same day access centres. These are often closer to where patients live (compared to hospital settings).

First time:

- Management of MSK caseloads through FCP allows the individual to access a practitioner with MSK expertise without a GP referral.
- This results in shorter treatment pathways and fewer referrals for imaging and secondary care treatment overall.
- It means patients receive timely preventative and rehabilitation interventions.
- At the start of the pathway, FCPs are in an excellent position to promote the benefits of improving health through smoking cessation, reducing weight and increasing physical activity.

Watch Health Education England's video series on MSK First Contact Practitioner services

Cheshire and Wirral Partnership NHS Foundation Trust

on the success of their 2015 FCP pilot, system-wide savings and subsequent expansion to 35 GP practices.



Gloucestershire Care Services NHS Trust

on how they established and embedded their FCP service within a GP cluster and the benefits and challenges of transforming the MSK pathway.



Frimley Health NHS Foundation Trust

on the impact of their service and their programme to develop new FCPs to enable sustainability and growth.





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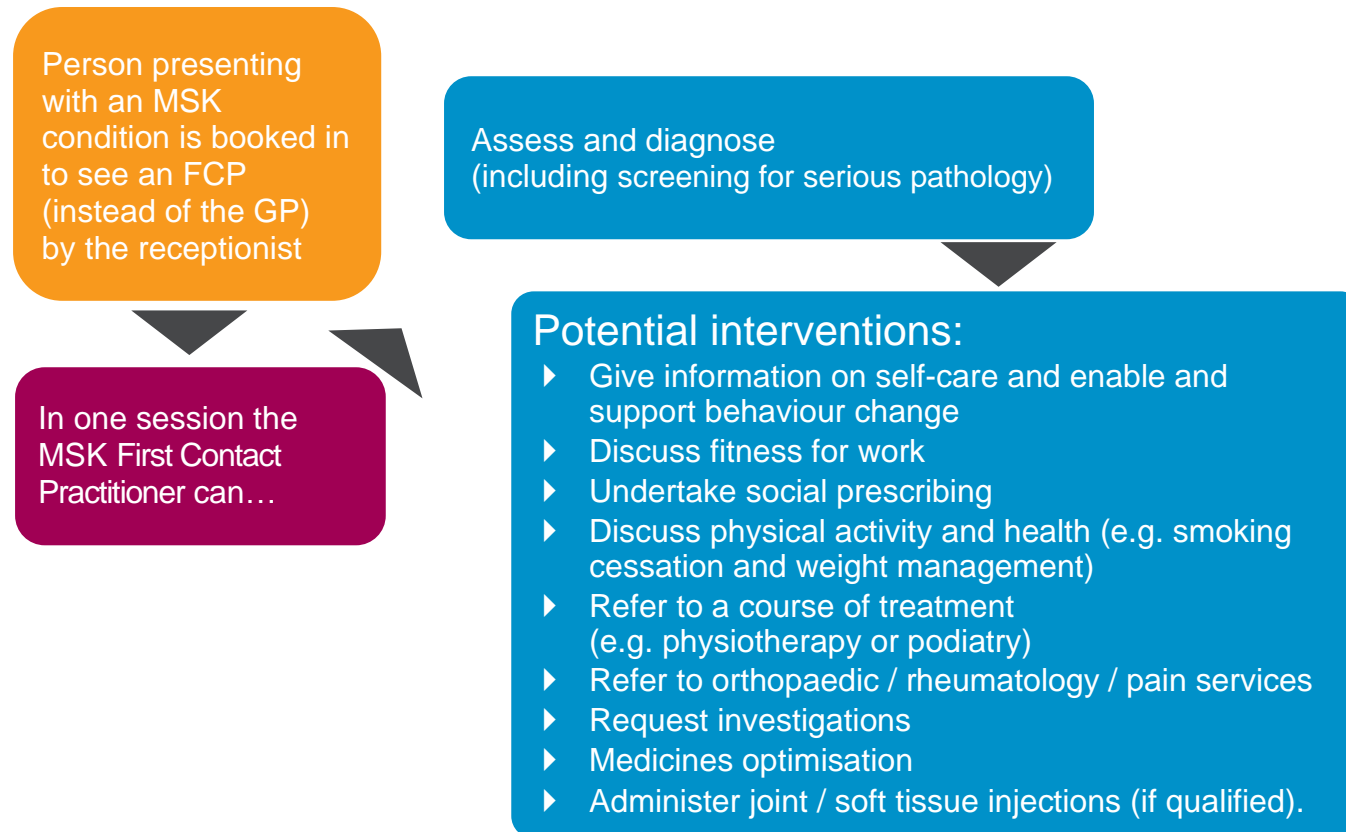
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What MSK FCP delivers

The FCP consultation will typically follow this path:



The FCP appointment:

Most FCP appointments are 20 minutes and, like most GP appointments, are delivered face to face. (Some areas are also exploring services delivered by telephone and video conference facilities.)

FCPs use the same referral pathways as GPs to secondary care, imaging and social prescribing, and review the results (diagnostic tests / imaging). Where necessary, FCPs can refer to the GP (and vice versa).

Safety netting: FCPs determine action plans in a timely manner. This includes being aware of potential presentations of systemic disease and the assessment of factors associated with serious pathology.



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How FCP fits into the MSK pathway

Most MSK pathways present several routes for patients to access the care they need.

Typically, the patient has received first-line treatment from their GP before being referred to an MSK service providing physiotherapy for treatment and before the decision is taken for onward referral to secondary care. Although FCPs can refer to the same MSK services as GPs, having the FCP at the front of the pathway streamlines and accelerates the patient's journey allowing quicker treatment and response and immediate management within the first appointment. (Only a small proportion of patients requiring onward referral and an even smaller number needing referral to a GP.) As such, referrals for investigations and specialist care are often made within the same day.

How FCP differs from other services

FCP and direct access / self-referral to MSK services: Unlike FCP, direct access / self-referral services are accessed by patients who know they need to see a clinician MSK expertise. The latter usually consists of a course of treatment, whereas FCP consultations primarily provide assessment, diagnosis and management advice. Because most people with an MSK issue

still go to their GP first, even when they can self-refer, these services do not significantly reduce demand on GPs.

MSK triage services: Clinical MSK triage services provide specialist clinical assessment of patients often carried out by advanced MSK physiotherapists or GPs with Special Interest. Whilst some specialist assessment and investigations may be delivered by FCPs, a proportion of patients will still require specialist assessment and investigation (delivered in a triage setting). Clear referral pathways can be developed to ensure that duplication is avoided

Integrated MSK Models: In some areas where, for example, interface services are not in place, service models are developed so that MSK patients are managed through an expanded MSK multidisciplinary team in Primary Care before Secondary care referrals are made.

For more information about how FCP transforms the MSK pathway, view NHS England's [First Contact Practitioner for MSK Services](#) specification.



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Why is FCP more efficient?

- Most patients are managed with self-care advice only (at first contact) with no onward referrals or investigations requested.
- Positioning MSK FCPs in primary care reduces the number of investigations (for imaging and blood tests), prescriptions and referrals to physiotherapy than usually requested in primary care.
- Fewer orthopaedic referrals are made however and an improvement in improved conversion rate to surgery has been demonstrated.

Case study: Forth Valley NHS

An FCP services provided by Forth Valley NHS published two years of data in 2019 from two GP practices in Central Scotland. The service was launched in November 2015 in response to GP shortages. Of the 8,417 patients analysed, 87.3% were managed within primary care. More specifically:

60.4% provided self-management advice only

10.4% referred to physiotherapy

9.9% required injections

9.2% referred for imaging

2.9% referred to orthopaedics

2.6% referred to physiotherapy (urgent)

1.8% sent for blood tests

1% referred to the GP

0.6% referred to podiatry

2.2% other intervention

Published in the [British Journal of General Practice](#)



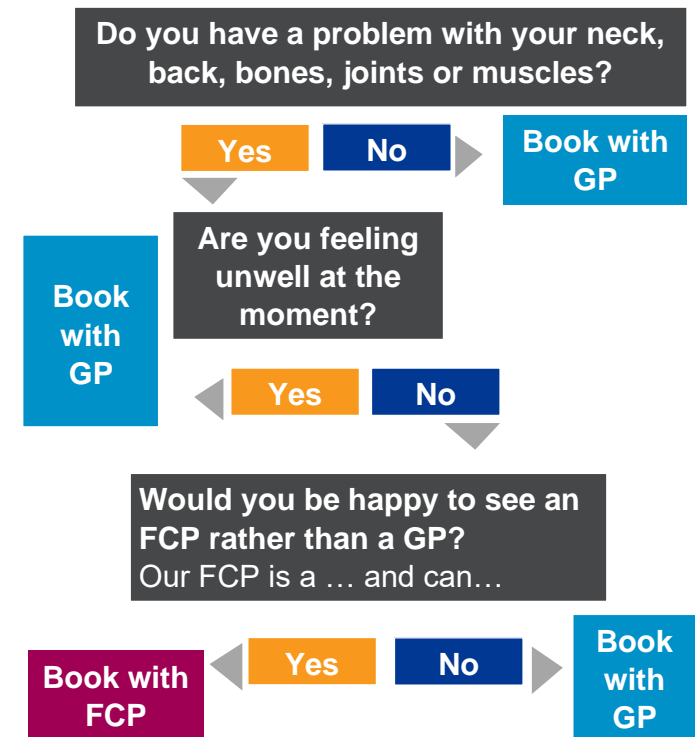
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Patient eligibility

Effective FCP services require appropriate care navigation. Receptionists play a vital role in this by directing patients to the most appropriate healthcare professional. The inclusion / exclusion criteria (below) and decision tree (right) provides an **example** of the care navigation process for a FCP. In some practices, the navigation process will need to account for the wider primary care teams. (The process of developing care navigation criteria and algorithms can support effective understanding of the role.)

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • All soft tissue injuries, sprains, strains or sports injuries • Arthritis – any joint • Possible problems with muscles, ligaments, tendons or bone (e.g. tennis elbow, carpal tunnel syndrome, ankle sprains) • Spinal pain including lower back pain, mid-back pain and neck pain • Spinal-related pain in arms or legs, including nerve symptoms (e.g. pins and needles or numbness) • Post-orthopaedic surgery 	<ul style="list-style-type: none"> • Acutely unwell • Children under 16 • Medical management of rheumatoid conditions • Women’s health, antenatal and postnatal problems • House-bound patients • Medication reviews for non-MSK conditions • Neurological / respiratory conditions • Headaches • Acute mental health crises • Patients who do not want to see an FCP

Example of a care navigation decision tree





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Stakeholder engagement

As a system solution that represents a new way of working, the implementation of FCP needs proactive, co-ordinated communication and engagement with a wide range of stakeholders.

This requires clear and open conversations about what the system is hoping to achieve and how this might happen. This involves:

- Identifying an executive sponsor(s) and clinical champion(s) who will advocate for FCP service development and encourage wider engagement.
- Seeking input from a cross-system implementation team that may include the following stakeholders:
 - MSK service
 - GPs, Practice managers and teams
 - Secondary care consultants
 - CCG, STP and Federation leads
 - Primary Care Network (PCN) clinical directors
 - Patient participation groups / representatives
- Developing mechanisms for stakeholder engagement that include the wider primary and secondary care team
- Reviewing the current MSK pathway, models of care, staff deployment, levels of referrals and investigations and comparing gap analyses with national guidelines and good practice examples
- Setting goals that are consistent with and support the local system's strategic aims for improvement that have been widely shared.
- Developing a service specification.

“The [GP] cluster pilots that we're running at the moment have been a fantastic opportunity for us to really build up closer relationships and closer working with primary care. There's a real role within community organisations and community services to work more collaboratively and we found that the ...benefit for patients is significant when you actually work collectively...”

Sarah Morton, Gloucestershire Care Services NHS Trust



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Employment and funding models

FCP roles can deliver sustainable cost benefits across the MSK pathway when supported by long-term commissioning models. This requires the chosen funding, commissioning and employment models to align with the needs of the local population, the Primary Care Network (PCN), the general practice(s), the FCPs and the local MSK services.

In England, FCP services are saving significant sums of money across their MSK pathways. These savings are being made in a variety of ways as local drivers for change determine which part of the system primarily pays for FCP roles. For example:

- If the main driver is reducing pressure on GP services, particularly in areas where recruiting GPs is challenging, the FCP service can be funded from the savings made from employing FCPs instead of locum GPs.
- If the main driver is reducing elective care demand, the FCP service can be funded from the savings made.

Commissioners are not expected to cut other primary care services to fund FCP. Instead, staff transfers, and recruitment must be made in ways that are both sustainable and scaleable.

Employment models

Potential employers of FCPs include:

- PCNs
- General practices
- GP Federations
- NHS trusts (or whoever is the existing MSK provider).

Though the CSP, BMA and RCGP recognise that different models have their own benefits, on balance, they recommend that existing providers of NHS services employ FCPs. This option helps to embed and integrate FCPs across the MSK pathway (where they can access training and peer support). It also enables the provider to ensure service consistency and staff continuity. In addition, this option provides stronger links



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between FCPs working in general practice and other MSK services across the MSK pathway.

View the NHSE's [five-year framework for GP contract reform](#) and the [BMA's PCN Handbook](#)

The Additional Roles Reimbursement Scheme

First Contact Physiotherapist roles created from 31 March 2019 are likely to be funded in part by PCNs through the **new Additional Roles Reimbursement Scheme** (ARRS). This is detailed in the [five-year framework for GP services](#) as agreed between NHS England and the BMA General Practitioners Committee (GPC) published in January 2019. The scheme is intended to create an estimated 20,000+ additional posts in five reimbursable primary care roles by 2023/24. These are:

- Clinical Pharmacists
- First Contact Community Paramedics
- First Contact Physiotherapists
- Physician Associates
- Social Prescribing Link Workers

Through ARRS, NHS England will reimburse employment on-costs, and 70% of the ongoing salary costs. By 2024, an average PCN will have access to sufficient funding to employ three FCPs, in addition to five clinical pharmacists, three link workers, two physician associates and one community paramedic. However, the framework grants flexibility to PCNs to determine the staff mix of the extended team employed through the Scheme. (**Please note:** NHS England's GP Contract Framework only names First Contact *Physiotherapists* as reimbursable under ARRS.)

Where FCPs are employed by an NHS trust or other non-PCN body, the proportion of time that the FCPs spend on PCN-related activity (WTE) will be used to calculate the actual salary costs eligible for reimbursement through the ARRS.

The ARRS does not prevent PCNs, or member practices, from employing staff outside of the scope of the Scheme – for example, other Allied Health Professionals in MSK FCP roles, or First Contact Physiotherapists working in pathways other than MSK. In order to claim reimbursement, members of the PCN will need to agree over the make-up of their workforce and to include any FCPs employed or contracted prior to April 2020. In addition, FCPs employed or contracted prior to April 2020 and becoming a PCN resource will need to be reimbursed from within the ARRS (see section 4.2 and 4.3 of [Network Contract Directed Enhanced Service Guidance](#)).



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The GP contract framework agreement leaves it to PCNs to decide how new roles are employed through the ARRS (as listed on the previous page). The BMA's [The Primary Care Network Handbook](#) provides further information about employment options including the 'Non-GP provider model'.

It is possible PCNs' membership agreements can be expanded to describe members' responsibilities regarding additional staff groups. Each PCN is expected to provide details in their members shared and legally binding Network Service Agreement on their arrangements for employing or contracting an extended general practice team through the ARRS, and how relevant individuals will be deployed in relation to the PCN activity.

Other funding sources

For the other 30% of FCP salary costs, and for FCP posts established before 31 March 2019, the funding options include:

- Commissioning by the CCG as part of an integrated MSK pathway
- Savings from reductions in secondary care referrals and surgical interventions

- Transformation funding maybe available and is used by some CCGs and STPs. It is typically fixed-term and designed to foster and facilitate the adoption of innovative practice. It is important that this is replaced with mainstream CCG funding once the pilots have demonstrated their value.
- Lead providers within an Integrated Care System could directly employ FCPs or contract from GPs
- GP practice funded: The GP practices and PCNs can choose to fund or partially fund their own FCP posts. For example, this could be from income generated by the FCP (though administering soft tissue and joint injections) or through reduced locum or GP salary costs. In these cases, the FCP could be contracted from the Trust, directly employed or join the practice as a partner).

Download the [MSK Cost Calculator](#) to calculate the cost savings and benefits of having FCPs in GP surgeries.

View the CSP's factsheet on [FCP funding and employment options](#)



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Indemnity

FCPs have autonomous clinical responsibility for patients and, as regulated professionals, are legally required to hold appropriate indemnity cover for their work. This may be via an employer, a professional body or other provider.

If GPs employ FCPs in their practice, then as an employer the Practice is required to provide suitable indemnity for their employees including FCPs. If the Practice is contracting directly with an FCP, then the individual FCP must ensure their own indemnity cover is suitable for their FCP role. The GP contract framework agreement includes the introduction of a state-backed indemnity scheme for general practice.

The [Clinical Negligence Scheme for General Practice](#) went live in April 2019 and provides all staff working in and for a general practice with clinical negligence cover subject to the terms of the policy. This includes Allied Health Professionals working in the delivery of primary medical services.





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Skills and Capabilities of the FCP

As regulated MSK practitioners, FCPs work at an Advanced Clinical Practice (ACP) level. This “is a level of practice characterised by a high degree of autonomy and complex decision making... It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people’s experience and improve outcomes”. The skills and knowledge required for this role are attained through postgraduate-level MSK learning, which may include independent prescribing skills, injection therapy skills and imaging expertise.

Two national frameworks outline the requirements to ensure patient safety, public confidence, and the development of professional competencies. These are:

Multi-professional Framework for Advanced Clinical Practice in England

The national ACP framework has been developed to provide a structured process to recognise the four pillars of Advanced Clinical Practice: clinical capability, leadership and management, education, and research skills of practitioners in Advanced Clinical Practice roles. As a minimum standard, FCPs must meet (or be working towards with appropriate mentoring) the capabilities as detailed in the Musculoskeletal Core Capabilities Framework.



Musculoskeletal Core Capabilities Framework for FCPs

This framework, commissioned by Health Education England and NHS England, sets out the core capabilities to deliver high quality, consistent and person-centred care for MSK patients presenting to an FCP. The following page provides information on the capabilities.





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The MSK Core Capabilities Framework

The Capabilities Framework enables commissioners of services to specify minimum standards for FCPs and supports managers to demonstrate that their staff meet these core capabilities or have developmental plans in place and clinical supervision to do so.

This [Framework](#) underpins the continuing professional development of FCPs to ensure their practice remains up-to-date, safe and effective. It also highlights that people with MSK conditions must be supported to make informed choices about effective treatment, care and support as part of shared decision-making.

The Framework comprises 14 capabilities across four domains (A-D) in addition to core knowledge, values and behaviours.

A. Person-Centred Approaches

1. Communication
2. Person-centred care

B. Assessment, Investigation and Diagnosis

3. History-taking
4. Physical assessment
5. Investigations and diagnosis

C. Condition Management, Interventions and Prevention

6. Prevention and lifestyle interventions
7. Self-management and behaviour change
8. Pharmacotherapy
9. Injection therapy
10. Surgical interventions
11. Rehabilitative interventions
12. Interventions and care planning
13. Referrals and collaborative working

D. Service and Professional Development

14. Evidence-based practice and service development

FCPs should work with their managers to identify areas of training and development required for the delivery of the local service using the MSK Core Capability Framework. Supervision and Continuing Professional Development (CPD) should be part of a sustainable job plan to support the delivery and the maintenance of clinical standards.

"I use the Framework to record my FCP-related CPD activity to demonstrate my competence in this role and to identify and plan areas for development. My aim is to complete the competencies over a two-year period to align with the HCPC audit cycle. I'm also looking at how this CPD can be matched as evidence towards the four pillars of Advanced Clinical Practice."
Corinne Birch, FCP, Somerset Partnership NHS Foundation Trust



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Job grading and titles

Grading

The grade of a specific FCP role will be assessed locally, taking into consideration the service needs. Currently advanced MSK practitioners working in the FCP role are either NHS Agenda for Change band 7 or 8a. For the *Additional Roles Reimbursement Scheme* (ARRS), NHS England has calculated its maximum reimbursement rates against these pay bands. How the role is evaluated will be determined by the complexity of the clinical workload and the scope of the role. Example job specifications for band 7 and band 8a will be released into the system early 2020.

Title

The term 'First Contact Practitioner' refers to nonmedical practitioners working in a role where they are the patient's first point of contact. The FCP has a duty to ensure that the patient understands who they are seeing and why. In order to ensure that patients are fully informed about who they are seeing, it is recommended that there is specific reference to the FCP's profession e.g. First Contact Practitioner (Physiotherapist), First Contact Practitioner (Osteopath), First Contact Practitioner (Podiatrist). This means that there is no ambiguity about the practitioner's professional background.

'Physiotherapist', 'osteopath' and 'occupational therapist', for example, are protected titles and require individuals to be registered and regulated by the [Health and Care Professions Council](#) (HCPC) or the General Osteopathic Council. The regulation of these titles' safeguards patients' interests and safety, and upholds public protection.

NB: Roles that are based partly in primary care and partly in community and/or secondary care services have been found to benefit recruitment and retention and improve links between services across the MSK pathway.



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Job planning

Job planning provides an opportunity to clearly define elements of practice. The FCP and their line manager should be able to agree and outline all the activities undertaken.

The amount of time spent on each activity will depend on the role and local service needs and should reflect the four pillars Advanced Clinical Practice Framework. These might include a combination of:

- Face-to-face and non-face-to-face patient interventions
- Continued professional development activities
- Teaching and training others including students
- Audit and research
- Management and leadership activities

Potential components of FCP job plans

Face-to-face and non-face-to-face patient interventions

- Average 6-8 appointments per session of 20 -30 minutes
- Telephone or virtual appointments
- Referrals to secondary care / imaging / social prescribing
- Review of results and clinical admin
- Supervision

Continued professional development activities

- Personal CPD and performance monitoring
- Peer-to-peer review
- Mentorship and training

Teaching and training others including students

- FCP-led training for clinical and non-clinical members of the primary care team about the FCP role and MSK pathway (This may also include GPs looking to increase their MSK expertise as well as trainee GPs shadowing FCP appointments.)

Management and leadership activities

- Practice meetings and governance activities
- Case review and triage

Audit and research

- Service evaluation

- View the CSP's [job planning tool](#)
- View example [job description](#) for FCP Physiotherapists



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Governance considerations

Appropriate governance arrangements are key to the success and sustainability of FCP posts. The design of these will be undertaken in conjunction with local planning and commissioning leads for MSK transformation.

These may include:

- standard service level agreement
- contract monitoring arrangements
- evaluation collection, reporting and review procedures
- mechanisms to support compliance with the HEE *MSK Core Capabilities Framework*
- shared protocols to support the safe management of patients presenting with systemic conditions and serious findings that may require early diagnosis and intervention
- procedures to cover for annual, unexpected or sick leave
- format for clinic documentation, standardised examination tools, protocols for patient correspondence, communication with other services / stakeholders
- agreed procedures for:
 - case reviews
 - investigation referral and review, injection therapy
 - independent prescribing
 - complaints and serious incident reporting

Download the CSP's FCP
[implementation checklist](#)



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Facilities for the FCP

Space

Securing a dedicated clinical space for FCP consultations is vital for sustainability. The majority of FCPs operate from a room within the GP practice. If the FCP is working across a hub of practices, the FCP may work in all the surgeries (and therefore require a space in each) or require patients to come to the surgery where a dedicated space is available. Where space in the practice is not available, reasonable adjustments may be made (e.g. a room in a community hub or hospital within close proximity of the general practice). Considerations about space should also be made ahead of any expansions to the practice team.

Equipment

Equipment available to FCPs operating within the primary care team is down to local discretion. This usually includes IT and telephone access, a plinth to examine patients, and basic medical assessment equipment.

Clinical systems

In order to provide a patient-centred approach to care, the FCP requires full access to the primary care electronic patient record (EPR). They would also require access to systems for referral, investigation request and review, interpreting services, for prescribing medications and appointment booking.

Chaperoning

To ensure that a patient's safety, privacy and dignity are protected during examinations by the FCP, the local chaperoning policy for the Primary Care Team should also apply to the FCP role.





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Resources for first-line interventions

FCPs will need the following for consultations:

- Access to (virtual and paper) patient exercise and information materials
- Access to the [Allied Health Professions Advisory Fitness for Work Report](#)
- Access to information (and/or directories) on local services and activities for social prescribing
- Resources to support the delivery of healthy lifestyle messages (see [Making Every Contact Count](#))
- Access to language line (if required for local population)
- Mechanisms for providing prescriptions on the appropriate form*
- Access to the British National Formulary (BNF)
- Equipment for soft-tissue and joint injections*

Information on prescribing
from [the CSP](#)

Medicines use and injection therapy

All FCPs are able, with appropriate training, to advise on over the counter (OTC) medicines. They can also supply and administer some medicines using patient group directions (PGD) or patient specific directions (PSD). First Contact Podiatrists will have specific exemptions to the medicines legislation that allow them to sell, supply and administer from a specific list of medicines used within the scope of their practice.

FCPs who have successfully completed an HCPC-approved prescribing programme and had their HCPC annotation updated, can prescribe medicines permitted to their profession using independent and/or supplementary prescribing routes. FCPs who have successfully completed training in injection therapy can deliver soft-tissue and joint injections provided they are able to use an appropriate medicines framework to access the medicines required.

Related resources

- [Social Prescribing at a Glance: HEE](#)
- [Social Prescribing: NHS England](#)



Booking appointments and service promotion

Care navigators, such as receptionists, play a fundamental role in ensuring the right patients are referred to the FCP.

Reception staff will need allocated time for training on which patients should be directed to the FCP and provided a visual guide to assist their decision-making (see page 7). Practices with multi-disciplinary teams and patient involvement groups are encouraged to develop their own care navigation guides to reflect the make-up of their teams. In addition, GP booking systems (including online and telephone systems) require updating to enable direct appointments with the FCP. Crucially, the primary care team must understand that FCP is not a service that primarily receives referrals from GPs nor is it a replacement for traditional physiotherapy treatment.

Service promotion

It is also vital to promote the FCP service to the general public using all available marketing channels to announce and maintain the profile of the FCP within the practice. Methods may include:

- patient flyers (with details about patient eligibility, the FCPs' availability and ways to book)

- the practice website and social media channels
- television screens in the surgery
- posters and signage
- the practice's patient newsletter
- at patient / local events
- local media.

Depending on your local population, it may be necessary to provide some of these resources in additional languages.

NB: Some existing FCP services have experienced higher demand at the start of delivery. However, this tends to settle as care navigation embeds.



Download the [CSP's FCP care navigation guide](#), [patient flyers](#), [posters and visuals for screens](#)



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Evaluating impact

FCPs require the means to capture standardised data to monitor and evaluate the effectiveness and efficiency of their service.

Evaluation of FCP starts with identifying baseline measures and, from thereon, collecting standardised FCP appointment data, patient satisfaction surveys and methods already employed at the practice (such as the Friends & Family Test). Services also need to consider local and national drivers when planning how to demonstrate impact. It is vital to ensure adequate resources are available to support service evaluation. This includes embedding a collection template on the GP clinical system (such as EMIS, Vision or SystemOne) ensuring FCPs record appointment activity.

Examples of FCP service impact

For patients

- Quicker access to assessment, diagnosis, first-line treatment
- Improved patient self-care and experience
- Improved speed of return to work
- Quicker recovery
- Shorter pathway to imaging and referral

For primary care teams

- Increased staff satisfaction and wellbeing
- Maintaining safety – reporting of any adverse events
- Improved GP capacity
- Improved level of MSK expertise within primary care team
- Increased MSK expertise within team
- Increased clinical leadership and service development capacity

For local healthcare system

- Reduced prescribing rates and costs
- Reduced secondary care referrals
- Improved conversion rates to surgery
- Reduced referral for further investigation (MRIs /x-rays)
- Reduced referral for the same condition
- Improved use of third sector / community programmes
- Improved timing of imaging referrals
- More appropriate referrals to secondary care services

Download the [CSP's FCP data guidance](#)
and example [patient questionnaire](#)



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FCP dataset

[The standardised national data collection templates \(and guidance\)](#) enable services to collect FCP appointment activity on primary care data systems and export the data for reporting at local and national levels. NHS Digital and the CSP is revising this national FCP dataset. It will include standard patient data fields (including demographics, past medical history, social history and employment status) alongside fields to support clinical decisions, audits and impact measuring. These include:

- Whether the patient has seen the FCP previously
- Consultation medium (e.g. face to face, telephone, online)
- Source of referral (e.g. self-referral, GP, A&E)
- The date of the referral request
- Changes to prescription data
- Onward referral location
- Clinical intervention
- Request for radiology or pathology
- Advice given (such as advice on physiotherapy, smoking cessation, weight management and social prescribing)
- Primary care actions (such as a referral to GP for a non-MSK problem or for a FCP follow up)
- Work advice

The dataset will be available on GP clinical system in due course.

Feedback examples

Patient, Rotherham: “I found the physio very professional with expertise in my particular problem. He assessed me fully and, just through my time with him, I became more confident in how to treat my problem.”

GP, West Cheshire: “The service has been an extremely valuable addition to patient care allowing for timely assessment and advice for common MSK problems. If anything, as the service has bedded in, I would suggest we actually need increased capacity. Given the delay in patients waiting to see a physio via GP referral, it would make more sense to develop the service so that additional time is put [FCP] allowing more appropriate selection of patients who need ongoing physio ‘input’.”

Simon Platt, Commissioning Manager, West Cheshire CCG: “After rolling out [FCP] across 35 of our West Cheshire practices, we’re continuing to see positive [results]. Last year, we saw 11,000 patients through the service and, through our monitoring of MRI investigation requests, made an additional £100,000 of savings against the previous year.”



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Induction into primary care team

As with any new staff member working in primary care, a thorough induction programme is required for FCPs. This may be delivered through a range of methods, such as meetings, shadowing and in-house training. The induction should include opportunities to:

- introduce the FCP to the primary care team, wider MSK service and key local services that he or she may encounter when supporting patients
- ensure all members of the primary care team (including receptionists) understand the FCP's role, the appointment booking criteria and care navigation
- familiarise the FCP with the relevant guidance, policies, digital systems and equipment
- ensure an awareness of the local support services within the social care and voluntary sectors.

Use an induction checklist to ensure that all areas are covered. If the FCPs work across several GP practices, it may be beneficial to consider a 'GP Training Hub' to provide consistency and avoid duplication.

Download the [CSP's induction checklist](#)



Continued training and development

As regulated healthcare professionals, FCPs will be required to engage in appropriate continuing professional development (CPD) activities. The [MSK Core Capabilities Framework](#) can help to identify the key areas for professional development and highlight gaps in the FCP's knowledge, skills or experience, and to ensure maintenance of their broad clinical competence. More courses (face-to-face and online) are becoming available.

Mentorship

FCPs, if new to this primary care role, will benefit from a period of mentorship as part of an extended induction programme or as an ongoing support. This will support effective integration into the primary care team and ensure that there is clarity on responsibilities and duties and the way they are discharged. This could be in the form of regular GP group teaching sessions, focusing on gaps in knowledge or skills, shadowing members of the GP's clinical team during face-to-face and telephone consultations. FCPs may also benefit from supervision and/or peer support from other experienced FCPs or staff within the wider MSK service.

E-learning:

- [MSK in Primary Care](#)
- [Person-centred approaches](#)



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A day in the life of an FCP

As one of three FCPs in my neighbourhood of GP practices, I work across three practices, holding two FCP sessions at each practice. Each four-hour session consists of an average of ten 20-minute FCP appointments with time allocated for maintaining patient records, completing referrals to onward care and contributing where appropriate to general practice management and leadership activities. The latter includes being actively involved, as required, in activities such as governance assurance, service evaluation, MSK education and performance management.

My day starts with an opportunity to discuss a couple of complex patients at the case review meeting, where we agree appropriate care management plans. I see eight pre-booked patients, one of which was a follow up appointment following referral for an MRI scan. I then confirm that two very appropriate patients have been allocated to the walk-in clinic, an acute back pain and an acute neck following a car accident two

days ago. After a 20 min catch up on imaging results and referral letters, I take a 30-minute lunch break and travel to the other practice. My eight-patient session included one UTA (unable to attend) that had been filled with a walk-in appointment, followed by a DNA (did not attend). This gave me the chance to catch up with one of the GPs on the audit I'm conducting to review the MSK pathway and share feedback with the local MSK interface service. I finished the session with a scheduled meeting with my mentor.

Once a week I hold an evening session made up of three pre-booked appointments and three walk-in appointments. Today this included prescribing Vitamin D supplements post blood results and a confirmed tibial stress fracture. I also gained agreement from two patients to contact the local social prescribing programme to help to manage their chronic pain and mental health and saw a follow up patient for steroid injection to manage their shoulder pain.

I then make a coffee and write my presentation on 'Implementing the FCP role' for another neighbourhood of GP practices that my lead GP has arranged.

Although my working week is often busy, it does give me great satisfaction to have the opportunity to successfully manage a patient's care right from the initial presentation of symptoms and, in many cases, reduce the time it takes to resolve their symptoms or effectively manage their condition. The feedback from patients daily makes it all worthwhile.





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AHP	Allied Health Professional	MDT	Multi-disciplinary team
ARRS	Additional Reimbursement Roles Scheme	MSK	Musculoskeletal
BMA	British Medical Association	NHSE	National Health Service England
BNF	British National Formulary	OTC	Over the counter
CCG	Clinical Commissioning Group	PGD	Patient group directions
CPD	Continuing Professional Development	PSD	Patient specific directions
CSP	Chartered Society of Physiotherapy	PCN	Primary Care Network
DNA	Did not attend	PLI	Professional liability insurance
EPR	Electronic Patient Record	RCGP	Royal College of General Practitioners
FCP	First Contact Practitioner	STP	Sustainability and Transformation Partnership
GPC	General Practitioners Committee	UTA	Unable to attend
HCPC	Health and Care Professions Council	WTE	Whole Time Equivalent
HEE	Health Education England		

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