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First Contact Practitioner (FCP) in MSK services: Frequently Asked Questions (FAQs)

1	If we already have an FCP service does this count as a FCP site?
	Any existing FCP service needs to comply with the FCP specification to be counted as an FCP site and meets the key criteria defined in the System Readiness Sustainability Tool designed to help local systems identify potentially operationally ready sites.
2	Where will the workforce come from for FCP roles?
	FCP roll out will largely be delivered from within the existing workforce, with physiotherapists currently deployed as part of triage, interface services, hospital outpatients or within community physiotherapy teams being re-deployed to work part of their week in primary care and GP practices. An under-supply of physiotherapy graduates over several years has created recruitment problems in some areas. However, this is changing rapidly, with physiotherapy education provision across England expanding to meet demand (demonstrated by a 15% increase in 2017/18). Indications from the Chartered Society of Physiotherapists show a projection of an increase of 41% physiotherapists completing training by 2020/21. Wider roll-out of FCP is phased over a five year period in-line with the NHS Long Term Plan and also mirrors NHS England's Primary Care Workforce workstream trajectory of recruiting 5000 additional physiotherapists in primary care over the next five years.
3	Will the local physiotherapy workforce have the right capabilities?
	The CSP estimates that approximately 10,000 registered physiotherapists (Full Time Equivalent) currently work at the recommended Bands (7-8a) and so are likely to have the advanced physiotherapy skills required for FCP. In addition, there are a number of potential MSK FCPs who could undertake further training to upskill as part of a phased rollout. FCP services are also expected to reduce referrals into triage and secondary care physiotherapy services, enabling staff to move into First Contact roles. To develop and maintain the capabilities for the role, FCPs must meet the requirements of the HEE & NHSE MSK Core Capabilities Framework.
4	Have the FCP case study sites met the FCP specification?
	The FCP case studies included in the FCP specification have demonstrated good practice in their development and implementation. Learning from the case studies has been used to inform the development of the specification. The case studies have not been assessed against the full specification requirements.

5	Can we work with a Primary Care Network if the population is below 50,000?
	To gain economies of scale and allow sustainable implementation we would expect these services to be piloted in larger networks or CCGs. However, if a locality believes this is feasible in a Primary Care Network with a smaller population (some are 30,000) then this can be agreed locally. We would expect any FCP site to cover multiple practices.
6	How will having an FCP affect MSK Triage, ESCAPE-Pain and existing waiting lists for community physiotherapy?
	FCPs should be able to refer patients to MSK triage for additional in-depth assessment and/or access to specialist investigations, where not available in Primary Care. Numbers of patients being referred to MSK triage however should reduce if FCP is delivered according to the specification. Referral to evidence-based interventions such as ESCAPE-Pain should also be streamlined as appropriate patients will be referred. FCPs, at the start of the pathway, manage a large proportion of patients who require advice, support and exercises. This reduces the numbers of those who are referred into community physiotherapy, so that a greater proportion of community physiotherapy services can be targeted at people who require a programme of physiotherapy treatment.
7	How much pump priming is needed for FCP services to be established?
	While some FCP services have not used pump priming, other FCP areas have. They have then absorbed this funding into the running cost of the service. These monies have been used to offset any double running costs when first establishing the service or to support service redesign, putting in place new processes, stakeholder and patient engagement, relationship-building and promotion. Pump priming costs have varied: • Cheshire & Wirral FCP service cost £300,000 in year one; £146,000 thereafter each year. • West Suffolk used £44,000 from CQUIN funding in the first year and the two practices subcontracted a physiotherapist to provide the service. • South Lincolnshire CCG received £27,500 funding from the NHS England regional team to provide FCP services to a population of 23,500 in the first year. The service continued into 2017/18 with the CCG funding £101,000 for the year on an invest-to-save basis. The funding for the service is now split between the CCG and GP practice.

8	How can the FCP role be funded in a sustainable way following the new GP contract and publication of the Long-term Plan
	The costs and benefits of FCP roles are realised across the pathway, and to be sustainable in the long term, commissioning mechanisms to reflect this will need to be negotiated and developed where they are not already in place. The local drivers for change will determine which part of the system primarily pays for FCP roles. For example: • If the main driver is reducing elective care demand, this is where the main savings are likely to be seen by implementing FCPs, and these savings could be used to fund the service. • If the main driver is reducing pressure on GP services in an area finding it difficult to recruit GPs, the main savings of the FCP are more likely to be directing MSK demand to FCP and a reduced demand for locum GPs, and these savings could be used to fund the service. We would not expect commissioners to cut other primary care services to fund this service, it should be established in sustainable way by transferring staff and making efficiency savings. As part of the new GP contract, NHS England is committed to funding additional practice staff including pharmacists, physiotherapists, paramedics, physician associates and social prescribing workers. through additional roles reimbursement scheme for Primary Care Networks (PCN) which will guarantee funding for over 20,000 additional staff. The physiotherapists funding within PCNs will commence from 20/21.
9	Will having an FCP in the pathway increase patient demand?
	Evidence demonstrates that the demand will remain the same. The difference is that now a proportion of MSK patients will be seen by an FCP rather than a GP. This increased use of the FCP's expertise enables more patients to effectively self-manage and reduces repeat appointments with the GP and onward referrals to secondary care. This role will increase capacity in the primary care team. However, if within a locality, there has been historically poor provision of MSK physiotherapy services; there may be a latent need within the population. Any provision of a new service will then be subject to an initial increase in demand. Evidence from national and international trials suggests this increase is very short term.

10	Will it be necessary to stimulate patient demand for FCPs?
	Yes. Public polling by the Chartered Society of Physiotherapy in Autumn 2015 and in December 2018 shows that most people are open to the benefits of seeing a physiotherapist in primary care without needing to see a GP first, but that a sizable minority would need convincing. Alongside other examples of expanding the GP team, there needs to be cultural and behavioural change in relation to patient expectations of GP services. To ensure (the right) patients see the FCP services either at or via the GP, reception staff need resources and training to enable them to promote the service and effectively navigate patients.
11	How can musculoskeletal (MSK) triage be incorporated into the FCP role?
	Clinical MSK triage services provide specialist clinical review of referrals after a GP has made a referral for an MSK condition. This can either be a review of the referral or face to face. The review is carried out by an advanced practice (sometimes called 'extended scope') physiotherapist or by a GP with Special Interest. As such, the same staff group can be delivering both FCP and MSK triage services in some systems. Where this is happening, it may be sensible to wrap MSK triage time into the FCP role when operating out of practices to allow quicker triage and direct support to GPs. This has occurred in the Taunton and Somerset FCP service which is highlighted as a case study in the FCP specification.
12	Does having a physiotherapist prescriber in an FCP role risk increasing levels of prescribing?
	Being able to prescribe medicines brings an additional value to FCP roles but is not a prerequisite. Large-scale evidence of physiotherapists' prescribing behaviour is not yet available. However, existing evidence shows that early advice from a physiotherapist reduces reliance on medicines. In keeping with the ethos of the profession and professional standards, prescribing FCPs are likely to reduce levels of prescribing in General Practice.
13	Can physiotherapists issue Fit Notes?
	Advice from the joint DWP and Department of Health and Social Care Joint Health Unit is that AHP Advisory Fitness for Work reports (AHP Fit Notes) issued by AHPs including physiotherapists can be accepted by employers as evidence of fitness for work, in the same way as a GP Advisory Fitness for Work report (GP Fit Note). Both are up to the employer's discretion.

14	Will GP premises be needed to accommodate more professionals in primary care?
	An important principle of the FCP role is that it is part of the GP team, as well as part of the wider MSK pathway team, ideally collocated in general practice. It may not always be possible for an FCP to operate from the GP practice – for example, because of limitations of premises and the practicalities of having a base at multiple GP surgeries. In these cases, alternative premises, located in close proximity to the practice(s), may be required. From whatever location the FCP operates from, the FCP and GP reception staff will need access to an integrated administration and booking system.
15	Who should employ FCPs?
	The CSP, BMA and RCGP recommend that FCPs are employed by existing providers of NHS services. This sees physiotherapists working within the GP practice team, as part of the MSK service that includes secondary care and/or community settings. In England, the evolution of Primary Care Networks, announced in the NHS Long Term Plan in early 2019, may see the emergence of different FCP employment models. Gloucestershire CCG has funded the Community NHS Trust to host advance practitioners to work half time in primary care and half time in advanced practice roles in the community organisation's MSK Interface service. The model provides indemnity, reduces clinical isolation, allows flexibility in moving workforce to deal with spikes in demand and provides a more sustainable model in terms of maintaining skill sets and competencies.
16	Will FCPs de-skill GPs in MSK?
	Although GPs will continue to see a proportion of MSK patients, FCP services will move a significant proportion of the MSK workload from GPs which will free up GP capacity to concentrate on more complex care. Patients retain the choice of which appropriate clinician they see. FCPs will provide advice and expertise into the whole GP team that could support GPs in developing their MSK skills. Having an FCP service provides upskilling opportunities for the wider Allied Health Professional team and physiotherapists.

17	How will the FCP sites be evaluated?
	The FCP evaluation will be led nationally, although this should not preclude local evaluation. The national Elective Care Transformation Programme (ECTP) team will track metrics to understand the impact of the FCP on activity, including secondary care referrals and GP workload. To facilitate this we recommend the use of data capture systems such as integrated primary care systems, and ideally using the standardised national data collection template for First Contact Practitioners.. The FCP evaluation involves: these are 1. Implementation of pro-forma - an initial template to articulate the approach taken locally to establish a FCP service 2. Quantitative data collection to: • Evaluate baseline pre-go live using NHS e-Referral Service data • Track progress against key performance indicators 3. Qualitative data collection including patient experience, outcomes and potential telephone/face to face discussion about what has/hasn't worked to understand underlying reasons why. The national ECTP team are exploring options of automating the process of collecting and submitting FCP evaluation data. This is still in the early stages; further information will be provided by end of July 2019.
18	How does FCP link in with existing community MSK services? Is there evidence of a collaborative approach in the pilot?
	There is evidence of a collaborative approach in the case studies provided in the FCP specification. The FCP service in West Cheshire link closely with an MSK triage service and are able to do triage work in their first contact role in general practice. The case study shows that this has greatly reduced the referral rate into their MSK triage or interface type services, so bringing the triage right into general practice.
19	How are FCPs linked with community physios and physios in secondary care, do they work together as a team. Is there any evidence that supports areas where it has worked and where it hasn't?
	Early pilots found services work best when FCPs are part of the MSK service. This brings secondary care and pathway expertise to the beginning of the pathway, bringing together the musculoskeletal integrated team across primary and secondary care. This also helps FCPs to build and maintain relationships with key stakeholder working in the local physiotherapy services, interface or triage services, orthopaedics, rheumatology and pain management to ensure the pathways are as streamlined as possible.

20	Is the model presented for FCP a Band 8A therapist?
	FCP is recognised as an Advanced Practice role as it requires the skills and knowledge to manage complexity and uncertainty with a high degree of independence and autonomy. The capabilities and experience this require strongly suggests that roles are at Band 7 Advanced Physiotherapist or Band 8a Principal. NHS and non-NHS employers should follow the Agenda for Change Job Evaluation Scheme and band profiles. Evidence shows that lower bands, such as Band 6s, tend to refer back to GPs more than the higher bands and require longer with patients and will require significant training to be compliant with the MSK Core Capabilities Framework.
21	How many physiotherapists would you expect to be employed in the practice with a population size of X?
	The number of FCPs required is dependent on a number of factors including what MSK services already exist in the locality and on the population's size and needs. The MSK calculator can help to work out how many FCPs are required for your population. This resource is available on the ARMA website : http://arma.uk.net/musculoskeletal-networks/network-resources/#MSK-First
22	Do you need to have shared electronic records?
	FCPs require access to integrated systems including booking systems and electronic records. The CSP has developed templates for capturing FCP appointment activity on primary care clinical systems. More information is on www.csp.org.uk/publications/first-contact-physiotherapists-fcps-standardised-data-collection
23	Given the current workforce constraints, are the sites expecting that the FCPs will be within a practice?
	FCPs work best when embedded in the general practice team and collocated in general practice. Some existing services encourage FCPs to work across primary care and secondary and/or community care settings. This helps to address concerns around fragmenting physiotherapy services, professional isolation and the loss of advanced knowledge and skills further along the MSK pathway. Risks can also be minimised by assessing the skills mix and ensuring FCPs maintain links with hospital orthopaedic teams.
24	Is the workforce currently out there?
	Physiotherapy as a profession is growing across the UK with a 35% increase in Higher Education Institute (HEI) pre-registration intakes since 2015. This expansion can provide backfill for mainstream MSK physiotherapy roles in order to allow clinicians with more advanced skills to adopt FCP roles, should they wish. In addition, it is anticipated that preregistration training will shift focus to build foundations for future primary care roles that will help sustain the future workforce.

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26	Has there been any resistance from practices in hosting FCPs
	Feedback from sites suggests that there has been some resistance from practices purely because of space in hosting FCPs, and so the services needed to look at other solutions to that. It is most ideal for physios to be collocated in general practice, but where that really isn't possible, then coming up with local solutions would be the second best option. Systems should work together to deliver the best services for patients and working to deliver multidisciplinary primary care workforces, which is in everybody's interest. It will allow GPs to focus their work on the more complex patients with long-term conditions and allow those patients that have physiotherapy concerns to see the MSK practitioner.
27	Is there any evidence of reduction in long term pain medication prescribing?
	The interim evaluation early adopter sites have evidenced a reduction in prescribing generally, however this will be evaluated as part of further evaluation work during 2019/20.
28	What data is there to support workforce planning? Are there any tools that you recommend to work out what we need for our population?"
	The Southwest Central CSU has developed a tool (hosted on the ARMA website) for calculating the financial and resource savings of MSK FCP services at practice, CCG and STP levels. Using assumptions pulled from the FCP literature, it estimates the number of FCPs needed for a certain population please follow link: http://arma.uk.net/musculoskeletal-networks/network-resources/#MSK-First
29	How does the MSK Core Capability framework support FCP implementation?
	HEE's MSK Core Capabilities Framework was written to enable services, commissioners, GPs and individuals to demonstrate and support the development of advanced clinical skills that provide patient safety, public confidence, and the development of professional competencies. HEE, NHSE and the Elective Care team agree that FCP roles require advanced level skills to manage uncertainty and risk with a high degree of independence and autonomy. The capability framework ensures that health professionals who provide care for people with MSK problems are equipped to consistently deliver person-centred care, can play a full role in helping to manage problems appropriately at the first point of contact and help towards achieving better outcomes across the system.

30	How are FCP services governed?
	Having appropriate governance structure are vital to the success and sustainability of FCP service. The design of these will be undertaken in conjunction with the local STP/CCG lead and PCN lead for MSK transformation. Governance structures needs to provide FCPs 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 and acquire new knowledge and skills, and engage in peer-to-peer review and reflective learning and practice.
31	Who is responsible for indemnity for FCP MSK service?
	Physiotherapists have autonomous clinical responsibility for patients and carry their own professional liability insurance. 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 Public Liability Insurance (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 Chartered Society of Physiotherapy (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 Clinical Negligence Scheme for General Practice (CNSGP) will be run by NHS Resolution and will become operational from April 2019 and will provide all GPs and all staff working in/for a general practice with clinical negligence cover, as well as the additional staff that have been negotiated to be employed as part of the primary care network 'contract'. The scheme will provide cover in perpetuity for any event that takes place after April 2019 (i.e. even after retirement of scheme members). The scheme will cover the NHS contracts that these staff operate within, including the core GP contracts (GMS, PMS, APMS) as well as out of

	hours contracts, local contracts and work requested/ commissioned by local authorities (e.g. public health related work). The scheme will provide cover for events that occur after April 2019, but run-off cover may be required for those who currently hold claims made cover. DHSC also intends to establish arrangements for an existing liabilities scheme from April 2019, whereby existing liabilities transfer from the Medical Defence Organisations (MDOs) to the state, however this is subject to negotiation with the MDOs. Practices will still require cover for vicarious liability, and individuals will still require MDO cover for work that sits outside of the primary medical services contracts (e.g. private work), as well as for representation and support (e.g. GMC hearings, responding to complaints). This cost will be significantly lesser than current subscriptions. Many practices currently purchase this cover for all staff within the practice, and we see no reason why this would cease. A funding adjustment to the core contract was agreed as part of the negotiations, however this is more than offset by additional funding going into the contract, therefore there is no risk to practice funding due to the introduction of the scheme.
32	How does FCP impact on MSK triage and can these services be integrated?
	We would expect FCP to impact other services such as MSK triage and physiotherapy. What this impact looks like will vary due to factors such as local population, workforce and commissioning models. In some areas the need for these services will continue, although the demand may reduce as more patients' access expertise earlier in the pathway. Where triage services are available, FCPs will have the option to refer patients to MSK triage for additional in-depth assessment and/or access to specialist investigations, where required.
33	How does FCP align with the NHS Long Term Plan?
	The NHS Long-Term Plan includes a clear commitment to build on the work undertaken during 2018/19 to ensure patients have direct access to MSK FCPs. The NHS Long Term Plan makes a commitment to build on work already undertaken to ensure patients have direct access to MSK First Contact Practitioners (FCP). The ambition is that the whole NHS England patient population has direct access to MSK First Contact Practitioners by 2023/24, across all primary care networks. This will be achieved through a national roll out of *additional* roles to increase the skill mix in primary care and to relieve pressure on GPs. This is outlined in the new GP contract published in January 2019 to fund over 20,000 through a reimbursement scheme. The scheme will meet a recurrent 70% of the costs of additional first contact physiotherapists. See: https://www.england.nhs.uk/publication/gp-contract-five-year-framework/

34	Where does the MSK triage service sit in the new patient pathway?
	An MSK triage service provides the option for referral of patients by the FCP and GP for additional in-depth assessment and/or access to specialist investigations, where not available in Primary Care. FCPs will provide accurate and detailed referrals ensuring that the right pathway can be identified without causing duplication.
35	How does the implementation of FCP link in with Care Navigator?
	Care Navigation is helpful in ensuring the flow of correct patients to the FCP who can assess and manage the undifferentiated MSK patient (without a previous diagnosis). The CSP has developed an algorithm and inclusion/exclusion criteria to support primary care teams have a clear understanding of FCP. See: https://www.csp.org.uk/professional-clinical/improvement-and-innovation/primary-care/first-contact-physio-patient-and Evaluation demonstrates that referral back to GPs is less than 2% when using effective care navigation.

If you have further questions or need additional clarification, please contact the team at:

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