

Musculoskeletal Physiotherapist First Contact Practitioners

Title: learning from case study sites

Number of case study sites: 16

NHS England and NHS Improvement

January 2020
Version 0.9



Birmingham and Solihull

First contact practitioners (FCP) model

SDS Healthcare provides a community-based musculoskeletal (MSK) triage service and first contact physiotherapy service in a hub location among the participating GP practices. The first group of FCPs were all senior Band 8a staff (except for one staff member) working at advanced practice level in a specialist orthopaedic hospital. The FCP service was funded through a £50,000 transformation fund and offered a 20-minute appointment slot.

The service is accessed via the GP clinical system as a task and not a referral.

The service offers a combination of virtual triage, telephone or digitally based and face-to-face assessments of patients.

Various MSK assessments and treatments are provided, such as holistic assessments – including many of the primary care QOF assessments – joint injections, imaging, blood tests and physiotherapy.

Payment to the GP provider is by an activity-based tariff structure.

Challenges

- Sourcing FCP staff was an issue. However, agreement was reached with one of the three local providers to provide suitable staff for the FCP pilot. Also, work is ongoing to secure FCP staff from the other providers for future expansion.

Key success criteria

- Effect on number of secondary care referrals and conversion rate.
- Satisfaction of service users, including patients, FCP staff and GPs.

Feedback

Patient:

- On average more than 75% of the 95 patients who completed survey rated the FCP service as excellent and helped them take control of their condition.

FCP:

- 100% indicated there was enough training for the role.
- Generally, their roles had the right balance between primary care and secondary care roles.
- Patients say it adds value.

GP:

- Delivers a rapid expert assessment leading to increased patient satisfaction and less need to refer to hospital.

<ul style="list-style-type: none"> • Induction and training of the initial group of FCPs. A training and induction package were developed by an FCP expert and an MSK GP with a special interest (GPwSI), and there has been daily support in clinics and after each session. • The FCP team had many specialists ranging from spine, knee, hip and shoulder. Training has been arranged to cover foot and ankle and hip specialisms, as a six month locally designed programme of four full days with coursework, as these areas were weaker. • Due to IT issues, it was difficult to promote close working and collaboration between practices. Further work is required to support and optimise this. <p>Results</p> <p>A six-month evaluation was completed. Data shows 2,477 appointments were booked. Within these:</p> <ul style="list-style-type: none"> • 2,229 (90%) of FCP face-to-face appointments were completed • 6.4% of patients were offered joint/soft tissue injections • 9.4% of patients were referred to secondary care consultant led service • 0.8% blood tests were ordered by FCPs • 19.9% of diagnostics were ordered by FCPs <p>2236 based on number of completed EMIS templates</p> <p>Outcome</p> <ul style="list-style-type: none"> • 6% patient DNA rate. This is much lower than other primary care appointments which can be as high as 15%. • 80% of patients report being 'likely or very likely' to recommend FCP service to friends and family. 	<ul style="list-style-type: none"> • A much shorter wait and more local access for patients. • Reduction in follow-up appointments, freeing up some GP slots for other uses. • Quicker follow-up scans, injections, physio and referrals into secondary care if required. <p>Lessons learned</p> <ul style="list-style-type: none"> • Possible change to GP practice model rather than a HUB approach as: <ol style="list-style-type: none"> 1) No personal contact with other GP practices. Leading to disconnect and poor communication between GP practices and FCPs. 2) Difficulty engaging and supporting care navigators in all the GP practices, as it is a key component of first contact work to help direct patients appropriately. • Continuously work with system partners, if physiotherapists only work in primary care, to prevent concerns of potential loss of MSK skills. • Continued engagement with trusts over: <ol style="list-style-type: none"> 1) concerns of potential loss of income due to decreased referral rate of 45% 2) inconsistency of support and resistance from the NHS providers - acute and community.
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<ul style="list-style-type: none"> • 75% or over of patients in employment report receiving specific advice with working with their MSK condition. • Shorter wait for an appointment for patients, and more local appointments available. • 45% reduction in referrals to secondary care. • FCPs offer a more detailed assessment of the patient using enhanced clinical skills. • The total number of FCP slots per month, if fully taken up, would equate to 216 hours of GP time. This equates to at least a 0.5WTE GP at half the price. 	<p>Further opportunities</p> <ul style="list-style-type: none"> • Expansion to include additional geographic areas in Birmingham to get to 100% cover of MSK FCP by 2023. • Inclusion of other professional staff involvement, particularly Podiatry to support workforce.
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Cambridgeshire and Peterborough	
<p>FCP model</p> <p>The service is delivered at Granta Medical Practices as part of a primary care network (PCN), which includes five practices.</p> <p>The FCP service was not commissioned. Band 8a extended scope practitioners (ESPs) (1WTE) were provided out of existing services between Cambridge Community Services and Cambridge University Hospital. As such it was a very small pilot but did provide the system with good learning on how FCP services could be implemented within an integrated MSK system.</p> <p>The FCP pilot was part of the GP rapid access clinics (RAC) and managed patients with routine chronic MSK conditions. This meant there was always a GP lead present, whose role was to support all staff working in the RAC,</p>	<p>Outcome</p> <ul style="list-style-type: none"> • Most patients received an appointment on the day or within a week which offered very timely access to MSK specialist management closer to home. • The FCP service has been shown to deliver timely expert MSK management to patients closer to home. It has shown that most patients can be managed within primary care with few patients requiring on-ward referral to hospital or requests for investigations or prescriptions.

including FCPs. This resulted in excellent joint working between the primary care multidisciplinary team (MDT).

The GP receptionists booked MSK patients into the FCP diary initially for a 10-minute telephone call. Approximately a third of patients required a further face-to-face appointment with the FCP which usually occurred on the same day as the telephone appointment.

We used a hub and spoke model where staff spent one or more days working in FCP clinics and the rest of the time within their normal NHS trust. This model ensures the FCP role is wholly integrated and the practitioners are supported as part of a wider service.

Challenges

- The main challenge was setting up a non-commissioned service within a six-week time frame. However, the collaborative working with Granta Medical Practices made this possible.
- As it was a non-commissioned service only one WTE could be used to deliver this service which meant the impact on the wider system was reduced due to the minimal staffing of the post.

Results

Between December 2018 and October 2019, there were 2,879 patient contacts – an average of 261 contacts per month – of which:

- 73% of attendances resulted in self-management (advice and exercises)
- 9% of attendances resulted in referral to a physiotherapy service

- Patients gave excellent feedback with system savings seen as most care was provided closer to home.

Feedback

Excellent patient and GP satisfaction received.

88% (66) of patients rated their overall FCP experience as being 10/10.

Some patient comments below:

“Very helpful to see someone who was a physio specialist, spoke on the phone earlier in the day and was seen after lunch, quick, efficient. Very happy.”

“Clear discussion developed a plan of action and not allowing me to get ahead of myself with diagnosis. Much appreciated.”

Lessons learned

- A named GP and physio lead will provide smooth implementation and running of the service.
- Written FCP processes which cover everything from sick processes to referring

<ul style="list-style-type: none"> • 0.6% of attendances resulted in referral to an MSK specialist interface service • 0.6% of attendances resulted in referral to a secondary care consultant led service • 5% of prescriptions were requested by FCPs • 1% of blood tests were requested by FCPs • 4% of x-rays were ordered by FCPs • 0.7% of MRIs were ordered by FCPs. 	<p>and requesting procedures are also essential.</p> <ul style="list-style-type: none"> • Working off the primary care IT system and using their requesting and referral processes was key for successful implementation.
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Dorset	
<p>FCP model</p> <p>FCP MSK roles were first implemented in Dorset in February 2016. There are currently three NHS providers delivering 13 sessions per week at GP practices within what are now three Dorset PCNs, with more coming online from November 2019. The majority of FCPs are Band 8a except those in development posts, which are Band 7. Most of the current FCPs work part-time as an FCP as well as being part-time at other NHS MSK physiotherapy services. Prior to working in their FCP roles, all the physiotherapists had experience working in advance practice in orthopaedics (elective or trauma).</p> <p>If a patient presents with an MSK condition, the reception staff can suggest an appointment with the FCP having received written and verbal training relating to appropriate problems for the FCP clinics. The clinics have 20-</p>	<p>Key success criteria</p> <ul style="list-style-type: none"> • Patients receive timely specialist MSK assessment/diagnosis. • Existing model for primary care FCP in line with proposed national model. • ICS support for wider implementation of the role. • Dorset ICS support a collaborative approach between PCNs and NHS providers. • Individual roles have evolved with strong collaboration between primary care and physiotherapy. • Efficiency in case management in line with GIRFT.

minute face-to-face appointment times, 10-minute phone-call slots and time for other administration.

Patients are assessed with a view to forming a diagnosis and management plan and are then set up for the most appropriate treatment pathway. This includes access to the available investigations e.g. x-ray, ultrasound scan, bloods/pathology, with all FCPs being compliant with the pan-Dorset imaging policy for non-medical referrers. In addition, most of the FCPs are now independent prescribers.

From April to August 2019, Dorset integrated care system (ICS) commissioned a project to scope the readiness for further implementation of the FCP role and the findings were presented at the ICS clinical reference group and integrated community and primary care programme board.

Challenges

- FCP roles are not using national data collection template.
- Electronic prescribing on SystmOne. For difficult, as the FCP had restricted access to the GP system
- Demand to roll-scale at scale from April 2020
- FCPs did not feel part of a primary team as there are just a few clinical sessions per week.
- Arranging a suitable governance framework that is applicable to FCPs not employed by NHS providers.
- Lack of suitable FCP training programme tailored to physiotherapy.
- Protecting time for all four pillars of advanced practice (not just clinical) in the FCP job plans.

Results

Feedback

Patients:

- “Excellent appointment. Described the problem clearly and gave me plenty of options to manage the condition.”
- “Assessed quickly and expertly. Listened to my questions and gave me options on the best way to move forward.”
- “Fantastic, I got a quick appointment straight to the therapist rather than waiting longer to see my doctor.”
- “more understanding of condition, exercise plan and medication plan.”

FCP:

- They enjoy control over their clinical practice.
- Value support within practice teams so clinical development is comfortable.
- There are valuable opportunities for career progression.
- Appreciative of personal development as well as opportunity to develop others in their profession.

GP:

- Quicker access.
- More appropriate referrals / investigations.

<p>Detailed results for the Westbourne GP practices supported by an FCP from June 2017 to May 2018:</p> <ul style="list-style-type: none"> • 809 clinical appointments utilised (99%) • 75% (809) of patients are discharged after seeing the FCP with advice/exercise/reassurance • 18% of patients were referred for ongoing physiotherapy • 7% of patients for onward referral (this includes secondary care, intermediate care MSK interface service) • 121 steroid injections administered (78% are to knee and shoulder / subacromial). <p>Outcomes</p> <p>The following are the overall outcomes for Dorset FCPs up to July 2019:</p> <ul style="list-style-type: none"> • 3,919 appointments • referral for investigations (x-rays, bloods) = 9.2% • referral to secondary care = 4.2% • GP review of patient requested = 0.9% 	<ul style="list-style-type: none"> • Stronger links with other elements of MSK pathway (such as secondary care). • Smoother patient pathways. • Educational value to the GPs. • It benefits the practice FCPs who also work in secondary care. • Slight reduction in overall GP workload as patients know to go straight to the FCP. • GPs develop better management of patient pathways with their more up-to-date MSK knowledge. <p>Lessons Learned</p> <ul style="list-style-type: none"> • Ensure early engagement with GPs. • Implementation is easier when there are strong existing relationships.
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Dudley	
FCP model	<p>Outcome</p> <ul style="list-style-type: none"> • GP workload has altered so they see fewer MSK patients.

Initially Dudley Group Foundation NHS Trust (DGFT) provided the First Contact Practitioners (FCP) and the staff were assigned from current staff or appropriately skilled bank staff at band 8a & band 7 level.

Initially 7 practices were covered receiving 1-4 FCP clinical sessions per week based on population.

The FCP Service provides direct access for patients to a specialist MSK clinician for assessment, investigation and treatment as appropriate.

DGFT & the CCG supported further roll out and recruited 8 WTE staff to support the service.

From January 2020, 20 practices will be receiving an FCP service and there is a presence in each of the 6 Primary Care Networks in the CCG.

Aiming for hub and spoke model moving forward to cover entire Dudley CCG population.

- Waiting times to see GPs are expected to reduce.
- £26,000 in Q1 saved in QIPP.
- Year-to-date M5 £50,000 gross savings on acute outpatients.
- Year-to-date M6 1,154 GP appointments saved.
- In the initial seven practices participating, 22% of all MSK primary care attendances are seen by FCP.
- On average 30 attendances per month per practice.
- 10% reduction in GP referred acute outpatients in 2019/20 for FCP participating practices within trauma and orthopaedic as well as pain and rheumatology.

Feedback

Patients, clinicians and GPs have been extremely positive about the service and can see the benefits of it.

There is concern GPs could be de-skilled over time, but patients with MSK conditions will continue to see their GPs if they wish to do so.

East Riding of Yorkshire CCG

FCP model

As a consequence of the request to provide MSK triage services, clinicians in primary care were consulted on a model that would suit their needs. The outcome of this was that a first contact practitioner would support decision making within general practice, and also maintain MSK knowledge and understanding within primary care.

The current model is for general practice to recruit directly, and work to the national service specification and core capabilities framework.

From September 2019 patients in 13 of 30 practices, covering 53% of the registered population (161,000 patients), will have access to an MSK FCP.

Challenges

- General practice may want the practitioners but do not have spare capacity in their consulting rooms.
- Convincing general practice that MSK FCP provide a viable solution to the workforce issues and shortages of GPs.
- When understanding the benefits through data analysis, it is difficult to identify all the influencing factors i.e. operational changes within trusts and possible coding and counting changes.
- Perception of what the MSK FCP role offers. Some GPs thought they were getting a physiotherapist, consultants didn't understand the benefits to their service and physiotherapists may not think it would offer the same level of job satisfaction.

Key Success Criteria

- Building secondary care relationships through working with the orthopaedic teams to establish a trusted assessor relationship.
- Encouraging the use of NHS e-Referrals advice & guidance feature to initiate dialogue and decision making prior to referral.
- Having a GP champion is a huge advantage. One with a special interest in MSK is more advantageous. This provides credibility for the programme.

Lessons learned

- Information regarding the function and benefits of an MSK FCP needs to be robust.
- Considering sustainability and workforce capacity should be paramount at the start. Involving all organisations who have physiotherapists in their workforce and key stakeholders is an absolutely essential element.
- Not all physiotherapists will have sufficient experience working in a primary care setting, so understanding the training and knowledge requirement to aid this transition is crucial.

Further opportunities

<ul style="list-style-type: none"> Due to insufficient suitably trained staff in the system, a rapid roll out of this service might compromise community services and possibly secondary care. <p>Results</p> <p>Data between October 2018 to June 2019 shows there were 1,754 FCP attendances and an average of about 195 MSK patients seen by FCPs each month. Within these:</p> <ul style="list-style-type: none"> 19% (326) of patients were referred to a physiotherapy service 6.3% (110) of prescriptions were ordered by FCPs 6% (101) of patients seen had an x-ray ordered. <p>Outcome</p> <p>Over a six-month evaluation period:</p> <ul style="list-style-type: none"> Orthopaedic referrals to secondary care reduced by up to 10%. GP and self-referrals to the community physiotherapy service have reduced 12% year on year. 	<ul style="list-style-type: none"> Work is underway to discuss opportunities to provide PCNs with the necessary staff through the community and acute providers. Opportunities are being investigated and provided for patients to self-care or better manage their condition at a level that reduces the need to access clinical services. ESCAPE-Pain for Hips/Knees, exercise on referral, web-based advice, shared decision-making service, training of Public Health Trainers (Joint Pain Advisor) and possibly leisure staff are some of the interventions being put in place to reduce the demand for MSK FCP appointments and reduce the likelihood of patients frequently returning.
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East Surrey	
FCP model	Key success criteria

East Surrey's FCP service now operates in five different practices with each practice delivering the service one day per week. Two FCPs (total of 1.2 WTE to allow for leave, training, etc) are employed on a fixed-term contract by first community health and care (FCHC) to provide the service across the week. When they are not an FCP in one of the practices, they are also part of East Surrey's MSK physio team, also provided by FCHC.

The patient pathway involves them being triaged by the practice reception team – or by a GP in some practices – and then booked directly into the FCP clinic. Each FCP appointment is a 20-minute slot.

The clinical assessment and management records are made on the GP clinical system (EMIS or SystmOne). A minimum requirement for each practice participating is that there is a private clinical room with examination plinth.

The FCPs are mostly able to provide self-management advice to patients; however, if the patient needs to be referred, they are able to refer into the MSK single point of access (SPA) – which is part of the existing MSK service provided by FCHC – just as a GP would. If a patient requires secondary care referral, they would be referred through the SPA following the existing pathway.

There are discussions ongoing to ensure there is one FCP in each East Surrey PCN.

Challenges

- Getting each practice to triage consistently.
- Issues using SystmOne and EMIS with existing templates.

- The model used in the pilot to split posts between FCP and MSK outpatients has had a beneficial impact on the FCP team. It enabled them to work as part of the wider MSK team, maintaining their MSK treatment skills, and ensured MSK supervision and mentoring has been available. We would strongly advocate for this model of delivery going forward, rather than FCPs solely within practices or PCNs.

Feedback

Patient:

- "The physiotherapist was very thorough, gave useful and expert advice and I didn't have to wait long for an appointment. This service is a great addition to the surgery."
- "I did not have to see a doctor to get referred. Listened patiently to my explanation of my symptoms. Put me through a number of movements to establish the problem with explanations. Advised on a number of exercises with explanations and also gave me written description and program to follow. Hopefully this early action will prevent need for further referral to the main physiotherapy."
- "Immediate care for a knee injury was ideal. This appointment saved me wasting the doctors time and a possible x-ray"

- Issues with logistic of appointments e.g. rooms, adjustable plinth being available, admin time, etc.

Results

Between September 2018 and August 2019, there were 1,086 FCP attendances, and 36% (394) of patients were referred to a physiotherapy service.

Outcome

The service has:

- freed up GP time so they can see other patients
- streamlined referrals through the pathway, so patients can see specialists sooner
- managed MSK demand into the system; FCPs can provide self-management advice and options for more patients, preventing them from being sent through the MSK service
- provided direct access to FCPs for patients
- provided opportunities for shared learning, knowledge and skills/peer learning. FCPs and clinicians in the practices have been able to learn from one another and share knowledge
- provided earlier assessments and treatment so there is less risk of the patient's problem becoming chronic.

Lessons learned

- More time was needed to collate accurate data about GP MSK attendances, as it is now proving more challenging to demonstrate the impact.
- It is important for staff to be suitably qualified and experienced in MSK, at least at Band 7 level having worked extensively at Band 6 in MSK. Our model worked well with Band 7s, as we have a very smooth pathway through to the 8a advanced practitioners for those patients needing that level of assessment.
- It has worked well to incorporate the FCPs into the main MSK team.

Gloucestershire

FCP model

The FCP service was a host provider model. The FCPs are employed by trusts and hosted by primary care.

Staff work across a split role in primary care and MSK triage or core physiotherapy roles.

The FCP service was communicated to patients via adverts on GP waiting room TVs, posters and leaflets.

Challenges

- IT access and sharing of patient information across GP surgeries and sites.
- Access to pathology and radiology is restricted to FCPs.
- Access to electronic referral systems is restricted to FCPs.
- Developing relationships with local services.
- Educating staff and clinicians about our service and role.

Results

FCP monthly evaluation data from 18 September to 19 August 2019 shows there were a total of 1,914 patient contacts during this period; this equates to an average of 239 seen per month. Of the 1,914:

- 6.3% of patients were referred to physio service

Feedback

Patient:

- 98% of patients surveyed stated they were satisfied with the appointment offered.
- 55% of patients said the service exceeded their expectations, while 43% stated their expectations were met.

Lessons learned

- Greater emphasis on managing risk, safeguarding and safety netting.
- It is important there is a relationship between everyone involved, including care navigators, receptionists, clinicians, CCGs and PCNs,
- IT, imaging, referral access and radiology need considering prior to implementation of services,
- It is important there is an awareness of the level of training support, mentorship and time required to deliver a new FCP service within primary care.
- GP, reception and patients' understanding of what to expect from our service, what we do and what our service provides is crucial.
- There should be better management of patients with atypical and evolving presentations.

<ul style="list-style-type: none"> • 3.4% of x-rays were requested by FCPs • 1% of patients seen had blood tests ordered. <p>Outcome</p> <ul style="list-style-type: none"> • A patient satisfaction survey found the service met or exceeded expectations for most patients. • Total hours of GP time saved was 97.5 hours. 	<ul style="list-style-type: none"> • Relationships with CCG, PCN, local physiotherapy and orthopaedic services are important.
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Kernow	
<p>FCP model</p> <p>The FCP service involved six GP practices covered by three FCPs working up to one session per week in each of the practices; this varies from 0.11WTE to 0.21WTE. The practice population is above 12,000 having 0.2WTE and a total of 1.08 WTE.</p> <p>Five of the FCP clinics are run within the GP practice, with the other clinic run from a CFT (Cornwall Partnership NHS Foundation Trust) building neighbouring a GP practice due to space restrictions.</p> <p>The FCP service offered a 30-minute appointment slot and was delivered Band 7 staff.</p> <p>The service provided onward referral to MSK interface service and secondary care. Conditions patients presented with included: cervical</p>	<p>FCPs:</p> <ul style="list-style-type: none"> • It has been useful being onsite with the GPs and having the opportunity to speak directly to them and to have access to the full relevant medical, medications and investigations history. <p>GPs:</p> <ul style="list-style-type: none"> • Having FCPs working alongside GPs has been a great help with managing our workload in the practice and has been a great service for the patients, as they receive an in-depth 30-minute appointment for their problem which would normally have to be dealt with in 10 minutes by a GP.

spine, thoracic spine, lumbar spine, hip, knee, ankle/foot, shoulder, elbow, wrist/hand, obstetric (pelvic girdle).

Challenges

- For the site outside the GP practice, direct communication is a little more challenging but the FCP is still able to work on the GP IT system.

Results

During February 2019 to July 2019, there were 1,160 patients seen by FCPs. Out of 1,160 patients seen there were:

- twenty referrals to secondary care
- nine MRIs and 3% x-rays ordered
- twelve nerve conduction study and 0.7% blood test referrals
- seventeen prescriptions
- two fit notes.

Outcome

- Shorter waiting times for MSK OP appointments with an MSK professional.
- Discussion of case management with the practice nurses and pharmacists.
- Reduction in referral rates to the physiotherapy service.

Feedback

- Provides a thorough assessment and good management plan and can be seen locally at Callington so very convenient for patients.
- An excellent service and I hope this remains available
- Hugely beneficial, both for our patients and clinicians.
- Really helpful in targeting correct investigations, management and referrals for patients and especially valuable for difficult/tricky cases where the way forward is not clear'

Lessons learned

- Workforce availability is key. Recruitment of Band 7 FCPs is challenging. Potential in the future to advertise FCP roles at Band 8 in order to attract more good quality candidates. This is a major risk to roll out across the county, particularly due to the rurality of Cornwall and the historic challenges of recruiting Healthcare professionals generally in the west of the county. It was also noted that Outpatients community physio waiting times have increased while the existing workforce has been moved around within CFT to staff the FCP clinics.

Further opportunities

<p>Patients:</p> <ul style="list-style-type: none"> • Patients rated the benefit of their appointments with the MSK FCP service as 'excellent' on the patient questionnaires. • Patients that completed the questionnaire said they are better able to manage their condition. • Patients are 'extremely likely' to recommend the MSK FCP service to their friends and families. • Patients have said they are 'extremely satisfied' with the quality of service provided. • All the patients completing the questionnaire said they received advice on managing their condition. • Patients believed there will be changes in their day-to-day life / daily activities / mental health. 	<ul style="list-style-type: none"> • The PCN intends to enter a collaborative working relationship with the MSK community provider to continue to employ the FCPs. • Regular FCP quarterly networking events between providers, FCPs and all other interested stakeholders. • Innovative recruitment methods are being explored in order to make an attractive employment offer to prospective candidates, e.g. funding and time off to complete postgraduate studies or prescribing qualifications.
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Leeds	
<p>FCP model</p> <p>The FCP pilot comprised of seven general practices within a primary care network of c67,000 population size. Mobilisation of the FCP service involved commissioners, local provider of FCP (Leeds Community Healthcare Trust) and locality medical and managerial leads.</p> <p>FCP sessions are delivered by a team of experienced physiotherapists (Band 7 and 8a), with at least one session per week being delivered in</p>	<p>Feedback</p> <p>Patients:</p> <ul style="list-style-type: none"> • Pleased with convenience and rapid access. <p>GPs:</p> <ul style="list-style-type: none"> • "The FCP service is working really well. It definitely has made an impact on our workload

each participating practice. The FCPs perform all the equivalent functions of a GP such as onward referral/requests for imaging/joint injection, except independent prescribing. Access to other services were the same for FCPs as it is for GPs.

Patients access the service through care navigation at GP reception.

Challenges

- Lack of access to the GP ordering system for diagnostic imaging, various options are currently being explored to resolve issue.
- On site primary care drugs couldn't be used due to licensing issues. This was mitigated by using LCH (Leeds Community Healthcare) drugs, which were purchased, transported and stored by the community provider. However, this solution is cumbersome.
- Lack of access to patient records across participating GP practices. This restricts patients being able to access FCP services at other participating practices.

Results

Data shows there were 3,390 FCP attendances, an average of about 565 MSK patients seen by FCPs each month, varying between 128 (January 2019) and 859 (July 2019) of that:

and I feel I am seeing less MSK patients and doing much less MSK referrals.”

- “The FCPs do a very thorough assessment and examination.”
- “The FCP has settled into the practice really well and feels part of the team and is really approachable.”

Lessons learned

- More training and awareness required around first contact and self-referrals.
- It will be helpful for FCPs to order their own investigations via ICE (Integrated clinical environment).
- Not all FCPs can inject, but still a valuable service.
- A prescribing qualification is not essential — very few patients required a prescription which was easily sourced remotely within the practice if required.

Further opportunities

The Leeds GP confederation are working jointly with the largest provider of FCPs through a committee in common, to develop plans for how FCP services can be expanded across the city in line with the ambitions

<ul style="list-style-type: none"> • 15% (504) of patients referred to a physiotherapy service • 1.5% (50) of patients referred to orthopaedics • 1.4% (47) of patients had an x-ray requested. <p>Outcome</p> <ul style="list-style-type: none"> • GP seeing less MSK patients and doing fewer MSK referrals, as such, saving GP appointments. <p>Key success criteria:</p> <p>Discuss cases with GPs on a weekly basis.</p>	<p>set out in the national GP contract document. However, there are still major challenges impacting on expansion, these include:</p> <ul style="list-style-type: none"> • development of workforce to meet the needs of increasing numbers of PCNs who wish to provide FCP services • individual PCNs having differing visions of how they would like FCP services to be provided • funding challenges within general practice in finding the remaining 30% of the direct costs associated with establishing FCP services.
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North Central London	
<p>FCP model</p> <p>The FCP service was piloted in three GP practices for six months and two of the practices were further extended for another six months.</p> <p>The FCP bypassed the single point of access which is the current pathway.</p> <p>The FCPs provide 12 hours of service on each site per week. There are six direct patient appointments of 30 minutes and two indirect appointments of 15 minutes with 30 minutes of administration per clinic.</p>	<p>Feedback</p> <p>GP/practice staff:</p> <p>“Very helpful as it has significantly reduced the number of low back pain patients representing and patients are happier to see a specialist than a GP.”</p>

Challenges

- It is difficult retrieving GP baseline data prior to FCP service to allow for good comparison.
- Unable to prescribe on EMIS as an FCP – this is a national problem.
- No links between IT services in acute and community service e.g.: PACS (Primary and Acute Care Systems).

Results

Between September 2018 to August 2019, there was:

- 1,270 appointments booked
- 4.9% (62) of patients referred for diagnostics
- 68.5% (870) of patients discharged to self-manage after first appointment
- 22.9% (291) of patients referred to physiotherapy
- 8.6% (10) of patients had follow-up appointments made
- 1.3% (17) of patients referred to secondary care services. This includes: 0.4% (5) referred to orthopaedic clinic who were listed for a spinal injection, 0.3% (4) to referred rheumatology clinic, 0.2% (3) to pain clinic, 0.1% (1) to A&E, 0.3% (4) to neurology clinic.

Outcome

- We have achieved our aim of reducing referrals for investigation and secondary care while maintaining high patient satisfaction.
- Reduction in pain medication prescriptions.

“A large proportion of our patients suffer with low back pain so having the service has freed up GP appointments for patients with other conditions.”

“The service provides a rapid patient assessment and intervention.”

Patients:

- 96% are extremely likely/likely to recommend service to friends and family
- 97% felt that the FCP explained the next steps clearly in a way they could understand
- 97% felt they were involved in decisions about their care
- 99% felt they were treated with dignity and respect
- 94% felt they had complete trust and confidence in the APP (Advanced Practitioner Physiotherapist).

Some of the patient stories captured are:

- “I feel reassured regarding my back issues and have come away with lots of helpful advice. Very impressed!”
- “She has given me so much confidence to cope”.
- “Listened and explained. Answered questions. Did not feel rushed on a clock.”

<p>Key success criteria</p> <ul style="list-style-type: none"> • During implementation the FCPs and service leads attended and presented at practice engagement events, practice meetings involving both clinical, reception and administrative staff. • Regular engagement and informal learning for both FCPs and GPs through case discussion • Regular, both formal and informal discussions with practice staff to ensure best utilisation of the service to improve the self-referral rate and regularly updated the outcomes of the service to ensure ongoing engagement. 	<ul style="list-style-type: none"> • "Friendly service, explained everything about my back so I could understand." • "Explained and did not judge." <p>Lessons learned</p> <ul style="list-style-type: none"> • Good relationships and clear communication with GPs are essential. • Strong established links with secondary care services and consultants is essential for decision making if considering secondary care referral. • Needing good clear on-going promotion of FCP service reiterating the fact that the service is not a physiotherapy treatment service.
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North East Essex	
<p>FCP model</p> <p>The pilot has been provided by the Colte Partnership of practices and delivered within eight of their practices covering a population of 120,000 patients which is 45% of their adult population. The FCP service is provided by a Band 8a and currently being provided within a PCN.</p>	<p>Feedback</p> <p>Patients: Patients have appreciated the opportunity of seeing a professional sooner rather than waiting for a GP appointment.</p>

MSK patients are triaged by reception and then phoned by the physiotherapists providing this service (without the need to see a doctor).

Results

Data shows a total of 3,515 FCP attendances, of which there was:

- 26% (904) of patients referred to physiotherapy
- 0.7% (23) of patients referred to orthopaedics
- 1% (31) of patients needed an x-ray

Outcome

- The data shows that clinical time has been saved and the idea of seeing the right person in the right place has been achieved. At the start of the pilot it was around 50 hours GP time saved each month and this has increased to 70 in the additional three-month period.
- The direct referral into secondary physiotherapy services has reduced during the pilot, following changes to the advice given, and based on feedback from the secondary care provider.
- A very small number of people are going back to their GP after seeing an FCP, allowing the GPs to concentrate on patients with complex needs.
- With over 400 FCP appointments each month only about two or three patients are returning with the same condition.

GPs:

- All the doctors that have been involved in the pilot feel it is a worthwhile service and that patients have benefitted from it.
- It provided GPs more time to deal with more complex patients.
- Some of the individual responses from seven doctors shows GPs would like the time gained back, providing a service in clinic seeing patients while two doctors would like it spent doing administration work.
- Overall, eight GPs feel they have seen a reduction in MSK related conditions in clinic while five GPs confirmed they are yet to see any reduction in patients presenting with MSK type conditions.

Lessons learned

- During the pilot there were changes to the triage arrangements through reception and this helped to increase the utilisation rate, and enabled more appointments to be provided, with over 400 appointments each month.

North Norfolk

FCP model

The local pilot was hosted by North Norfolk CCG practices, with the NN1 locality selected to participate which has approximately 41,000 patients.

The MSK FCP service was provided by Ascenti (the lead provider) on a 'hub' model, with a team of two FCPs based at Holt Medical Practice over four days (two days per FCP). The service accepted referrals from four centres across the locality.

The FCP service started in January 2019 and was live for six months while based at Holt Medical Practice, ending in June 2019. However, there were delays with the start of referrals to the service in participating practices, therefore the data collected and discussed in this case study covers between four to six months.

Challenges

- Delay to the start of service. This was mainly due to interoperability issues between EMIS (Holt practice) and SystmOne (other 3 practices) and getting the FCPs IRMER trained to be able to request diagnostics. An interface system was put in place called Black Pear that enabled the SystmOne practices to book appointments. This created additional delay but was worth doing to make sure that everything was in place and appropriate before commencing.

Key success criteria

- Fast access for patients (same or next day) made early intervention possible.
- Access to duty GP for support.
- Ability to access patients' GP notes was useful for holistic assessment and management.
- Prescribing via duty GP made it possible to manage patients in a 'one-stop shop' way.

Outcome

- Across the four practices, there was a noticeable decrease in the number of GP appointments for MSK conditions, from 1,400 between January and June 2018 to 1,154 between January and June 2019.
- Although the number of GP appointments for MSK conditions decreased by 17.6%, the high number of appointments for MSK conditions with both GPs and FCPs suggests that FCP appointments are meeting an increased demand for appointments by patients with MSK conditions.

- Hub practice used EMIS and other participating practices used SystmOne, which created difficulties initially with both systems being able to interact and booking appointments. This was mitigated using the above.
- Due to the age demographics and rurality of the north Norfolk area a number of patients declined an appointment as they were unwilling to travel due to the distance involved (approximately between 7-13 miles). Other reasons for declining an FCP appointment included:
 - **Patient requesting a home visit** – The North Norfolk area has the highest ‘older people/aging’ population in England. As a result, many are frail or infirm and unable to attend the GP practice. Other than an FCP dedicating time to make home visits, which wasn’t practical, there wasn’t much that could be mitigated against for this cohort of patients.
 - **Patient wanting to see a practice nurse or a GP** – A large percentage of patients at participating practices consists of elderly patients who found it difficult to embrace something ‘new’ and insisted on seeing their own GP or Nurse. From discussions with the Practice Manager at Holt this appeared to be due to the fact that patients had formed a relationship of trust with their GP, or Practice Nurse, and felt more comfortable being seen by someone they knew and trusted rather than being seen by someone they didn’t know. As the pilot continued and people became more aware of the service and spoke to people (via word of mouth) who had used the service, they became more inclined to try it for themselves.

- In addition, the implementation of the service also contributed to releasing GP capacity.
- All patients who attended FCP appointments were subsequently discharged from the FCP service.
- The service was consistently well-received by patients and satisfied with the service, in particular with the availability of appointments and the short waiting times.
- Working aged patients could access the service quickly and it helped them to stay in work or get back to work much quicker than waiting to see the Physiotherapy service.
- Patients who had tried the service really liked it and feedback was consistently very good.
- Overall, if there was more capacity and more appropriately qualified staff to be able to undertake this role, there are more advantages than disadvantages for patients and GP practices.

Feedback

Patients:

The overall patient satisfaction response was positive with a total of 86 patients completing the survey. 21% (18) of patients selected either “agree” or 79% (68) “strongly agree” they were satisfied with the FCP service.

- **Patient being able to access same day appointment with their own GP** – Wells practice has an elderly population who can access a same day appointment with their own GP. It was difficult to try to persuade patients to travel 13 miles to see an MSK ‘specialist’, especially if they didn’t have access to a car and had to travel by bus. The bus network in that part of North Norfolk is regular but there can be many hours between buses departing and arriving back to Wells, which would have discouraged many patients. The learning that we took from this is that any future model would ideally have an FCP embedded within each practice at least once or twice a week, or half day sessions, which would hopefully release GP time and ensure that patients were seen by an experienced and appropriate MSK clinician.
- **Patient preferring to go to the Melton branch surgery** – Work aged patients were more likely to travel to see an FCP, to enable them to continue or get back to work. Some patients though couldn’t travel to Holt to see an FCP and although Holt has a branch surgery some patients preferred to remain to be seen at their own practice. Again, we’ve learnt that any future model would need to incorporate an FCP within each practice, where practicable. The difficulty we encountered was the lack of sufficiently qualified FCPs able to undertake this though.
- **Inability to attend an FCP appointment during working hours** – We could have extended the working hours to encompass patients who had to work but, as this was a

Participating practices

- “Very easy to book appointments.”
- “Lots of appointments available to book
- waiting time is short.”
- “Useful service that is a benefit and patients can be seen quickly.”

FCP feedback

- Service has, “great potential”.

Lessons learned

- Waiting for duty GP to become available to write a prescription could lead to clinic running behind.
- Further considerations are needed regarding the implementation of the service based on a hub model, as this may have contributed to low appointment uptake due to patients not willing to travel to a practice located further away from their own practice.
- Some patients were unwilling to travel to a practice located further away than their own.
- Demographics and rurality of north Norfolk should be taken into account when selecting a specific model for the service. As patients needed to be happy to travel for the service to be effective.

pilot, we did not do this. We have learnt that for any future FCP service we would need to take this into consideration and plan to have early and late appointments.

- Due to the lack of qualified FCPs restricted what we could do and how far we could roll the service out. It meant that we had to ensure that we had at least 2 FCPs working within the practice so that there was essential cover for sick leave/annual leave etc

Results

In total, participating practices reported making 567 referrals to the MSK FCP service between January 2019 and June 2019. A total of 555 patients were reported as having been discharged from the FCP service throughout its duration (this is excluding referrals to secondary care for diagnostics) as shown in the table below:

Discharge destination	Actual number	%
Self-care	375	66%
Community physiotherapy	147	26%
GP	20	3.5%
Referral to secondary care	13	2.3%
Referral to secondary care for diagnostics	12	2.1%
Total	567	

Northamptonshire

FCP model

Service delivered through three Sixty Care Partnership, GP Alliance and local GP federations. The FCP service was funded by Northamptonshire Healthcare NHS Foundation Trust (NHFT) in partnership with local GP federations.

There were additional physiotherapists recruited to provide the service, as well as undergoing a transformation of their current MSK workforce, creating mixed MSK/FCP roles across specialist, advanced and extended scope physiotherapy positions.

This pilot site uses an appointment model offering:

- 30-minute appointments
- 11 to 15 appointments per clinic
- admin block after three to four patients
- offered in half day clinics across the week, which varies by location and for number of appointments needed to be provided to cover practices.

Results

Evaluation of one of the sites between January 19 – March 19 shows approximately 300 contacts, of which:

- 80% (240) of patients discharged after initial appointment
- 9% (27) referred onto MSK physiotherapy
- 2% (6) referred for follow up with ESP (within MSK service)

Feedback

Patients:

- 99% of patients said they would recommend the service
- Patient: "Perfect for my condition, much better than going to the GP. Excellent service provided."

FCPs:

- "Have enjoyed working in the FCP service and feel that they were well supported to implement this new service."
- There is a debrief session for 30 minutes at the end of each clinic, this allows time for staff to feedback on the FCP service as well as use for clinical supervision/support.

GPs:

- "It complements our other services available to patients both within and out of hours. We can already see a tangible difference in the reduction of MSK presentations on same day demand."

- 5% (15) of patients redirected to a GP
- no secondary referrals
- 2% (6) of patients required investigations
- 2% (6) DNA rate

Outcome

- Now nearly one year on from implementation, we are now live across approximately 44 GP practices across Northamptonshire and offering around 1,300 appointments a month at full capacity.
- Patients are seen within three to five days
- Three-hundred appointments have been delivered,
 - priced at £20 per appointment = £40 pound per hour FCP service. A GP cost is approximately £85 per hour, saving approximately £45 per hour. Total saving for 300 appointments of FCP instead of GP = £6,000.
- The apportioned appointments for Wellingborough locality is approximately 150 appointments a month at full capacity. Therefore, providing a 12-month saving of £72,000 per annum, and a release for Wellingborough locality alone of 1,800 GP appointments each year.

Key success criteria

- partnership working
- senior leadership support
- staff engagement
- care navigation
- FCP competency framework.

Lessons learned

- GP and practice level engagement are central to success and embedding of the FCP model.
- Patient involvement and support has been central to recruitment and development of the service.
- A dynamic and controlled feedback-review-change approach is essential for success and buy in.
- Patient education and promotion of the FCP service nationally and locally is required for best use of the service.
- Using a skill mix approach in the FCP service has been successful and allowed for increased capacity to be offered.
- Further FCP training needs to be developed centrally to support national and local roll outs.
- Dedicated leadership through a secondment role and engagement of clinical and operational leads has been essential for delivery.

Further opportunities

	<ul style="list-style-type: none"> Continuing to review and develop the service, care navigation and training programmes further.
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Somerset	
<p>FCP model</p> <p>Service delivered from the French Weir Health Centre and GP Practices and has been delivered from pilot status in 2015.</p> <p>Initially two FCP sessions per week, which increased to five in 2016, following the initial success and demand for the service.</p> <p>FCP is provided 'in-house' within each GP practice, with 0.5 FTE at French Weir Health Centre to 0.2 FTE in some of the other practices. This is based on one session per 5,000 population but also on the provision requested by each practice. Patients are booked into FCP clinics by the care navigation team in each GP practice using CSP (Chartered Society of Physiotherapy) flowchart for guidance.</p> <p>The majority of the FCPs are Band 8a except those in development posts who are Band 7. All of our FCPs are employed by the secondary care provider using a host model and also work across other aspects of the MSK pathway including MSK Triage, emergency department, physiotherapy and secondary care clinics. Each appointment is 20 minutes in duration and there are eight to 10 appointments per session.</p>	<p>Key successes</p> <ul style="list-style-type: none"> Developed a competency framework, job descriptions and governance framework to ensure we provide a safe and equitable FCP service across Somerset. Developed a business model which looked at possible recruitment and backfill for the expansion of the role. Having a strong FCP governance group and local FCP network that met regularly to ensure continual improvement, collaboration and shared learning opportunities. Set up an FCP working group represented by service leads from each trust and local commissioners to ensure all FCPs in Somerset used the same data collection tool. Offering a host model where all FCPs are seconded to the PCNs from the local trusts

Challenges

- Due to different start dates of FCP service in Somerset, there were various FCP models being employed e.g. skill set of staff/appointment duration and no collaboration among providers.
- Data was not consistently being collected across all the trusts, making comparing and identifying the optimal FCP model for Somerset challenging. The issues were resolved by ensuring all FCPs in Somerset used the same data collection tool and established an FCP working group represented by service leads from each trust and local commissioners. The data was reviewed to establish the optimal model for the benefit of the patient and local healthcare economy.
- Developing the FCP workforce to meet demand in a safe and sustainable way without destabilising other parts of the pathway such as the MSK physio teams. Demonstrating a system wide improvement may lead to redeployment of more skilled clinicians to the front of the pathway.

Results

From a total of 3,287 FCP contacts:

- 41% (1,343) were self-referrals
- 35% (1,160) were referred by GP/nurse
- 22% (726) had follow-up appointments
- 3.9% (128) DNA rate

Outcome

ensures staff have access to peer support, regular training and robust governance frameworks. It also helps reduce any potential contractual issues that may occur with direct employment by GP practice.

- System wide benefits where the Band 8 model has been employed.

Feedback

Patients:

Patients were very satisfied with the FCP service rating them, on average, 4.9 (out of five) as being listened to and 4.7 as happy with the advice given.

GPs:

- FCP has altered the blend of GP caseload
- “It has meant we have more capacity to see other non-MSK conditions but we still see MSK presentations so there are no concerns about us deskilling in this field.”

Lessons learned

- Having an FCP service that is fully integrated has been central to the success of the service. This has optimised

- 75% of patients were independently managed by the FCP.
- Only 1.4% patients required a follow-up with a GP.
- In-house FCP service has enabled upskilling across professions including GPs, FCPs and nurse practitioners and has been well received in the primary care team.
- Having FCPs with extensive MSK experience and local pathway knowledge has shown a year-on-year reductions in referrals to orthopaedic intermediate/secondary care suggesting system wide benefits of FCP.
- Having an FCP has provided patients with quicker access to specialist advise/care closer to home.
- Recruitment and development of more staff into FCP/advanced roles due to the exciting development opportunities.
- There are now 14 FCP sites across the three trusts in Somerset.
- The local trusts have committed to a system wide approach to improving the local MSK pathway by offering to fund the outstanding 30% cost for the FCP role in each PCN.

communication channels and improved patient care as a result.

- Future development/training programmes should be focused on providing more generalised skill sets.
- Demonstrate system wide improvements, as this may encourage more redeployment of staff to the front of the pathway.
- Collaborating with local service leads, commissioners, etc as early as possible to share learning but also overcome challenges regarding perceptions/concerns about the role.
- Establishing a GP champion who understands the role and is engaged to help influence the growth of the role locally among their peers.
- Always put the patient and system at the centre of decision-making when considering what is the preferred FCP model to implement and be aware of our own biases.
- Collaborate with service leads and create a local working group to ensure FCP is integrated into the local pathway to maximise its potential.
- Offering FCPs a portfolio working across the MSK pathway provides an attractive career opportunity but also provides a more integrated pathway between primary

	<p>and secondary care that has benefits for the patient and health system alike.</p> <ul style="list-style-type: none"> • Start off on a small scale such as one GP practice using a test and learn method to establish the best model for patients and the MSK pathway locally. • At the start of data collection in 2015, follow up appointments were coded as 'someone who had consulted for the same condition previously' but actually many of these were patients self-referring back to the FCP, as routine follow ups are only provided post investigation.
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South East London CCG	
<p>FCP model</p> <p>The FCP pilot model involved multiple GP practices referring into the FCP service. This allowed GP practices to book into appointments at a central site. The FCP clinics were added onto the same system that GPs use to book appointments at the extended primary care service (EPCS), as GP practices can book into these appointments directly.</p>	<p>In percentage terms, there has not been a reduction or downward trend in the number of GP appointments related to an MSK condition. However, the crude number of appointments has shown a downward trend.</p>

The service is delivered by the specialist physiotherapist (Band 8a) from the local acute trust. This has supported the FCP service integration with the wider MSK pathway.

The service is based in the EPCS of one of the GP federations in the area. However, patients registered with GP practices in that Federation could be referred to the FCP.

Sessions are provided at Bermondsey Spa Medical Centre, with two (four hour) sessions a week (10 x 20-minute appointments per session). FCPs write directly into patient's notes on EMIS so the GP practice has easy access to the consultation notes.

If the FCP thinks a patient needs to be referred on to hospital services, the patient's GP practice is contacted and asked to make a referral for the patient. The EPCS provided clinical oversight and support for the pilot, as such, if an FCP thought the patient needed a medical opinion, they were able to get advice from one of the GPs working in the EPCS.

Challenges

- The federation model requires engagement with a wide number of GP practices in a short amount of time. The team got the message out about the pilot e.g. what an FCP is, who should be referred to the FCP, how to refer to the FCP.
- Variation in use of FCP — some GP practices using the FCP a lot, others not using FCP at all.
- Optimising use of FCP's time - several patients directed to the FCP after they had had a face-to-face appointment with their GP. Working

	Total GP attendances	MSK related attendances	FCP appointments	% of GP attendances relating to an MSK condition
Jan-19	27186	2278	31	8.4
Feb-19	27000	2240	46	8.3
Mar-19	20504	1624	45	7.9
Apr-19	24317	2119	45	8.7
Jun-19	23380	2053	45	8.8
Jul-19	23968	1992	37	8.3

Feedback

Patients:

- Very positive feedback from patients.
- All patients that returned their patient survey reported that they were able to better manage their condition as a result of their FCP appointment.
- 100% of patients surveyed said they 'very likely' or 'extremely likely' to recommend the FCP service to their friends and family.
- 100% of patients surveyed said they were 'very satisfied' or 'extremely satisfied' with the overall quality of service provided to them.

Lessons learned

<p>to try and reduce the number of patients where this has happened to ensure FCP is having greatest possible impact.</p> <p>Results</p> <p>Between December 2018 to August 2019, there was:</p> <ul style="list-style-type: none"> • 415 FCP attendances • 24% (100) of patients referred to physiotherapy service • 2.5% (10) of patients had prescriptions ordered • 1.3% (8) of patients had referrals to orthopaedics service. <p>Outcome</p> <ul style="list-style-type: none"> • Quick access to an MSK specialist. • Strengthening of relationships between secondary care MSK teams and GP practices — GP practices very positive about the service. • The FCP has had a low onward referral rate to hospital MSK services. • Many of the patients have been managed by the FCP with advice, (very few patients have been prescribed medication or referred on for investigations). 	<ul style="list-style-type: none"> • Ensure engagement of GP practices in a federation model i.e. message out about the pilot e.g. what an FCP is, who should be referred to the FCP, how to refer to the FCP. • Constantly communicating and reminding GP practices of the FCP service, as you might have variation in the use of the FCP service. • Work with the practices to communicate the best pathway for the FCP service, which is where a patient is directed to the FCP from reception or telephone clinical triage rather than after the patient has been seen by their GP. • Account for time it takes for new services to be embedded and for GPs and patients to understand what the service and who is suitable to be seen in it.
<p>West Kent</p>	
<p>FCP model</p> <p>Ten GP surgeries across West Kent were approached to participate.</p>	<p>Feedback</p> <p>Patients:</p> <ul style="list-style-type: none"> • 80% of patients would recommend service to Friends and Family.

FCP clinics followed a cluster-model of service delivery with three surgeries selected to run the FCP clinics, with other surgeries able to access the clinics via Vision 360 software.

Each FCP session lasts four hours and comprises of ten 20-minute appointment slots and two 20-minute administrative slots.

Contractual agreements with any qualified providers (AQP) and closely working with various teams enabled clinicians to request and view diagnostic images and access local initiatives such as ESCAPE knee class via a streamlined patient pathway.

Challenges

- IT systems interoperability as the GP practices in the cluster were both on EMIS and Vision clinical systems. In mitigating the issue, an interim action was put in place. This involved manually collecting data from pilot sites using an Excel spreadsheet that was developed in-house from a previous local FCP pilot. The health informatic lead is currently looking at a longer-term solution by working directly with the major IT service providers for these clinics.
- Initial governance and system-related issues meant on some occasions, clinicians were unable to access patient information. This was mitigated by ensuring each clinician was provided with access to the local IT system and IT issues were logged with the service provider and the CCG.
- FCP service being used as an alternative physiotherapy service rather than a first contact service. The issue was addressed on an individual basis and continuously promoting the purpose and objectives of the service.

- 92% of patients had confidence and trust in the FCP they saw or spoke to.
- 81% of patients said they felt the clinicians involved them in decisions about their care.

Practice manager:

"I would strongly advocate this as a great service within primary care and one that I would hope could be expanded upon to offer even more physio availability."

GP feedback:

"Having an advanced physiotherapy practitioner within our local practices has been invaluable to our surgery and wider PCN... It has been really helpful having the APP (Advanced Practitioner Physiotherapist) order their own investigations and follow up and my patients who have seen the practitioners have been very satisfied with the care they have received."

Lessons learned

- Provide FCPs with equivalent support similar to that provided to GP practitioners i.e. direct support from senior GPs within the practice, support from administrative staff and governing bodies.

- The provision of injection therapy caused an unexpected issue due to funding concerns, as injection therapy was a valuable source of income for most GP surgeries. The CCG agreed GP surgeries could claim for any of their patients who were injected within the FCP clinic as if they were treated by a practitioner from their practice.

Results

Total attendances to FCP was 1,474 between September 2018 to August 2019. Of the 1,474:

- 23% (340) referred for physiotherapy
- 15% (215) requested diagnostics.

Outcome

- Patients received a more accurate diagnosis from physiotherapy.
- Administering injections to our patients took the strain away from patients previously having to book in with one specifically trained GP but also increased the financial income to the practice.

Key success criteria:

- All clinicians received training in the use of Vision 360 software which was introduced by West Kent CCG to facilitate the delivery of cluster-wide service.
- A template for each clinic was developed according to the flexible working pattern of the clinicians.

- The FCP service should be run by experienced members of staff who meet requirements necessary to work at a Band 8 level.
- Explore the use of clinicians to deliver FCP services once or twice a week with the rest of their time spent within either triage and treat or physiotherapy services, due to the additional pressures of delivering FCP clinics in comparison to traditional physiotherapy services.
- The FCP service should have been piloted for a single GP surgery within the cluster as against providing a cluster model. This would have enabled:
 - 1) the FCPs to utilise the templates developed for FCP clinics
 - 2) allowed FCPs to gather important information regarding GP activity and potentially provide FCPs with a better understanding of the overall impact of the provision of FCP clinics on diagnostic and onward referral rates
 - 3) allowed FCPs to familiarise themselves with the issues associated with running these clinics.