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**FCP Business Case Template**

This document has been developed by the CSP in consultation with members. It provides a framework for a business case to support the development of a First Contact Practitioner (Physiotherapy) role in Primary care in England. As this is an example document it has been written from one perspective, in this case, of a Therapy department seeking support from the local Trust board to deliver these services

The framework includes the information generally required in a business case. Each section provides a description of what should be included, followed by an example. The layout and information should be adapted to the format required locally for the target audience e.g. by the Primary Care Network, Trust, STPs or CCG and written from the appropriate perspective. Furthermore, the detail for each section should be individualised to the local health economy and the population the service will serve. In developing the business case particular consideration should be given to the mechanism of funding as this varies between STPs, areas, regions and localities.

Everything with an asterisk \* highlighted in red will require amendment/addition to reflect the local healthcare economy.

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| Title | **\*Delivering MSK pathways in Primary Care Network with a First Contact Practitioner (Physiotherapist)** | | |
| Accountable Exec/ Project sponsor | \*Add name.  The project sponsor will oversee the project, monitor its progress and provide representation at senior leadership level | Lead /  Project Manager | \*Add name.  The Project Manager will deliver the project, leading implementation of the service and reporting to the sponsor |

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| **Executive summary**   * **Include the key areas of the proposal for discussion or approval to influence whether the project is approved and can progress.** * **It is recommended that this section is the last to be completed to reflect the key elements throughout the detailed business case.** |
| **\*INSERT LOCAL EXECUTIVE SUMMARY HERE**  **EXAMPLE:** Sustainability of primary care is challenged due to the increasing pressure and emphasis on General Practice. The workload for General Practitioners and the primary care workforce is increasing. This is further compounded by the increasing emphasis on conservative management and the reduction in capacity to delivery primary care due to challenges in recruiting and retaining staff. This proposal is part of the wider MSK transformation which requires key stakeholders to work together to plan and develop First Contact Practitioner (FCP) services that maximise efficiency in the local system. Following the inclusion in the NHS Long Term Plan, General Practices are experiencing the benefits of the introduction of FCP roles in reducing the workload and subsequently improving the retention and recruitment of GPs. There is a strong evidence base for these roles, backed by NHSE, RCGP and BMA, that have been implemented throughout the UK.  Drawing together this proposal has involved clinical and non-clinical staff within primary care teams including GPs, the Primary Care Network (PCN), the therapy services manager, relevant executives, integrated care system leads, all providers of musculoskeletal services, and those involved in funding and commissioning MSK services. These key stakeholders will be involved throughout its implementation.  It is estimated that musculoskeletal (MSK) conditions account for 20-30% of the GP caseload. Positioning highly skilled and regulated musculoskeletal practitioners at the first point of contact in primary care for MSK conditions enables patients presenting in Primary Care with an MSK condition to see an FCP instead of a GP at their first appointment. These FCP services can be safely and effectively delivered by physiotherapists with advanced practice skills who are able to assess and manage patients presenting with MSK conditions at the GP practice, encouraging self-management or referring them on where necessary. FCPs will support the delivery of high quality clinical care for MSK conditions through direct patient care and as part of primary care case meetings, training and mentorship while supporting MSK pathway design.  Introduction of FCPs within the practice will release GP time for those appointments requiring a GP’s expertise. This will enable the General Practice to manage the workload, deliver safe specialist services and improve patient care though sustainable primary care services. Established FCP services demonstrate significant benefits for patient outcomes, experience and general practice sustainability through reduced MSK referrals into secondary care and a subsequent reduction in demand for orthopaedics and improved conversion rates to surgery. Reduced demand for pain services, rheumatology and other community based interface services have also been observed. Furthermore, there is effective use of resources through fewer requests for imaging, reduced prescription costs and issuing of Med 3 certificates (fit notes).  This proposal outlines the introduction of a physiotherapist in the FCP role. The \*Therapy Service within \*Trust will provide First Contact Physiotherapist(s) to \*GP to deliver effective implementation of First Contact Physiotherapy within the GP Practice. This proposal is aligned to both \*STP strategy \*PCN and the \*Trust Corporate Strategy. The FCP will remain employed by \*Trust who, as the employee, will provide the governance arrangements and enable the physiotherapist to be embedded within both the GP and the Therapy teams.  The cost of the service is £**\*** per annum. These costs are based on **\***Trust to provide a physiotherapist in **\***GP for 2 sessions per week. This will provide \*MSK appointments which would have previously been seen by the GP. In comparison, the costs for the GP to provide this service are\*. Once established, it is recognised that demand may be greater than the appointments available. A review will be undertaken at 3, 6, 9 and 12 months to consider the requirements of the role such as the skills needed and ongoing funding implications. |
| 1. **Introduction**   **Include a general overview of the service including;**   * **The key issue to be addressed e.g. addressing shortages in the primary care recruitment such as GP recruitment, shortening pathways** * **An overview of the Primary Care Network and the local health economy and specific General Practices** * **Include local data on the incidence of MSK conditions/ presentations in primary care** * **The role of the physiotherapist as an FCP** * **If possible include evaluation data from a PDSA of FCP roles or a pilot** |
| **\*INSERT LOCAL INTRODUCTION HERE**  **EXAMPLE:** General practice is a core element of Primary Care services, providing the first point of care for more than 90% of people’s contact with the NHS. However, the present model is unsustainable as the clinical workload in general practice is increasing throughout the UK, over and above the growth in the population and the growth in GP numbers. With an ageing population and an increase in the number of people with multiple morbidities, the pressure and demands on general practice will continue to rise. Furthermore, management is challenged by long patient pathways, re-referrals for chronic conditions, inappropriate referrals for imaging, secondary care treatment and rising prescription costs.  Musculoskeletal conditions account for 20-30% of the overall GP caseload, with over 30 million working days are lost annually due to MSK conditions in the UK. The Chartered Society of Physiotherapy (CSP) estimates that physiotherapists working as FCPs could see up to half of all patients with MSK conditions (up to 10% of all patients currently being seen by GPs), undertaking work that previously would have been undertaken by the medical profession. FCP services enhance existing primary care services by supporting the PCNs and GPs within them by building capacity through new ways of working, enhanced team working and improved links between primary and secondary care and diversity in the primary care workforce. FCPs provide a cost effective, clinically safe service that reduces the GP workload with less time spent on unnecessary or repeat appointments, allowing GPs more time to manage patients which require the GP’s skills and knowledge. |
| 1. **Strategic context**   **Include;**   * **Information that relates the national strategy to the local strategy for example corporate or organisational objectives from the STP, CCG, Trust, PCN and GP** * **The likely impact on the local healthcare economy** * **Information on the local demographics e.g. High levels of MSK conditions/ manual work** * **Workforce implications** * **Include relevant statistics for the area including the GP recruitment and retention survey for practice or STP, GP shortages and reason for leaving** |
| **\*INSERT LOCAL STRATEGIC CONTEXT HERE**  **EXAMPLE:** A significant proportion of the GP activity at \*practice relates to MSK conditions which could be managed by a first contact practitioner. (\*Add data here where possible). In 2018/19 NHS England national and regional teams supported the roll out of interventions and schemes to support Clinical Commissioning Groups (CCGs) to maintain the elective waiting list at March 2018 levels whilst improving clinical quality. As part of this, regional teams worked with sustainability and transformation partnerships (STPs) and their CCGs to deliver High Impact Interventions (HII) in the localities where they were most needed.  The HII specification set out the key enablers and actions that each STP should take and include the development of FCP services to ensure that, patients with MSK conditions are seen in line with the underpinning principles for the high impact interventions; by the right person, in the right place, first time; and as quickly as possible in accordance with the patient’s rights under the NHS Constitution.  Introduction of FCPs will enable the STP to participate in the NHSE FCP development collaborative \*(check present support offer). This provides implementation support, monitoring and evaluation for the roll-out approach recommended by the Mobilisation Plan for FCP. This plan includes the establishment of FCP services in a selection of sites or networks of GP practices, PCNs which cover populations of circa 30,000-50,000 to add to the 2018/19 cohort of FCP services.  The 5 year General Medical Services (GMS) contract from 2019/20 ensures general practice plays a lead role in every PCN. General practice is under increasing pressure whereby the accepted planning ratio for the number of GPs required for a population is 1 GP per 1,800 residents (\*add for this GP). However, the General Practice Forward View estimates that 28% of GPs who work full-time are considering working part-time. The GMS contract requires practices to self-assess for sustainability and local data identifies that. \*Add data for this locality.  The MSK first contact pathway is supported by the Chartered Society of Physiotherapy, the RCGP and the BMA as being the best pathway to ensure effective management of MSK in general practice. FCPs will improve access to the service in line with the NHS Long Term Plan’s expectation for all local health systems in 2019 to identify how they will specifically reduce health inequalities by 2023/24 and 2028/29. |
| 1. **Summary of current service provision**  * **Provide a diagram of the current pathway** * **Summarise issues relating to the pathway** * **It will be useful to include patient and clinician feedback particularly GPs challenged by providing the service** * **Consider including any complaints received or examples where targets couldn’t be met** |
| **\*INSERT LOCAL SUMMARY OF SERVICE PROVISION HERE**  **EXAMPLE**: When patients experience an MSK problem most will seek primary care advice in the first instance from their GP. Currently on contacting the practice patients will be booked into a routine GP appointment. During the appointment the GP may manage the patient within the practice with advice or medication, refer on for conservative management e.g. physiotherapy, investigate with blood tests or x-ray or refer on to an interface team or to secondary care. Some areas (\*name) have direct access or self-referral services for patients who are able to book a physiotherapy appointment directly when they know they need to see a physiotherapist. However, this has not been shown to significantly reduce the demand on GPs.  The shortfalls in the current pathway are;   * An unnecessary burden on GP appointments limiting access for those requiring a medical assessment * Potential for multiple contacts for the patient along the pathway * Inconsistent advice and management of MSK conditions * Unnecessary referrals for physiotherapy, radiology and secondary care which reinforce the patient’s perception that medical intervention is required * Following referral to secondary care, a low conversion rate to surgery * A delay for patients in receiving optimal advice * Inconvenience to the patient due to multiple attendances.   **\*The flow chart below is taken from the CSPs pathway information. This may be slightly different in each locality, so you could create your own.**  cid:image001.jpg@01D5994D.3E5188C0 |
| 1. **Presenting a case for change**   **Include;**   * **A pathway for the proposed service** * **Feedback from stakeholder consultation including PCN, Patient, GP and FCP. Also consider those along the pathway who will be affected such as Rheumatologists or Orthopaedic consultants.** * **Include data on the number of patients that will be affected by this service** |
| **\*INSERT LOCAL CASE FOR CHANGE HERE**  **EXAMPLE:**  **Stakeholders** The proposed FCP service is part of a coordinated approach to review the current MSK pathway, improve patient care and redesign pathways across \*STP within \*PCN. This proposal has been developed with and is supported by the following stakeholders;   * + MSK Therapy Service at \*Trust   + \*Primary Care Network (PCN) clinical directors   + GPs, Practice managers and teams from \*practice   + Secondary care consultants \*name   + STP and CCG leads \*name   + Patient participation groups \*name group and individual.   The FCP service will place advanced musculoskeletal practitioners (MSK) in primary care teams, at the start of the patient pathway. The FCP will work within the multi-disciplinary primary care team as part of the frontline general practice team, delivering additional capacity for MSK in the practice. The FCP will share knowledge, expertise, assessment, diagnosis and management advice which will increase GP capacity overall. This role will contribute to strong working relationships across primary and secondary care to ensure delivery of effective services within agreed pathways. Although the FCP service will take a proportion of the MSK workload and will provide advice and expertise to the team, there is no intention to de-skill GPs who will continue to see a MSK patients and be part of the pathway redesign.  Physiotherapists are able to undertake the FCP role, as autonomous, regulated practitioners, they hold their own professional insurance and practice without supervision or delegation from medical colleagues. Research shows that physiotherapists, aside from orthopaedic consultants, are the most expert professional group to manage MSK conditions and to safely and effectively identify red flags. Introducing the FCP service will transfer some of the current physiotherapy workforce from outpatient, secondary care and interface services to the front of the pathway in general practice.  The physiotherapists will remain employed by the Trust and part of \*Therapy team. For the FCP role they will be based in the Primary Care Network, undertaking scheduled clinics within the practice seeing patients every 20 minutes. This lengthened appointment time (in comparison to a GP) enables the FCP to undertake a detailed MSK assessment and provide immediate management whereby the majority of patients will be managed with self-care advice at first contact.  \*The FCP is able to advise on over-the-counter (OTC) medicine, supply and administer medicines using patient group directions (PGD)/ patient specific directions (PSD), prescribe medicines using independent and/ or supplementary prescribing routes and deliver soft-tissue and joint injections, order investigations, and plan complex case management. Rehabilitation will continue to be part of the MSK pathway and FCPs will refer for conservative management including ongoing physiotherapy treatment and rehabilitation, in addition to using links for social prescribing. It is anticipated that there will be fewer investigations (for imaging and blood tests), prescriptions and referrals to physiotherapy and orthopaedics than usually requested in primary care.  Although the FCP will provide a level of specialist assessment and investigations the FCP will triage patients to the appropriate services for further specialist assessment or investigations where required. The MSK triage services, delivered by advanced MSK physiotherapists or GPs with Special Interest, is included within the pathway to provide specialist clinical assessment of patients where initial conservative management has not been successful. The pathway ensures that duplication is avoided and it is anticipated that the number referred by the FCP will be significantly lower.  \*Trust will provide an FCP who:   * is a regulated and autonomous physiotherapist trained to provide expert MSK assessment, diagnosis and first-line treatment, self-care advice and appropriate onward referral * has advanced level skills to manage individuals with undifferentiated diagnoses at the start of the pathway recognising the uncertainty and potential complexity of patients * has the confidence and expertise to assess, diagnose and provide first-line treatments within the appointment time without increasing referrals into secondary care or back to the GP * is able to demonstrate the capabilities in the Musculoskeletal Core Capabilities Framework to meet the requirements of the role * works within and alongside traditional primary care and physiotherapy services to transform community or hospital based physiotherapy services   **Reported benefits of the FCP role;**  For patients;   * Quicker access to assessment, diagnosis, first-line treatment * Improved patient self-management and experience * Quicker recovery e.g. Improved speed of return to work * Shorter pathway to imaging and referral * Reduced attendance for the same condition * Prompt access to advice on preventative and rehabilitation interventions such as smoking cessation   For primary care teams;   * Increased staff satisfaction and wellbeing * Improved GP capacity * Improved level of MSK expertise within the primary care team * Increased clinical leadership and service development capacity * Opportunities for workforce development and individual career development   For the local healthcare system;   * Reduced prescribing rates and costs * Reduced secondary care referrals * Improved conversion rates to surgery * Reduced referral for and improved timing of imaging referrals (MRIs /x-rays) * Improved use of third sector / social prescribing/ community programmes   **Care navigation;** Patients will be able to access the appointments in the same way as GP appointments, via the receptionist (care navigator). The GP booking system, including online and telephone systems, and the care navigator will ensure that patients are seen by the right person as their first point of contact. Reception staff will have a visual guide to assist their decision-making. This care navigation will ensure the service is utilised and will support patients in becoming aware of the service and recognising its value. Promotional information on the FCP service will be based on the CSP care navigation guide, using a range of media including; the GP patient newsletter, patient flyers, posters and signage, the practice website and social media channels, television screens in the surgery, at patient / local events and via local media.  Access to the FCP service will be for patients who meet the following criteria;   * All soft tissue injuries, sprains, strains or sports injuries * Arthritis – any joint * Possible problems with muscles, ligaments, tendons or bone (e.g. tennis elbow) * Spinal pain including lower back pain, mid-back pain and neck pain * Spinal-related pain in arms or legs, including nerve symptoms (e.g. pins and needles or numbness) * Post-orthopaedic surgery   The following patients will be excluded from the FCP service and will have an appointment with a GP;   * Children under 16 * Women’s health, antenatal and postnatal problems * House-bound patients * Patients who do not want to see a FCP * Patients who are acutely unwell * Patient’s seeking an appointment for; * Medical management of rheumatoid conditions * Medication reviews for non-MSK conditions * Neurological / respiratory conditions * Headaches * Acute mental health crises   **Incorporating the FCP role within the primary care service will require the following to support consultations;**   * A clinical space within the practice which includes IT and telephone access, a plinth to examine patients, and basic medical assessment equipment * Access to the primary care electronic patient record (EPR), systems for referral, investigation request and review, for prescribing medications and appointment booking * Access to (virtual and paper) patient exercise and information materials * Access to the Allied Health Professions Advisory Fitness for Work Report * Access to information and directories on local services and activities for social prescribing * Resources to support the delivery of healthy lifestyle messages (Making Every Contact Count) * Access to language line as required for the local population * Access to the British National Formulary (BNF) * Equipment for soft-tissue and joint injections * Access to a chaperone to ensure a patient’s safety, privacy and dignity in line with the local chaperoning policy for the Primary Care Team. |
| 1. **Delivering safe and effective services**   **Outline local governance arrangements relating to legal, regulatory, professional, organisational and local frameworks to include;**   * **Risks** * **Benefits** * **Mitigating arrangements** * **Identify any concerns identified during stakeholder consultation and how these have been addressed. There may need to be an ongoing review or reporting mechanism to assure stakeholders throughout the implementation process.** |
| **\*INSERT LOCAL EXAMPLE OF SAFE AND EFFECTIVE SERVICES HERE**  **EXAMPLE:** Ensuring the service is implemented successfully and that it can be sustained requires support from all along the pathway, in the multi-professional team including the care navigators who are essential to signpost patients to the service and arrange appointments. These elements have been considered throughout the proposal.  A detailed service specification will be developed based on this proposal to include;   * monitoring arrangements * evaluation collection, reporting and review procedures * shared protocols to support patient management to include pathways where there is a presentation of systemic conditions or serious findings * procedures to cover for annual, unexpected or sick leave * format for clinic documentation, standardised examination tools, protocols for patient correspondence, communication with other services / stakeholders * procedures for case reviews, investigation referral and review, injection therapy, independent prescribing, complaints and serious incident reporting.   **Skills and Capabilities of the FCP;** The FCP delivering the service will hold the skills and knowledge for Advanced Clinical Practice (ACP), *“a level of practice characterised by a high degree of autonomy and complex decision making… includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people’s experience and improve outcomes ”* (HEE, Multi-professional framework for advanced clinical practice in England). The FCP has attained skills and knowledge for this role through postgraduate-level MSK learning and can demonstrate compliance with the two national frameworks; Multi-professional Framework for Advanced Clinical Practice in England and the Musculoskeletal Core Capabilities Framework.  **Title;** The term ‘First Contact Practitioner’ refers to nonmedical practitioners working in a role where they are the patient’s first point of contact. The term First Contact Practitioner – Physiotherapist will be used to safeguard patients’ interests and safety to ensure that the patient understands who they are seeing and the practitioner’s professional background as a physiotherapist working within the regulatory framework defined by the Health Care Professions Council (HCPC).  **Indemnity;** FCPs have autonomous clinical responsibility for patients and, as regulated professionals, hold appropriate indemnity cover provided via the \*Trust as the employer. \*Trust will ensure provision of a safe and effective service provided through the governance arrangements of the Trust and a range of additional mechanisms. The job description and person specification for the FCP will be agreed by the PCN, Trust and GP to ensure it reflects all elements of the role.  **Mentorship;** FCP should attend the GP group teaching sessions, as appropriate, and shadow the GP clinical team during face-to-face and telephone consultations. In addition, the FCPs will undertake supervision and peer support from the advanced practice physiotherapists within the Therapy service.  **Continued training and development;** The FCP will continue to engage in continuing professional development (CPD) activities included in the job plan to ensure the skills and knowledge required for the role are developed and maintained to support the delivery and the maintenance of clinical standards. The FCP will use the MSK Core Capabilities Framework to identify the areas for professional development and gaps in the knowledge, skills or experience.  **Induction;** A comprehensive induction will include meetings, shadowing and in-house training to:   * introduce the FCP to the primary care team and wider MSK service * ensure all members of the primary care team understand the FCP role and care navigation * familiarise the FCP with the relevant guidance, policies, digital systems and equipment * ensure the FCP is aware of the local support services within the social care and voluntary sectors |
| 1. **Interdependencies**  * **The stakeholder mapping exercise will inform this section** * **Include relevant services, pathways or organisations upon which the proposal depends or which will impact on its success** |
| **\*INSERT LOCAL INTERDEPENDENCIES HERE**  **EXAMPLE:** Key stakeholders have been consulted in preparation of this business case and will be involved throughout implementation and delivery of the service. Successful implementation and integration of the FCP role to deliver along the pathway requires support from all stakeholders. There will be a close working relationship between the general practice and the Therapy Department for delivery and professional support. Throughout implementation and delivery, the impact on secondary care services including radiology, orthopaedics, pain and rheumatology through a change in the pathway and potential reduction and change in referrals will be monitored. |
| 1. **Evaluation of the FCP service**  * **Include the key outcomes that will enable the service to be evaluated** * **Evaluation should include qualitative and quantitative measures which consider both cost and quality of services** * **It is recommended that evaluation includes information from a patient, GP, Therapy and Commissioner perspective** |
| **\*INSERT LOCAL EVALUATION PLANS FOR YOUR FCP SERVICE HERE**  **EXAMPLE:** The Standardised National Data Collection template (which can be embedded into Vision, Systm1 or EMIS in general practice) for First Contact Practitioners will be used to monitor evaluate, review and report on the service in a cyclical process. Throughout implementation this will be reported to the project sponsor and the information will be available to all stakeholders. This will enable reporting at local and national levels. Information gathered will include standard patient data fields, including demographics, past medical history, social history and employment status, alongside fields to support clinical decisions, audits and impact measuring.  Data will be collected and collated including the following;   * Timely access to MSK services for patients * Capacity and clinic utilisation data for MSK with FCP and GP * Integration across primary and secondary care and MDT working * Retention of current GPs and enhanced recruitment * Sources and numbers of ongoing referrals including to AHPs, social prescribing, investigations and secondary care referrals e.g. Orthopaedics * Length of the patient pathway * Conversion rate to surgery/secondary care treatment * A comparison of prescribing costs pre and post FCP implementation * Patient experience including FFT * Patient outcomes e.g. PROMs through collection of MSKHQ * KPIs required by the CCG * Feedback from those involved delivering the service; PCN, GP, FCP   As the service becomes established demand may exceed the appointments available and the service become saturated. The data will be used to review the long term capacity and resource requirements. |
| 1. **Resource implications**  * **Include here all of the resources required and the proposed savings to introduce and deliver the proposed service** |
| **\*INCLUDE LOCAL RESOURCE IMPLICATIONS FOR EACH SECTION HERE**  **EXAMPLE:**  **\*Financial;** Pay and non-pay costs Include an estimation of costs based on a band 8a of physiotherapist. The service proposed for 2 clinics per week, each of 3.5 hours will cost £\*. In comparison the service provided by a GP would cost £\*.  **\*Employment model;** \*Trust, will employ the FCPs. This will ensure governance for the post, provide sustainability enabling the provider to ensure service consistency and staff continuity and enable the FCP to remain integrated within the Therapy service. This option helps to embed and integrate FCPs across the MSK pathway where they can access training and peer support and share their skills and knowledge to develop others into the FCP role. In addition, this option provides stronger links between FCPs working in general practice and other MSK services across the MSK pathway (NHSE’s five-year framework for GP contract reform; BMA PCN Handbook).  The FCP role is supported by the long-term commissioning model to deliver sustainable cost benefits across the MSK pathway aligned with the needs of the local population, the Primary Care Network (PCN), the General Practice(s), and the local MSK services by;   * reducing elective care demand * reducing pressure on GP services * savings made from employing FCPs instead of locum GPs * reductions in secondary care referrals and surgical interventions   The evaluation process will identify the changes in service delivery and the cost savings.  **\*Job grading;** Initially the FCP will be a Band 8a. As the role evolves evaluation of the job description and person specification will be undertaken to tailor the role to the needs of the PCN.Local job evaluation will then determine the grading according. Within the Additional Roles Reimbursement Scheme (ARRS), NHS England calculated its maximum reimbursement rates against pay bands 7 and 8a.  **\*Funding sources;** The FCP will be funded as part of the Primary Care Workforce from the PCNs through the Additional Roles Reimbursement Scheme (ARRS). This scheme will fund 70% of salary with additional on costs. A range of options are being utilised to fund the remaining 30%. Further costs will be met through savings made through reduced need for locums. This funding will be further clarified once the business case has been accepted in principle and the project plan developed. As the FCPs will be employed by the NHS Trust, the proportion of time that the FCPs spend on PCN related activity (WTE) will be used to calculate the actual salary costs eligible for reimbursement through the ARRS. (See Network Contract Directed Enhanced Service Guidance). |
| 1. **Options appraisal**  * **Demonstrate that alternate options for meeting the demand have been considered** * **Include Option 1 as ‘do nothing’** |
| **\*INCLUDE LOCAL OPTIONS APPRAISAL HERE**  **EXAMPLE:**  **Option 1 - Do nothing**  MSK issues will continue to be managed by GPs rather than by expert physiotherapists in the FCP role. Costs   * Unchanged although may increase with the requirement for GP locums   Benefits   * No additional cost * Some GP Practices may fund FCP independently   Risks   * Continued and increasing burden on general practice * More GPs opting for early retirement, or leaving general practice * Practices unable to recruit due to the undesirable GP workload * GP Contracts being returned, resulting in CCG managed practices   **Option 2 – Implement the FCP model**  The \*Trust provides FCPs within \*PCN to \*Practice to work as part of the multi-disciplinary team. This option will provide \*appointments (to meet approximately 5% of the estimated MSK demand). The capacity can be expanded as demand is evaluated. The service will be led by an 8a Physiotherapist(s) with support from the Therapy Services Manager.  Costs   * The costs associated with this proposal in the first year are included above.   Benefits   * Support the retention of current GPs * Offer patients expert care, close to home * Provide potential cost savings in secondary care * Promote patient focussed care by the PCN and overseen by the Trust and General Practice   Risks   * May destabilise secondary care physiotherapy by recruiting from existing services * Non uptake of service by the practices * Non uptake of services by patients |
| 1. **Recommendations and conclusion**  * **A short paragraph to reflect the considerations and recommendation going forward. This should be reflected in the executive summary** |
| **\*INCLUDE LOCAL RECOMMENDATIONS AND CONCLUSION HERE**  **EXAMPLE:** The options appraisal clearly presents a case to introduce an FCP within \*PCN into the \*GP to manage MSK conditions. There will be a phased approach to implementation for 6 months. Data will be collected throughout with a formal mid- point review. Throughout the implementation process there will be a review of care navigation, training needs and referral pathways to optimise the benefits. Due to the changes needed along the patient pathway the maximum benefits will not be seen immediately and it is likely that the improvements will continue for 12 months and beyond as awareness and understanding of the service improves. |
| **Implementation Plan**   * **Include a visual plan for implementation** * **Implementation may be staged if appropriate and should apportion responsibility to named individuals** |
| **\*INSERT LOCAL IMPLEMENTATION PLAN HERE**  **EXAMPLE:** Transformation of the MSK primary care pathway will begin within \*PCN. The \*Therapy service is able to provide this service to \*GP within 12 weeks of approval. Throughout implementation the practice and PCN will be updated on progress and delivery of the service specification and performance together with performance against KPIs agreed within this. This information will enable the PCN to report to the commissioner and STP as required. |
| **Resources**   * **Include here links to resources that will support the business case** * **Examples of those likely to be included are below** |
| **\*INCLUDE ANY LINKS TO RESOURCES USED TO SUPPORT YOUR BUSINESS CASE HERE**  **EXAMPLE:**   * BMA 2019, The primary care network handbook <https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/committees/gpc/gpc%20england/pcn%20handbook.pdf?la=en> * BMA 2019, Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf> * BMA, NHSE, Network Contract Directed Enhanced Service <https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-guidance-2019-20-v2.pdf> * CSP, Care Navigation Guide <https://www.csp.org.uk/system/files/documents/2018-10/001536_First_Contact_reception_info.pdf> * CSP, FCP guidance <https://www.csp.org.uk/professional-clinical/improvement-and-innovation/first-contact-physiotherapy> * CSP 2018, First Contact Physios implementation guidance <https://www.csp.org.uk/publications/guide-implementing-physiotherapy-services-general-practice> * CSP, Medicines, prescribing and injection therapy <https://www.csp.org.uk/professional-clinical/professional-guidance/medicines-prescribing-and-injections> * CSP, MSK First Point of Contact Model <https://www.csp.org.uk/professional-clinical/improvement-and-innovation/costing-your-service/msk-first-point-contact-model> * General Practice forward view <https://www.england.nhs.uk/gp/gpfv/> * HEE, Care Navigation: A competency framework <https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf> * HEE 2018, Musculoskeletal core capabilities framework for first point of contact practitioners * <https://www.csp.org.uk/system/files/musculoskeletal_framework2.pdf> * HEE, Social Prescribing at a Glance <https://www.hee.nhs.uk/news-blogs-events/news/social-prescribing-glance> * HEE. Making Every Contact Count <https://www.makingeverycontactcount.co.uk/> * HEE NHSE CSP Standardised National Data Collection for First Contact Practitioners – Guidance <https://mskhub.org.uk/standardised-national-data-collection-for-first-contact-practitioners-guidance/>   <https://www.csp.org.uk/system/files/publication_files/Data%20Collection%20for%20FCPs%202ndEd%20Feb2019.pdf>   * Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/> * NHS England, 2017, Transforming musculoskeletal and orthopaedic elective care services <https://www.england.nhs.uk/wp-content/uploads/2017/11/msk-orthopaedic-elective-care-handbook-v2.pdf> * NHS England and NHS Improvement, 2019, Elective Care High Impact Interventions: First Contact Practitioner for MSK Services <https://www.england.nhs.uk/wp-content/uploads/2019/05/elective-care-high-impact-interventions-first-contact-practitioner-msk-services-specification.pdf> * NHS England, Social Prescribing, <https://www.england.nhs.uk/personalisedcare/social-prescribing/> * An example of FCP, <https://www.rcgp.org.uk/clinical-and-research/resources/bright-ideas/musculoskeletal-practitioners.aspx> * RCOT, AHP Health and Work Report <https://www.rcot.co.uk/practice-resources/standards-and-ethics/ahp-health-and-work-report> |
| **Glossary**   * **Include all acronyms and for abbreviations/ medical or specifically technical terminology** * **Examples of those likely to be included are below** |
| **\*ADD ANY ACRONYMS USED IN BUSINESS CASE HERE**  AHP Allied Health Professional  ARRS Additional Reimbursement Roles Scheme  CCG Clinical commissioning group  CSP Chartered Society of Physiotherapy  FCP First Contact Practitioner  HCPC Health and Care Professions Council  HEE Health Education England  MDT Multi-disciplinary team  LTP Long Term Plan  MECC Making Every Contact Count  MSK Musculoskeletal  OTC Over the counter  PGD Patient group directions  PSD Patient specific directions  PCN Primary care network  PDSA Plan-Do-Study-Act  PLI Professional liability insurance  STP Sustainability and Transformation Partnership |