TEPC #1687016 VOL 00, ISS 00

Musculoskeletal (MSK) practitioners in primary care: an evaluation of a MSK core capabilities framework and review process

Rachel Locke, Emma Wilkinson, Richard Collier and Beverley Harden

QUERY SHEET

This page lists questions we have about your paper. The numbers displayed at left are hyperlinked to the location of the query in your paper.

The title and author names are listed on this sheet as they will be published, both on your paper and on the Table of Contents. Please review and ensure the information is correct and advise us if any changes need to be made. In addition, please review your paper as a whole for typographical and essential corrections.

Your PDF proof has been enabled so that you can comment on the proof directly using Adobe Acrobat. For further information on marking corrections using Acrobat, please visit http://journalauthors.tandf.co.uk/production/acrobat.asp; https://authorservices.taylorandfrancis.com/how-to-correct-proofs-with-adobe/

The CrossRef database (www.crossref.org/) has been used to validate the references. Changes resulting from mismatches are tracked in red font.

AUTHOR QUERIES

Q1 Please provide missing affiliations for all authors as per the journal style.

Q2 The funding information provided "Health Education England" has been checked against the Open Funder Registry and we failed to find a match. Please confirm if the Funding section is accurate and also confirm the funder names.

Q3 The PubMed (http://www.ncbi.nlm.nih.gov/pubmed) and CrossRef (www.crossref.org/) databases have been used to validate the references. Mismatches between the original manuscript and PubMed or CrossRef are tracked in red font. Please provide a revision if the change is incorrect. Do not comment on correct changes.

Q4 Please provide the complete reference details for [4] references list entry.

EDUCATION FOR PRIMARY CARE
https://doi.org/10.1080/14739879.2019.1687016

Taylor & Francis
Taylor & Francis Group

EVALUATION

Musculoskeletal (MSK) practitioners in primary care: an evaluation of a MSK core capabilities framework and review process

Rachel Locke, Emma Wilkinson, Richard Collier and Beverley Harden

ABSTRACT

The General Practice Contract 2019/20 established first contact musculoskeletal (MSK) physiotherapists in primary care. This paper describes an evaluation exploring the feasibility of using the MSK Core Capabilities Framework and a peer review process to evidence capability. It discusses how this process may be developed to ensure MSK practitioners are able to evidence the level of practice required within the complex environment of primary care. MSK practitioners were supported to evidence their capabilities against the MSK Framework. Twenty-two participants took part in the evaluation of this intervention via semi-structured interviews. A robust and iterative process of qualitative data analysis was undertaken. The findings are framed in terms of Davis' Technology Acceptance Model of evaluation (i.e. user perceptions).

There were a range of perceived benefits of the Framework including as a means of quality assurance, career progression, the promotion of knowledge consolidation and reflective practice. There were however, a number of 'translation into practice' issues. Given the newness of the MSK Framework, it is perhaps not surprising there is a need for refinement. This evaluation highlights key enablers for reviewing capabilities of MSK practitioners: a curriculum; educational supervision; and accreditation. Learning also applies more widely to other emerging role opportunities.

ARTICLE HISTORY
Received 21 June 2019
Revised 28 September 2019
Accepted 13 October 2019

KEYWORDS
Assessment; primary care; professional development; evaluation; practitioner support

Q1

Introduction

The General Practice Contract 2019/20 signalled the national need for first contact physiotherapists as musculoskeletal (MSK) practitioners in primary care, placing expertise at the right place, early in the pathway [1]. One of the challenges of developing this role opportunity in primary care has been a lack of clear role definition and guidance for training, development and assessment. In response to a Health Education England review to better support new ways of working, an MSK Core Capabilities Framework was published to offer a clear definition of the core knowledge, skills, behaviours and capabilities required of first contact roles for people with MSK conditions, across the professions [2,3]. This is the only MSK Framework that has been developed, which made a pilot or study of feasibility important in determining its usefulness going forward [4].

Feasibility study involving the MSK framework and review process

Fifteen MSK practitioners were invited to submit evidence (e.g. written reflections, certificates of achievement) within four domains of the MSK Framework (see Table 1) and to submit evidence for review, by a panel, comprising four members (a GP, two advanced physiotherapy practitioners and one lay member). In the absence of a training infrastructure, this was a one-off equivalence review against the MSK Framework for experienced, regulated clinicians. The panel was tasked with reviewing evidence to assess whether it met the MSK Framework criteria. Four MSK fellows, who had at least 3 years of experience in senior MSK roles, were recruited to support MSK practitioners to work with the Framework and collect evidence.

This paper reports on an evaluation of the feasibility study and the extent to which the MSK Framework and an Annual Review of Competence Progression (ARCP) style review provide a means of reviewing capabilities. The aim of the evaluation was to identify how this process may be developed to ensure MSK practitioners were prepared and evidence their level of practice required to both support primary care and optimise the opportunity of early clinical assessment and management. This work will be of interest to those working in education and training of professional groups, beyond GPs, working in primary care environments. Its main audience is likely to be those working in settings (e.g. primary care in England) where first contact MSK physiotherapists are being established. The enablers and challenges identified in the following discussion were important learning for similar national and international arrangements.

CONTACT Rachel Locke Rachel.Locke@winchester.ac.uk

Table 1. Four domains of the MSK Framework.

Domains
A. Person-centred approaches
B. Assessment, investigation and diagnosis
C. Condition management, interventions and prevention
D. Service and professional development

Method

Evaluation of the feasibility study

Participants from the feasibility study were invited to take part in the evaluation. Semi-structured interviews were undertaken in which participants were asked about their experiences of engaging with the process and any associated benefits and challenges. Interviews were one to one, with the exception of one focus group conducted with four participants via Skype.

All interviews were recorded, transcribed and the verbatim interview transcripts were the key source of data. A robust and iterative process of data analysis was undertaken with the aid of the analytical software package, NVivo. The main findings derived from this qualitative data set are presented in this paper. They are framed using Davis' Technology Acceptance Model (TAM) [5]. Technology is defined in a broad sense here i.e. innovation/newness, and the model is used to assess the value of the MSK Framework and review process according to the perceptions of its users. This approach will assist in the production of knowledge that is useful to those involved in this process and the findings, and the interpretations thereof, have wider applicability relevant for future decision-making [6].

Results

There were 22 participants (15 practitioners, four fellows and four-panel members) in the evaluation from a total of 24 (two did not accept an invitation to be interviewed). The MSK practitioners taking part in the evaluation were physiotherapists and an osteopath, and either were already working in first contact MSK roles, or were interested in undertaking such work in the future.

There were two main areas of perception considered by employing the TAM: the usefulness of the intervention i.e. the Framework and review process; and the ease of use. These are covered in the following section from the point of view of: practitioners that took part in the feasibility study and submitted their evidence to a panel; fellows who supported these practitioners to understand the requirements of the Framework and portfolio approach as a new way of working; and panel members who were responsible for reviewing evidence.

Usefulness of the MSK framework and review process

MSK practitioners found it useful to submit evidence against the Framework because it provided both a good learning process and a sense of achievement for most, as well as contributing to a growing awareness of the need to evidence and document their developing practice in a systematic, reliable and retrievable way.

> *This is quite useful to know what evidence I've got about what I'm doing …, I probably need to make sure I've really got that evidence there. (Practitioner)*

Engagement with the Framework and review process meant they learnt more about the first point of contact MSK practitioner role and considering its scope, expectations and requirements was perceived as an insightful process.

For fellows and panel members, who were perhaps more concerned with the MSK Framework as a quality assurance process, a commonly expressed view was that successful submission of evidence against the MSK framework, as judged by a panel of experts, could provide a level of reassurance to fellow workers and employers within primary care and also to the public, in terms of giving assurance of a certain level of competence, the provision of good quality care and patient safety.

> *From the point of view of the GPs, we [MSK practitioners] may be a little bit of an unknown quantity coming in and seeing their patients and working in their practice and for their peace of mind to have some sort of formal process, and maybe an accreditation. (Fellow)*

Also, it could serve to highlight training requirements where gaps in knowledge exist. As such the Framework and review process were seen as a potentially useful tool in career development and as a support to employers. Views on its future status were raised and what the potential outcomes were for the participants.

> *It's a sort of self-review, but the issue is do you end up with an accreditation … if there isn't an accreditation attached to it, it just looks like a large volume of work. (Fellow)*

Perceived 'ease of use'

For practitioners, whose concern was to be able to evidence their capability and learning, concerns were raised about the usability of the Framework. The scope of some capabilities was too broad or complicated to answer in a comprehensive manner.

> *A couple of the points weren't as clear as they could have been. Some domains were confusing and took a while to decipher. They were about social issues, mental health*

and trauma … It was really hard to know what was expected of those ones. (Practitioner)

A key theme to emerge from the analysis was an overlap between the questions across the sections within each domain. Many MSK practitioners were concerned whether they could use a piece of evidence more than once. Many practitioners found it challenging to find sufficient examples of practice within their own sphere of work to reflect on. For some this was felt to be due to being at an early stage in their first contact roles and therefore having a limited evidence-base to draw on.

For the MSK practitioners to submit evidence against the MSK Framework as part of the feasibility study was a large-scale piece of work. It was difficult for them to find time to complete the exercise. Support from employers in ring-fencing time varied and some MSK practitioners needed to complete it in their own time. The timescale for submission of practitioners' evidence was short at 4 weeks. Most believed the tight timescale had an impact on both the quality and quantity of evidence submitted, including the level and depth of reflective work.

The slightly tight schedule for it probably affected the quality of the evidence and I certainly cut a few corners on mine just to get it done. (Practitioner)

The absence of an e-portfolio to support this process meant there were technological issues. To submit evidence a data entry system using a Word template with an embedding facility was employed. This system presented problems for fellows collating evidence, and for panel members accessing data and meant panel members could not easily review all the submissions.

The quality of evidence submitted against the MSK Framework was reported by the panel members to be variable in its presentation, quantity and the types of information perceived to be evidence. Although no evidence raised any concerns about patient safety, it was sometimes difficult to contextualise and needed either panel interpretation or a narrative to explain why it was submitted.

The key things that came out for me were that the evidence was variable. Some were very good and very on the button; some needed much more information. (Fellow)

Without having some narrative to explain it, it makes our job very difficult; we struggled sometimes to understand how it demonstrated the capability. (Panel member)

Questions were raised as to whether optimal methods of assessment were being employed to produce meaningful evidence. Several panel members and fellows believed that an external assessment of communication, for example a 360-degree review of a practitioner's communication skills, would produce more robust evidence, than the practitioners' self-reports. The variation in the evidence submitted may have been due, in part, to a lack of guidance as to what constitutes robust evidence and how best it should be submitted. Some practitioners found the language used for some criteria a little difficult to understand which heightened speculation as to how best to submit evidence.

The process of documenting evidence of one's practice at this scale, across a range of criteria, was seen as both a big cultural shift and steep learning curve for the participants, by most of the fellows and panel members.

This is a group of professionals who are not used to doing this sort of thing, whereas junior doctors fill in e-portfolios, and they're used to this progression and filling in things, measuring their training and where they're up to etc. (Panel member)

Discussion

Given the relative newness of the MSK Framework and the absence of a training scheme, educational supervision and a portfolio, it is perhaps not surprising there is a need for refinement. The MSK Framework and review process needs to be as user-friendly as possible.

The time frame to complete the evidence collection was very limited; a longer time frame would allow the MSK practitioner working in a first contact role the opportunity to build up evidence over time. They could collect and submit evidence in a considered way, carry out meaningful reflections on their practice, and where there are gaps in learning, have the opportunity to address these through training, assessment and pursuing new opportunities in the workplace. An online portal to manage submissions would facilitate this process by standardising the format of submissions, making the material easily accessible and enabling MSK practitioners to demonstrate level of capability. In future the Framework will be able to be used prospectively by those looking to move into primary care. Where a practitioner has successfully demonstrated capability by successful submission of evidence against the entire MSK Framework, there may need to be appropriate accreditation to recognise individuals.

A resourced and coordinated support and review process are required. Assessment could be done outside panel meetings and panel members could meet to discuss exceptions or outliers. Currently, a report from an educational supervisor is missing. If there were educational supervisors they could be involved in assessing some of the practitioners' evidence, for example, those requiring some form of external assessment, such as communication skills.

Their assessment would have the additional benefit of providing a quality assured level of assessment, which could be presented to the panel and give detailed and clear outcomes, for panel members to ratify.

Evidence varied, so guidance is needed as to what constitutes robust and relevant evidence for each capability. Guidance could outline standardised assessments and an acceptable level of narrative/reflection on practice linked to the evidence for each criterion. An e-portfolio would serve to guide MSK practitioners as to what evidence is needed. MSK practitioners are not only physiotherapists; they can include other professions with appropriate training such as podiatrists, occupational therapists and osteopaths. Any guidance produced needs to adopt language that is accessible to health professionals generally so that the process can be widely understood and accessed.

Conclusion

This first evaluation of the MSK Framework and review process has suggested that there is benefit to have established a threshold which MSK practitioners need to achieve to evidence the level of their practice for primary care, in first point of contact roles and as part of evidencing Advanced Level practice capability. This enables a level of assurance to self, colleague and patients that a sufficient threshold of capability has been achieved. It builds trust in workforce transformation and new ways of working. The lift and shift of a medical ARCP style process is difficult due to many complicating factors including a lack of educational infrastructure and historically different methods of assessment. However, the principle of capability assessment is valid and the detail of a process which is intelligent, proportionate and pragmatic is needed. Through this evaluation, we have established some key enablers:

- a suite of core capabilities – in this instance the MSK Framework offered this level
- educational supervision – which is hard to deliver in the absence of any educational infrastructure
- accreditation – a list of those accredited that meet full Advanced Clinical Practice criteria.

Further work is needed to evidence the added value of such a process as opposed to a self and/or employer assessment by a regulated professional. This evaluation is part of building the evidence base to achieve the above and support the agreement as to how to best review capabilities and contribute to further assessment. Important lessons have been identified for similar schemes, both nationally and internationally.

Acknowledgments

The authors thank all research participants (i.e. MSK practitioners, fellows and panel members) that took part in the interviews. The authors also thank Professor John Sandars for his advice on an early draft of the paper.

Declaration of interest

Dr Richard Collier is Clinical Lead for MSK Practitioners in Primary Care and Beverley Harden is Allied Health Professional Lead for Health Education England.

Ethical approval

The study was granted ethical approval by the University of Winchester.

Funding

This work was supported by the Health Education England.

References

[1] British Medical Association, NHS England. Investment and evolution: A five-year framework for GP contract reform to implement The NHS long term plan; 2019 [cited 2019 Oct 23] Available from: https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

[2] Health Education England. Enhancing training and the support for learners: HEE review of competence progression for health care professionals; 2018 [cited 2019 Oct 23] Available from https://www.hee.nhs.uk/sites/default/files/documents/ARCP%20Review%20-%20Enhancing%20training%20and%20the%20support%20for%20learners.pdf

[3] Musculoskeletal core capabilities framework London: skills for health; 2018 [cited 2019 Oct 23] Available from: https://www.skillsforhealth.org.uk/services/item/574-musculoskeletal-core-skills-framework

[4] Chance-Larsen K, Backhouse M, Collier R, et al.. Developing a national musculoskeletal core capabilities framework for first point of contact practitioners. Rheumatol Adv Pract. Forthcoming.

[5] Davis FD. Perceived usefulness, perceived ease of use, and user acceptance of information technology. MS Q. 1989;13(3):319–340.

[6] Sandars J, Brown J, Walsh K. Producing useful evaluation in medical education. Educ Prim Care. 2017;28(3):137–140.