GETTING IT RIGHT FIRST TIME

Chartered Society of Physiotherapy

GIRFT First Contact Physiotherapy (FCP) Initial Report: An evaluation of the current provision of FCP services within primary care in England

by Andy Saunders

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March 2026

GIRFT is part of an aligned set of programmes within NHS England

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Foreword by Professor Tim Briggs

Musculoskeletal (MSK) conditions are among the most common causes of pain, disability and reduced quality of life across the population. They also represent a significant and growing demand on NHS services. Ensuring that people with MSK conditions are assessed and treated promptly, in the most appropriate setting, is therefore essential to improving outcomes while supporting the sustainability of the health system.

The Getting It Right First Time (GIRFT) programme is a clinically led, data-driven initiative focused on reducing unwarranted variation and improving the quality and efficiency of care. By combining national data analysis with clinical insight, GIRFT works with providers and systems to identify best practice and support service improvement. This approach has now been applied across more than 40 specialties and is increasingly informing improvement across primary and community care.

Community MSK services play a critical role within the wider MSK pathway. Through the GIRFT Community MSK workstream, and the MSK Community Delivery Programme supported by the Government's Joint Work and Health Directorate (JWHD), GIRFT has worked with integrated care systems across England to strengthen community provision, improve access to treatment and reduce long waits for care.

First Contact Physiotherapists (FCPs) are an important component of this model of care. By providing advanced clinical assessment, triage and management for people presenting with undifferentiated MSK problems in primary care, FCPs can support timely specialist assessment while helping to release capacity within general practice.

However, as this GIRFT Initial Report demonstrates, there remains unwarranted variation in how FCP services are commissioned, delivered and governed across England. Differences in workforce assurance, scope of practice, governance arrangements and data collection mean that the full benefits of the role are not consistently realised.

Drawing on findings from a national survey of FCP provision, this report provides a clearer understanding of current practice and highlights opportunities for improvement. Its recommendations are intended to support commissioners, providers and Primary Care Networks to strengthen the quality, safety and value of FCP services.

This report has been written for those responsible for designing, commissioning and delivering MSK services. Ultimately, however, the beneficiaries of this work are patients. By addressing unwarranted variation and strengthening integrated MSK pathways across primary, community and specialist services, the NHS can ensure that people with MSK

conditions receive timely, effective care and the support they need to remain active and independent.

Professor Tim Briggs CBE

GIRFT programme lead and National Director for Clinical Improvement, Elective Recovery and UEC for NHS England

Professor Tim Briggs is a consultant orthopaedic surgeon at the Royal National Orthopaedic Hospital NHS Trust.

Introduction from Andy Saunders

On 18th December 2024, the Getting it Right First Time (GIRFT) programme launched a £3.5 million programme of activity funded by the Government's Joint Work and Health Directorate (JWHD). This GIRFT Musculoskeletal Community Delivery Programme (MSK CDP) worked with 17 integrated care systems (ICSs), spread across the seven NHSE regions, with large waiting lists for commissioned community musculoskeletal (cMSK) services, as measured within the **community waiting list dataset**. The aim of the MSK CDP was to support these 17 systems to rapidly reduce their waiting list backlog, with a focus on people waiting more than 18 weeks, improving access to MSK treatment and helping people to remain economically active. In 2025/26, a further £2.2 million was funded to the workstream to support on-going initiatives and an additional six ICBs.

The programme adapted the GIRFT 'Further Faster' principles and methodology. A six-point plan was implemented to support systems in evaluating their local community MSK provision, guided by a **Further Faster Community MSK Handbook**, to identify high-impact interventions which reduce waiting list backlog while sustaining optimal patient outcomes and experience.

GIRFT's cMSK workstream supports integrated care systems in the delivery of high-quality, personalised, equitable MSK services in the community, to benefit patients now and into the future.

The central aims of the workstream are to:

- ensure high-quality triage services and optimise referrals for diagnostics, orthopaedic, rheumatology and spinal services;
- enable the delivery of high-quality therapies to rehabilitate people who have sustained an injury or are recovering from surgery;
- support people to develop the knowledge, skills, and confidence to manage long-term MSK conditions, enabling them to remain in or return to work;
- integrate digital health therapeutics.

A key deliverable for the MSK CDP for 2025/2026 was to evaluate MSK First Contact Practice provision and inform recommendations for future quality improvement.

Andy Saunders

GIRFT Community MSK clinical advisor for First Contact Practice
Andy is an Advanced Physiotherapy Practitioner and Clinical Lead for the First Contact Practitioner service within Midlands Partnership University NHS Foundation Trust. As the GIRFT Community MSK Clinical Advisor for First Contact Practice, he is leading the rapid analysis of current service provision and the development of recommendations to support future practice. He also provides specialist expertise to the GIRFT programme in this area of MSK practice. Alongside his current roles, Andy is Chair of the Midlands FCP Clinical Forum and a guest lecturer at Keele University.

Statement of support

The Chartered Society of Physiotherapy (CSP) welcomes this GIRFT Initial Report examining the provision of First Contact Physiotherapy (FCP) services within primary care. As the professional, educational and trade union body for the physiotherapy workforce, the CSP recognises the vital role that physiotherapists play in delivering high-quality musculoskeletal (MSK) care and supporting people to remain active, independent and in work.

First Contact Physiotherapists are an important part of the multidisciplinary primary care workforce. By providing advanced assessment, triage and management for people presenting with undifferentiated MSK problems, FCPs help to ensure patients receive timely, expert care while supporting more efficient use of primary care capacity. When implemented well, the FCP model can improve patient experience, optimise referral pathways and contribute to better outcomes across the wider MSK system.

This report provides a valuable overview of current FCP provision across England and highlights areas of excellent practice alongside important opportunities for improvement. In particular, the findings underline the need for greater consistency in workforce assurance, governance arrangements and the application of nationally recognised educational frameworks. Addressing this variation will be essential to support the safe, sustainable development of FCP services and to enable practitioners to work effectively at the top of their scope of practice.

The CSP supports efforts to strengthen quality, safety and consistency across FCP services. By working collaboratively with NHS England, GIRFT, commissioners, providers and Primary Care Networks, there is a significant opportunity to ensure that the FCP role continues to develop in a way that benefits patients, clinicians and the wider health system.

The CSP looks forward to supporting the next phase of this work and to continuing to work with partners across the MSK community to ensure that physiotherapy expertise is used to its full potential in delivering high-quality care for patients.

John Cowman
CEO, Chartered Society of Physiotherapy

Background

First Contact Physiotherapists (FCPs) work in primary care, delivering advanced-level clinical assessment, triage and management of people presenting with undifferentiated and undiagnosed musculoskeletal problems, without the need for prior assessment by a primary care clinician.

There is evidence to suggest that FCPs can be a valuable addition to the primary care workforce, ensuring patients are managed appropriately and efficiently (Goodwin et al., 2021; Stynes et al., 2021). Previous evaluations of FCP service delivery have demonstrated that FCPs are widely accepted by primary care colleagues and patients, while helping to free up primary care capacity (Downie et al., 2019; Henning, Henning and Lynch, 2024; Wood et al., 2022). There is also evidence to suggest FCPs may deliver wider system benefits through cost-effective outcomes, reducing onward referrals to community and secondary care services, alongside reducing the use of prescribed medications (Downie et al., 2019; Henning, Henning and Lynch, 2024; Walsh et al., 2024).

Despite evidence demonstrating the potential value of the role, there is recognition of multi-faceted challenges and unwarranted variation in FCP service delivery, which may affect the longer-term sustainability and growth of the role.

These concerns have been outlined through multi-stakeholder engagement led by the Chartered Society of Physiotherapy (CSP). Further concerns have been identified in relation to recruitment, burnout, integration with local services, induction practices, and the reputation and model of FCP services (Hayward-Giles, 2025).

This GIRFT Initial Report synthesises findings from a national survey of FCP service provision in primary care. Its purpose is to identify unwarranted variation, highlight risks to safety and value, and set out practical, data-driven recommendations to support commissioners, providers and Primary Care Networks (PCNs) to improve outcomes, experience and efficiency.

Executive summary

First Contact Physiotherapy (FCP) services play an increasingly important role in the delivery of musculoskeletal (MSK) care in primary care, with the potential to improve access, optimise patient pathways and release capacity across the wider system. This GIRFT Initial Report examines the current provision of FCP services in England and identifies areas of unwarranted variation that may affect quality, safety, value and sustainability.

FCP services are delivered through a range of provider and employment models, including independent healthcare providers, NHS trusts or through direct general practice or primary care network (PCN) employment. This variation in delivery models is associated with differences in governance arrangements, assurance processes and service maturity.

Significant variation was identified in awareness and application of Care Quality Commission (CQC) regulatory guidance and the nationally recognised educational framework for FCPs. Assurance that practitioners had completed the FCP roadmap was inconsistent and, where this was not the case, alternative mechanisms for assuring capability and patient safety were not always clearly defined. This represents a potential risk to both quality and consistency of care.

There is variation in how FCP roles are operationalised within primary care. When evaluating specific FCP responsibilities, including access to prescribing, fit note certification, diagnostic requesting, injection therapy and direct referral to secondary care, the extent to which FCPs can utilise these skills is inconsistent. These differences limit the system-wide benefits of the role and may affect the quality and consistency of care.

Arrangements for job planning, clinical supervision and professional support were found to be variable, as were approaches to the collection and use of performance, quality and outcomes data. Patient-reported experience and outcome measures were not collected consistently, reducing the ability of systems to understand impact and drive improvement.

Governance and accountability for safety and quality were mixed. While some services demonstrated clear oversight and formal arrangements, others relied on informal processes, with variation also identified in Patient Group Direction (PGD) authorisation and use.

Most services reported an intention to sustain current FCP provision, with limited planned expansion and some consideration of provider model change. This suggests that without clearer standards, improved assurance and greater consistency, the future development of FCP services may be constrained.

This GIRFT Initial Report highlights substantial unwarranted variation in the commissioning, delivery, and governance of FCP services in primary care. These findings provide a clear case for further analysis and the development of practical, system-level recommendations to support commissioners, providers and PCNs to strengthen quality, safety and value in FCP service delivery.

Recommended enablers for good practice

Further to the observations from this FCP evaluation, we recommend that the following enablers of good practice are adopted by those commissioning and/or delivering FCP services.

1	Primary care services commissioning or delivering MSK FCP services ensure full awareness of and compliance with the Care Quality Commission (CQC) regulatory guidance for FCP roles (including GP mythbuster 106).This includes ensuring that all FCPs meet the required experience, expertise and governance standards for safe autonomous practice in primary care.
2	Where FCPs have not yet completed both stages of the MSK FCP roadmap to practice, PCNs, practices and providers maintain visible, time-bound, agreed plans for completion. Robust interim governance arrangements (including supervision and risk mitigation) are in place and clearly communicated to protect patient safety.
3	The role of FCP should be clearly understood by all stakeholders (including patient groups and the Voluntary Community and Social Enterprise (VCSE) Health and Wellbeing Alliance to ensure FCP appointments are used appropriately as part of general practice multidisciplinary teams, without duplication of care or delay in referral to alternative or GP-led services where clinically appropriate.
4	FCP service providers, irrespective of their employment model, actively engage with and collaborate alongside local community MSK services and seek regular feedback to optimise referrals and promote an integrated local MSK care system in line with NHS England » An improvement framework to reduce community musculoskeletal waits while delivering best outcomes and experience
5	All FCPs have an agreed job plan that allocates sufficient time for supporting professional activity (SPA) time, including clinical supervision, and a named, responsible and appropriately trained clinical supervisor that aligns to recommendations within NHS England » Supervision guidance for primary care network multidisciplinary teams
6	The factors contributing to unwarranted variation in FCP access to diagnostic imaging, secondary care referral pathways, injection therapy and prescribing are fully understood.

7	Where capable and appropriately trained, FCPs are supported to certify/amend fit notes and provide access to employment support services to help patients remain in or return to work.
8	All primary care services have formal, regularly reviewed, governance processes in place to oversee the quality and safety of FCP services. Collaboration between primary care and community MSK/secondary care services receiving referrals from FCPs is maintained to enable review of referral quality and appropriateness.
9	Patient group directions (PGDs) for relevant medicines, including injections, are authorised at the appropriate organisational level according to the FCP employment model in alignment with national guidance on PGD use in Primary Care Networks or in complex commissioning scenarios.
10	All FCP services routinely collect, share and analyse performance and quality metrics with relevant stakeholders (e.g., PCNs, practices, community MSK services and ICBs). This supports the embedding of a learning health system approach across the MSK care pathway.
11	FCP services routinely collect, share and analyse patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) with the same relevant stakeholders. This promotes continuous improvement, demonstrates service value, and aligns with national MSK priorities for optimal outcomes and patient experience.

Scope

Audience and purpose

This report on First Contact Physiotherapy (FCP) services is intended for NHS leaders, commissioners, integrated care boards (ICBs), professional bodies, and clinical and operational teams within musculoskeletal care.

Its purpose is to identify unwarranted variation in the commissioning, delivery and governance of FCP services across England.

The report draws on national survey data and insights from the GIRFT Musculoskeletal Community Delivery Programme (MSK CDP). It provides evidence-based recommendations to support commissioners, providers and Primary Care Networks in improving quality, safety, efficiency and equity in FCP service delivery.

Methodology

Survey development

An online survey was agreed by all stakeholders to be the most efficient method of gaining national oversight of FCP service delivery within the time frame of this work programme.

The FCP survey themes and the associated questions were co-created by collaboration from the following FCP evaluation stakeholders:

- Joint Work and Heath Directorate (JWHD)
- Workforce, training and education, NHS England
- GIRFT Community MSK workstream.
- Chartered Society of Physiotherapy (CSP)
- Chief Allied Health Professions Office (CAHPO)
- Edge Health

Survey aim and scope

The primary aim of the survey was to gain an overview of the current provision of FCP service delivery across England. General practice managers and PCN leads with responsibility for managing FCP services were identified as the survey participants, as it was felt they were best placed to provide insight and an overview of current FCP service delivery.

The survey was designed to evaluate the provision of FCP rather than any other profession working in first contact MSK roles. This aligns to MSK first contact roles that are reimbursable via the additional role reimbursement scheme (ARRS) as outlined within Network Contract DES and is also reflective of the largest non-GP or nursing profession assessing and managing people with MSK conditions in primary care within MSK first contact practice roles. Primary Care Workforce Quarterly Update

The key areas of focus included:

1. FCP employment characteristics
2. FCP capability
3. FCP appointment factors
4. FCP job plan and supervision provision
5. FCP scope of practice
6. Performance, quality and patient-related outcome measure collection
7. Oversight of quality and safety

Pilot study

An initial pilot survey was sent to five GP managers/PCN leads in October 2025. This allowed the functionality of the survey platform and the associated survey questions to be tested. Subsequent amendments were made to the final survey based on the pilot survey responses and the feedback provided. Pilot study data demonstrated that the survey took approximately 10 minutes to complete.

Survey distribution

Between November 2025 and December 2025, using a purposive sampling technique, the final survey invitation and access link were distributed via the following mechanisms:

- email distribution via the Practice Managers Association (PMA) contact list
- NHS England Primary Care Bulletin newsletter
- GIRFT website and social media channels
- CSP website and social medial channels

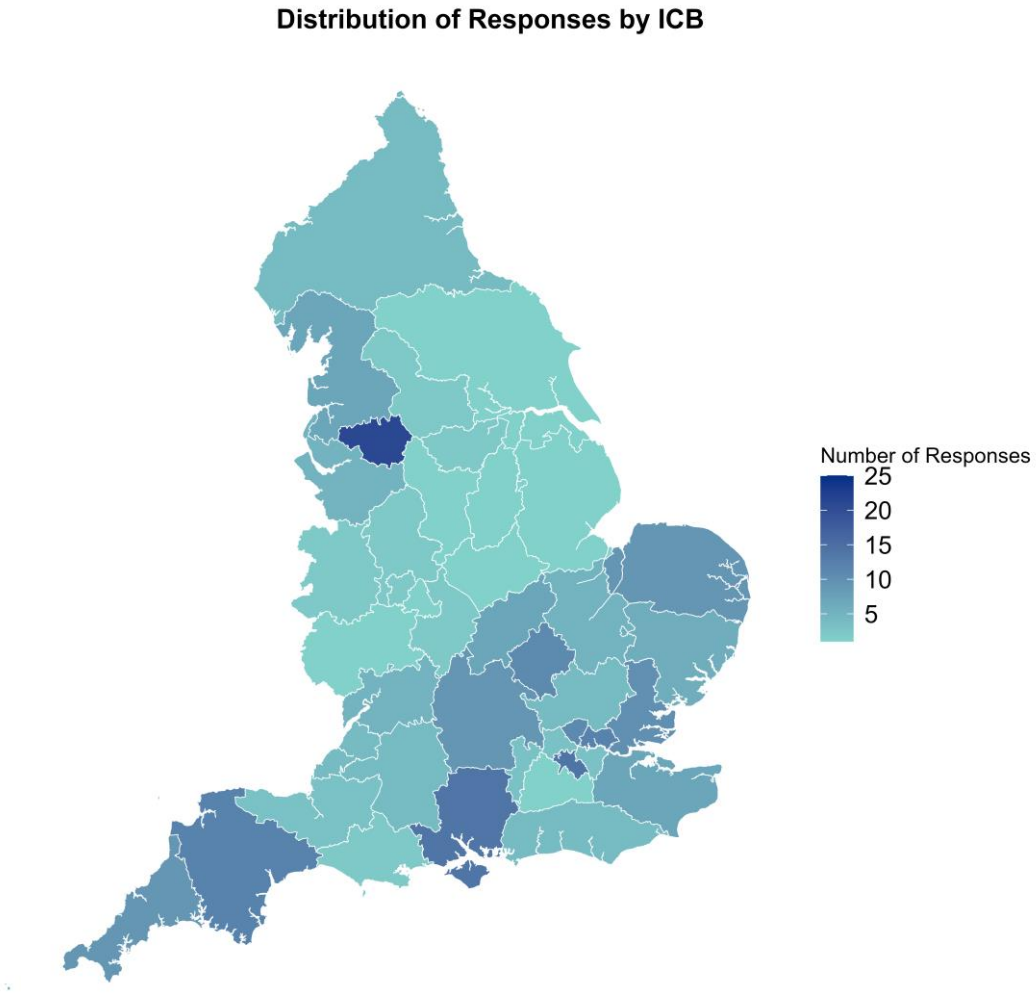
Survey access remained open for seven weeks and closed on December 24th, 2025.

Findings

Survey distribution and respondents

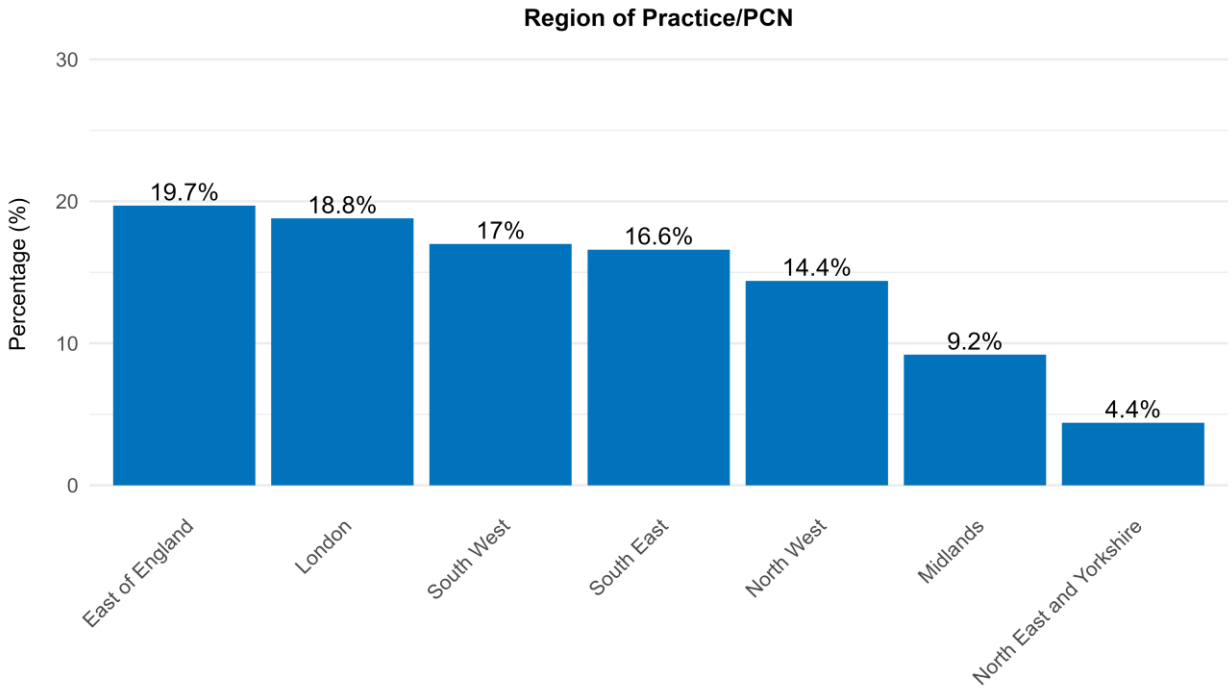
The survey received 229 total responses. At least one response was received from a PCN or GP practice within every integrated care board (ICB) within England. Of these 229 responses, there were 202 distinct PCN responses. This represents approximately 16% of PCNs within England NHS England » Primary care networks. The east of England and London had the highest response percentage across all NHSE regions.

The survey did not capture the number of FCPs employed within each PCN or GP practice. As a result, the data presented in this report summarises the FCP services delivered within individual GP practices or across PCNs, rather than the total workforce within those services.



Source: CDP National FCP Survey Data (2025)

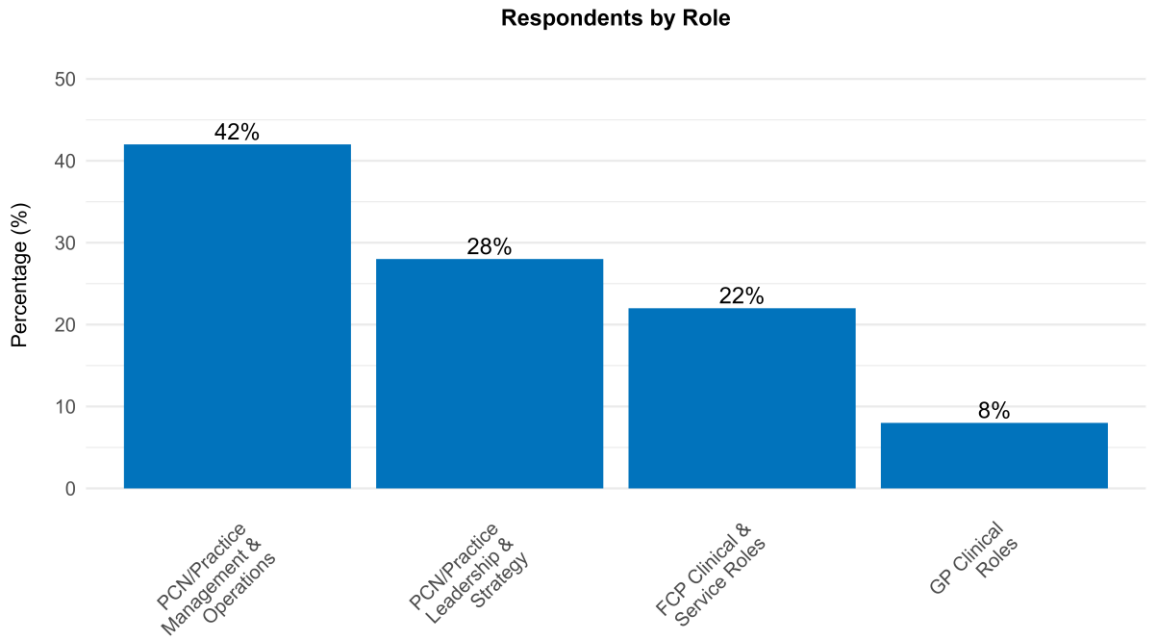
NHS regional response distribution



Overall, 120 (52%) of the responses were from participants answering on behalf of their GP practice, while 109 (48%) of the responses were on behalf of their PCN.

44% of respondents were practice managers; 37% were PCN leads, with 19% stating they worked in other roles within primary care or FCP service delivery.

Of the 19% working in other roles, the following graph demonstrates the grouping of these roles based on thematic analysis of the open text answers.



Of the participants who responded on behalf of their GP practice, 78% were practice managers, 18.3% were in other job roles, and 3.3% were working in PCN leadership roles. Responses submitted on behalf of the entire PCN were predominantly from those working in PCN leadership roles (73.39%), with 20.18% from other job roles, and 6.42% from practice manager roles.

On visual inspection of the data provided, there was evidence of greater uncertainty to some questions answered by those completing the survey on behalf of the GP practice compared to the PCN in its entirety. However, after allowing for this greater level of uncertainty, the answers to questions overall were broadly comparable; hence, throughout this report, the findings from both groups have been combined for analysis.

Additional support to complete the survey

Within the FCP survey invitation, participants were provided with supplementary information to highlight potential questions that might require additional support from FCP colleagues. This aimed to reduce the number of survey items that respondents might feel uncertain about and was based on findings from the pilot survey data.

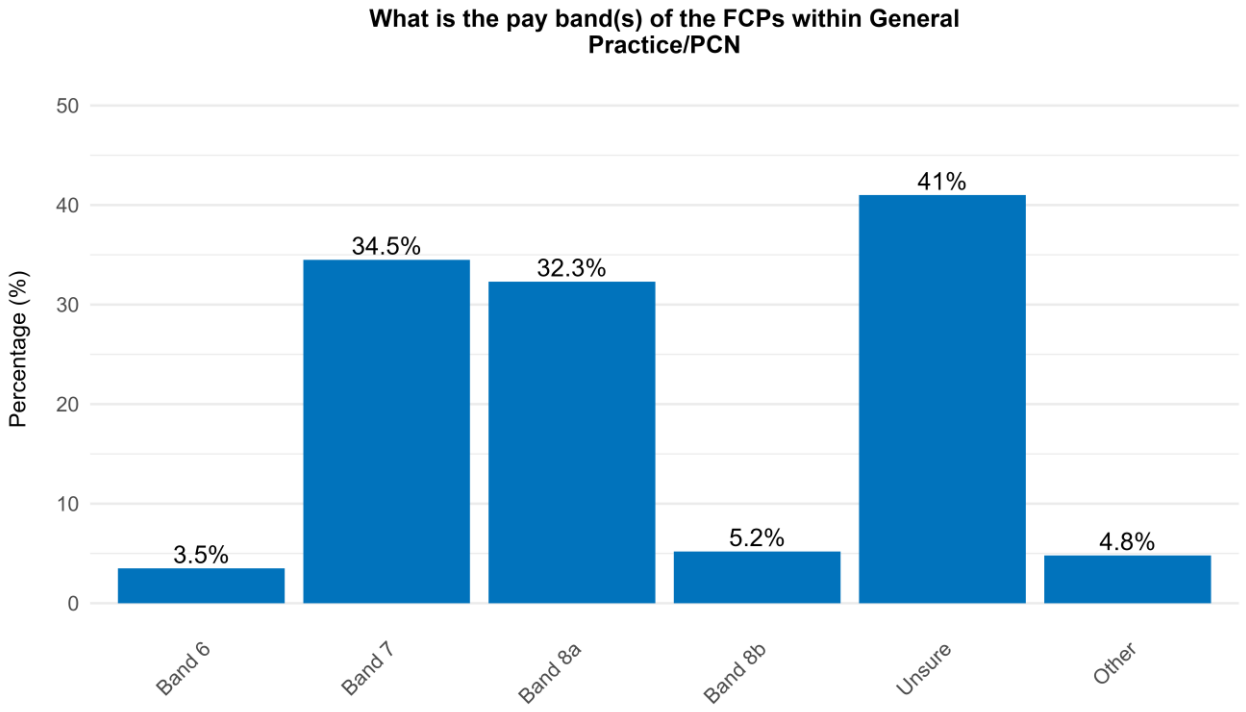
A total of 13 participants (5.6%) reported receiving additional support to complete the questionnaire. An FCP or FCP provider was the most frequent source of assistance across survey sections.

The survey sections most commonly requiring additional support were:

- roadmap completion
- FCP job plan/supervision
- Fit note/AHP health and work report
- Patient Group Direction (PGD) authorisation
- employment model

Workforce configuration and employment models

Pay band(s) of FCPs within general practice/PCN

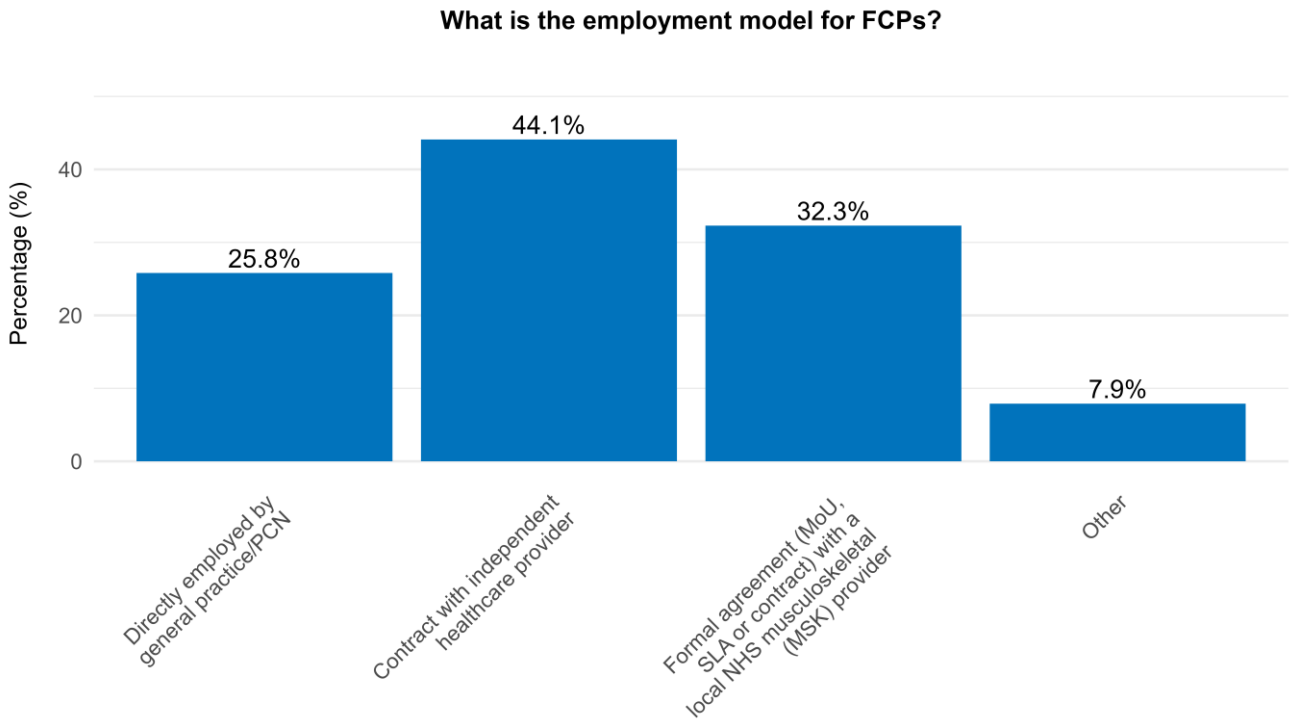


This graph shows that FCPs are most commonly employed on band 7 or band 8 Agenda for Change (AfC) pay scales. This aligns with the Additional Role Reimbursement Scheme (ARRS) remuneration as outlined in the Network Contract DES and is an expected finding of this evaluation.

A substantial proportion of services reported uncertainty regarding the AfC-equivalent pay band for their FCPs. This likely reflects the considerable number of FCPs working for independent providers or those directly employed outside of AfC structures, who operate under alternative pay frameworks.

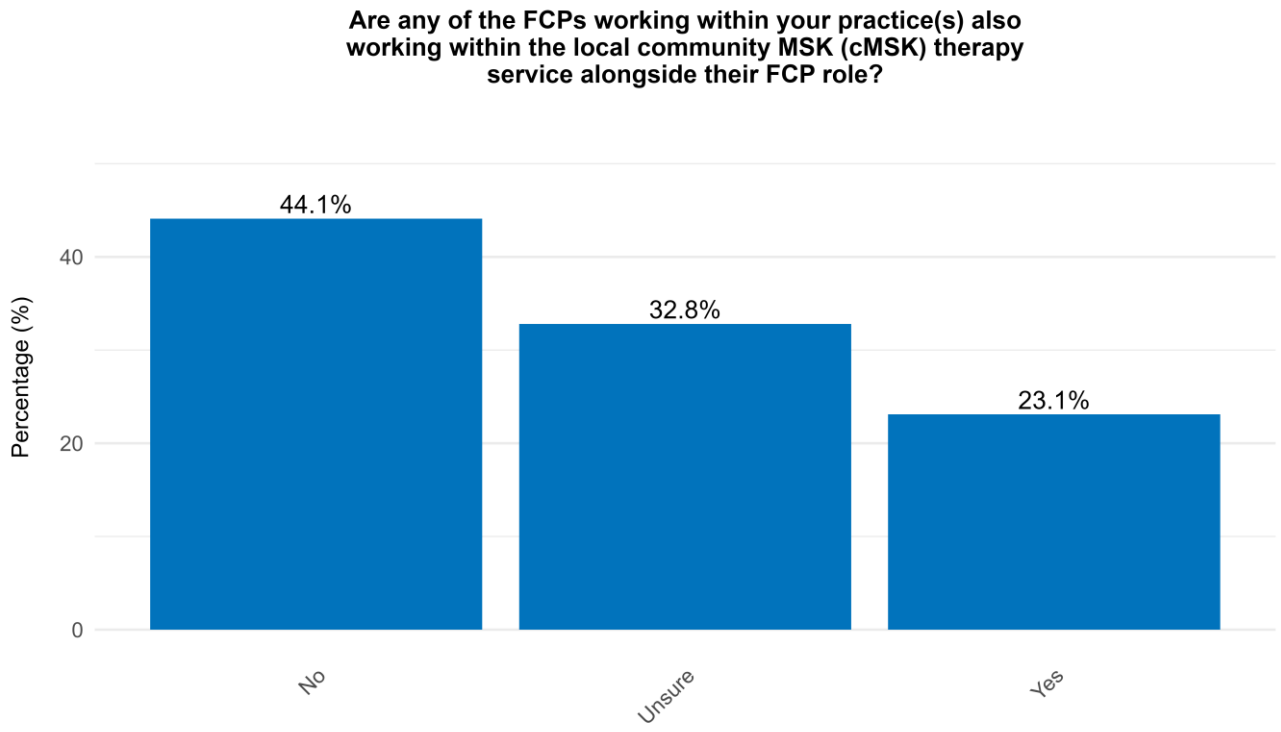
FCP employment types

The following graph illustrates the employment model of the FCP service delivering provision within the respondent's practice or PCN.



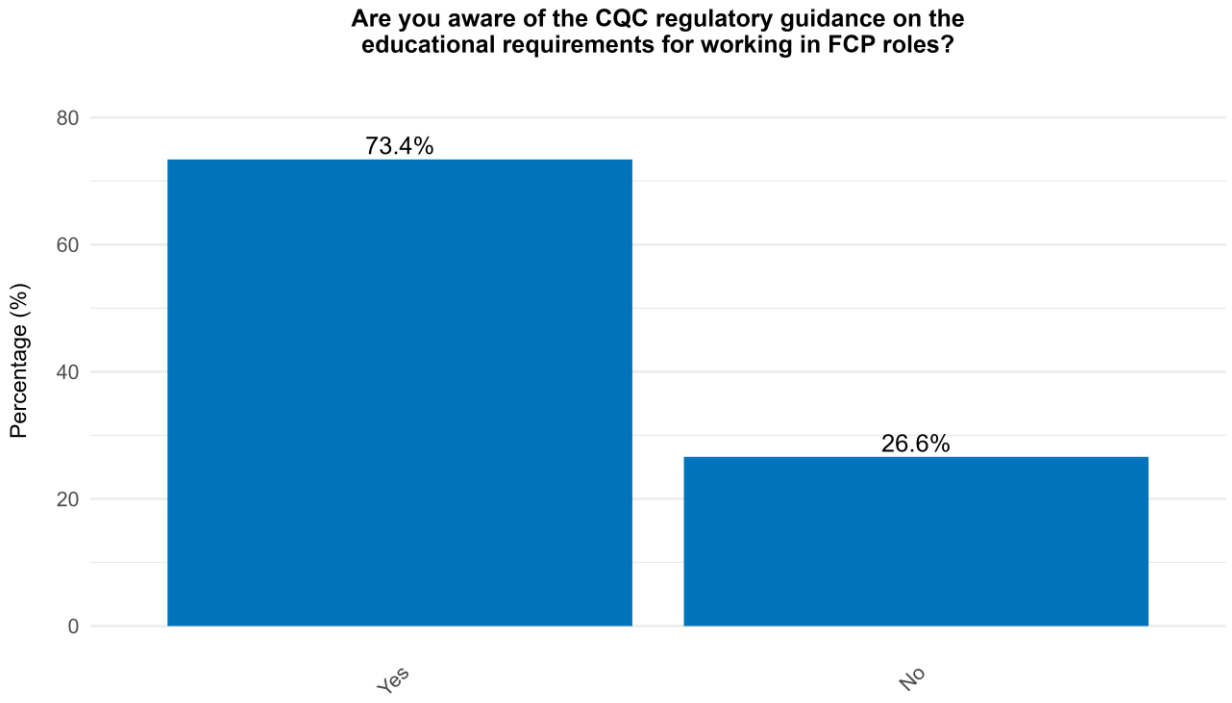
The survey indicated that the most common employment model for FCP services was delivery by independent health care providers. Local NHS MSK providers were the next most frequent, followed by clinicians directly employed by general practice/PCNs. A small proportion of services were delivered by other provider types. Analysis of free-text responses showed that these other models often included staff employed via ICB-level agreement or alternative contractual arrangements within the host GP federation.

The survey also explored whether FCPs worked within the local cMSK therapy service alongside their FCP role. This was intended to identify the proportion of FCPs working in hybrid roles, which can support integration between primary care and cMSK services while allowing clinicians to maintain and develop rehabilitation skills. The findings showed that nearly half of all FCPs were not in hybrid roles, and more than a third of respondents were uncertain of whether their FCPs held concurrent positions. Fewer than a quarter (23.1%) confirmed that at least one FCP within their service also worked in a cMSK therapy service, as shown in the next graph.



Education, training and assurance

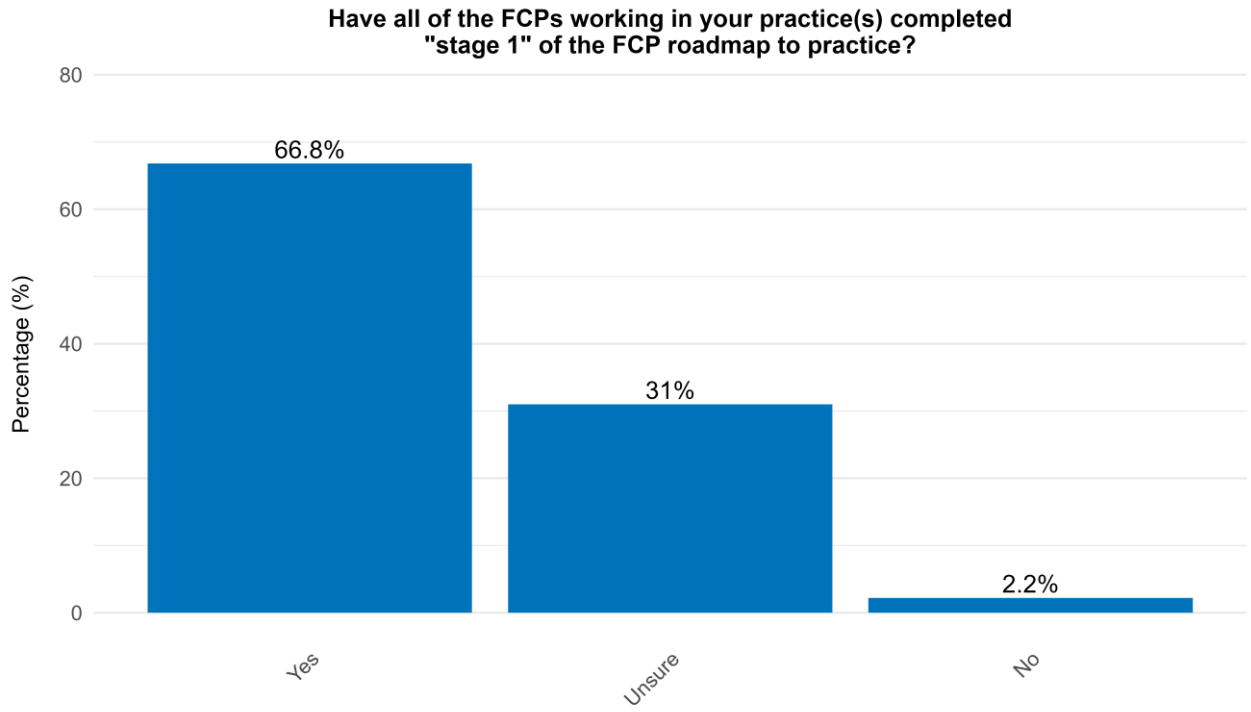
Overall, 26.6% of participants were not aware of the CQC guidance (CQC mythbuster 106) for working within FCP roles, while the remaining 73.4% reported that they were aware of this guidance. Levels of uncertainty were notably higher among respondents completing the survey on behalf of the GP practices (39.1%) compared with those responding on behalf of the PCN (12.8%)

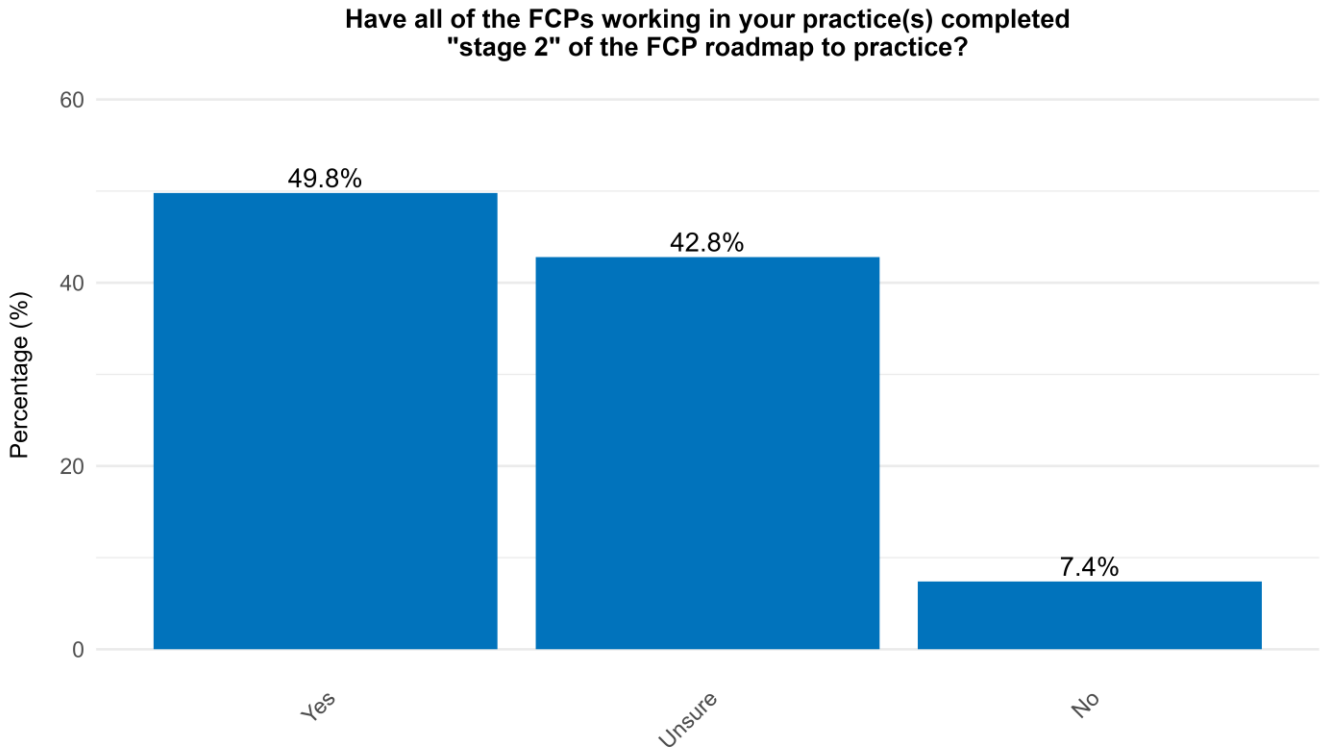


No further survey questions addressed the capability requirements for FCP roles, such as those outlined in the Network Contract DES, beyond confirming whether FCPs had completed the FCP Roadmap to Practice educational framework.

Respondents reported relatively high levels of uncertainty regarding completion of the educational frameworks required for FCP roles, specifically stage 1 and stage 2 of the FCP Roadmap to Practice. Stage 1 of the roadmap is expected to be completed prior to commencing employment in primary care, while stage 2 is undertaken during employment within primary care. Further information on employment arrangements for staff not directly employed by GP practices is available in CQC mythbuster 106.

Overall, 31% of respondents were unsure whether their FCPs had completed stage 1 of the roadmap, and 42.8% were unsure about completion of stage 2. A small proportion reported that their FCPs had not completed the framework, with 2.2% indicating non-completion of stage 1 and 7.4% reporting non-completion of stage 2.





There were notable differences between respondents answering on behalf of GP practices and those responding on behalf of PCNs. Among GP practice respondents, 42.5% were unsure whether their FCPs had completed stage 1 of the FCP roadmap, and 55% were unsure about the completion of stage 2. In contrast, levels of uncertainty were lower among PCN respondents, at 18.35% for stage 1 and 29.36% for stage 2. The reasons for this variation were not established within the scope of this phase of the evaluation but may be explored in further phases at a national level.

Assurance of capability in 'non-roadmap completed' FCPs

Among FCPs with no plans in place to complete the FCP roadmap, 64.89% of the respondents were unsure what mechanisms existed to ensure that the FCP had sufficient education, training and capability to undertake the role. A further 6% reported that no plans were in place to complete the required training.

As previously highlighted, uncertainty was higher among respondents completing the survey on behalf of GP practices compared with those responding on behalf of PCNs (72.96% vs 42.85%).

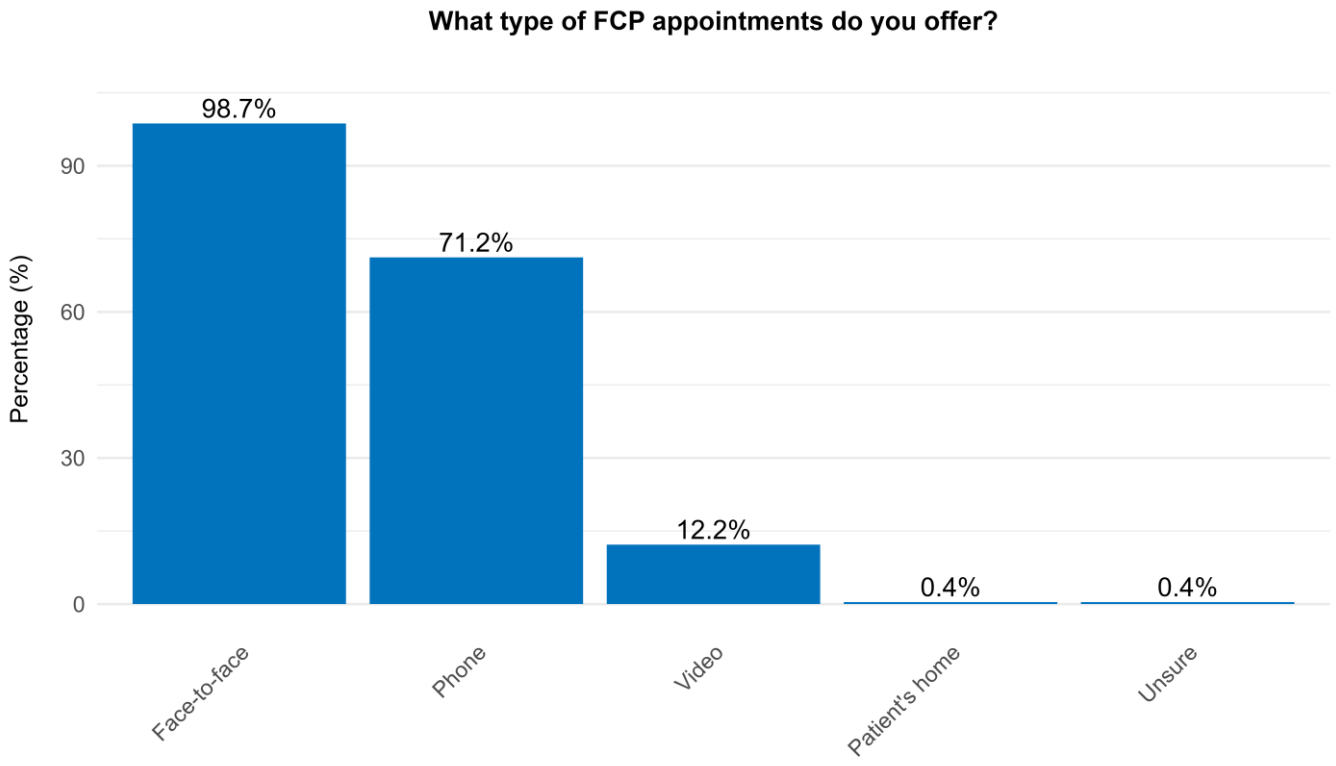
Of the 28.7% of services reporting that alternative mechanisms were in place for FCPs not completing the roadmap, a range of approaches were described. The themes identified included:

- FCP provider oversight and contractual assurance
- education, training and ongoing continuous professional development (CPD)
- advanced practice credentials and experience, e.g., working across all four pillars of advanced practice
- development of additional skills relevant to role e.g., injection therapy or non-medical prescribing
- previous experience within the role prior to development of FCP roadmap.

Access, clinical activity, and scope of practice

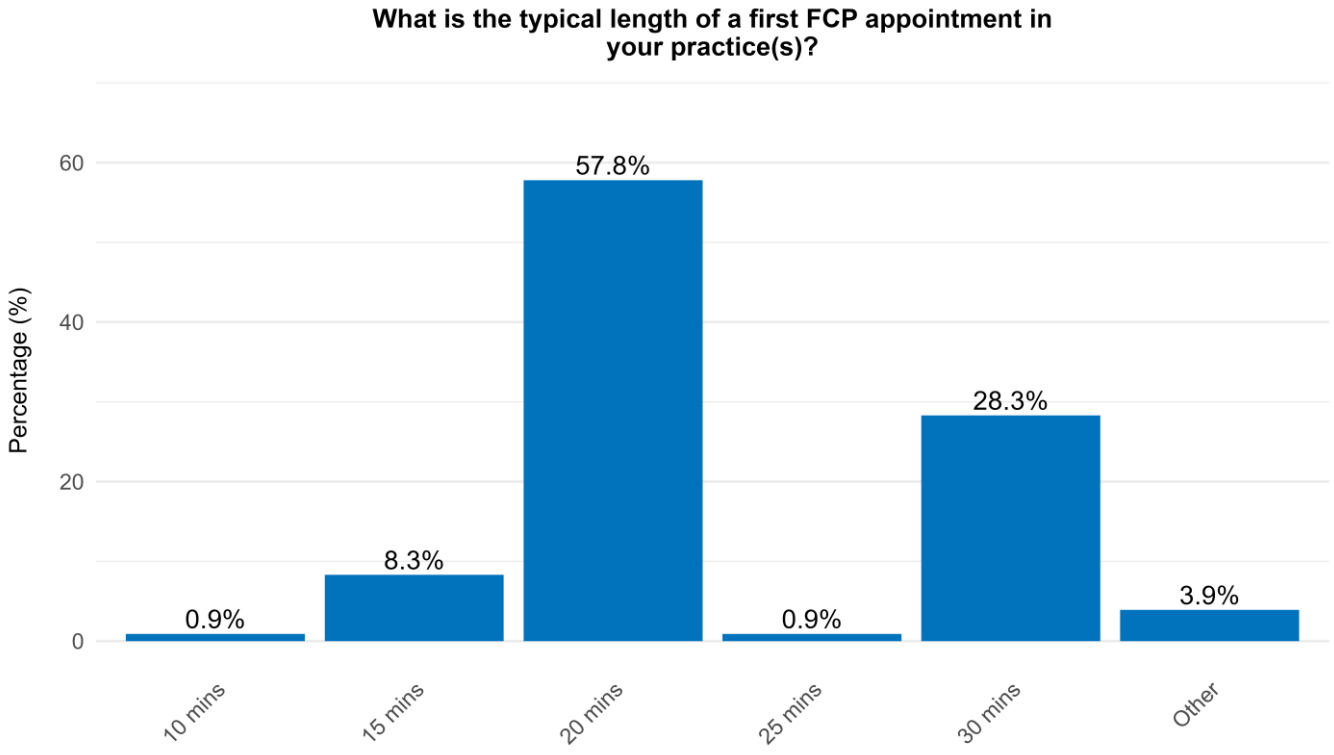
Type(s) of FCP appointment offered

The vast majority of services (98.7%) offered face-to-face FCP appointments within their service, with 71.2% offering telephone appointments. A small percentage of services (12.2%) offered video-based appointments. Only a very small percentage (0.4%) offered appointments within patients' homes.

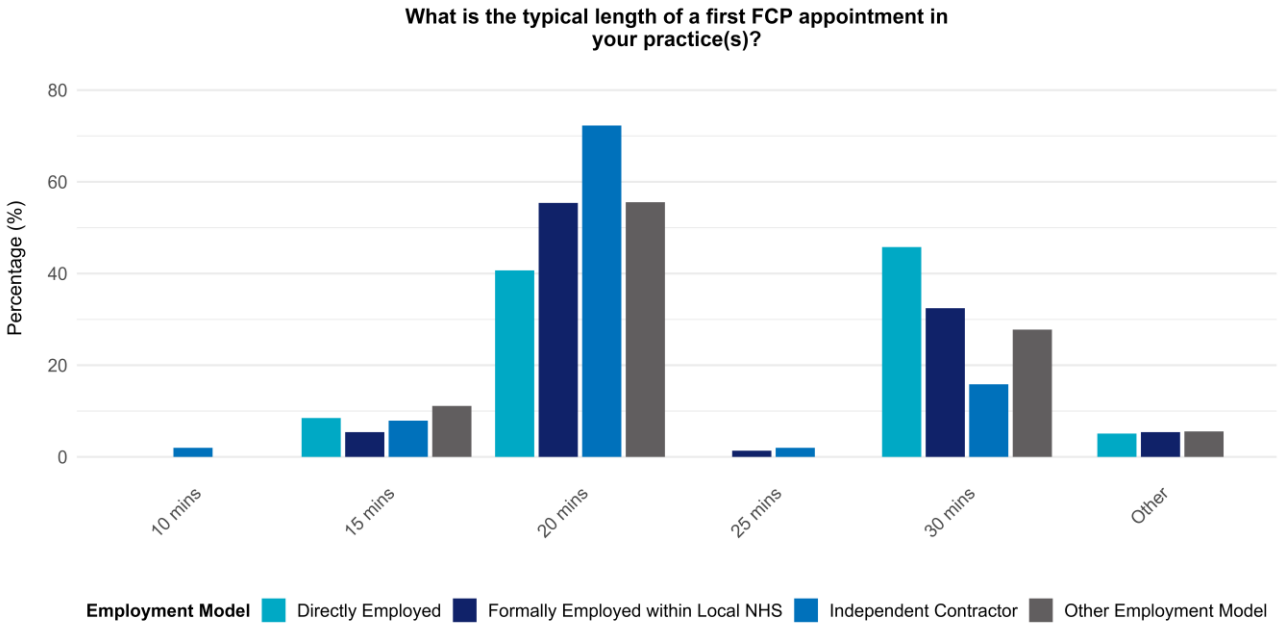


Length of first FCP appointment.

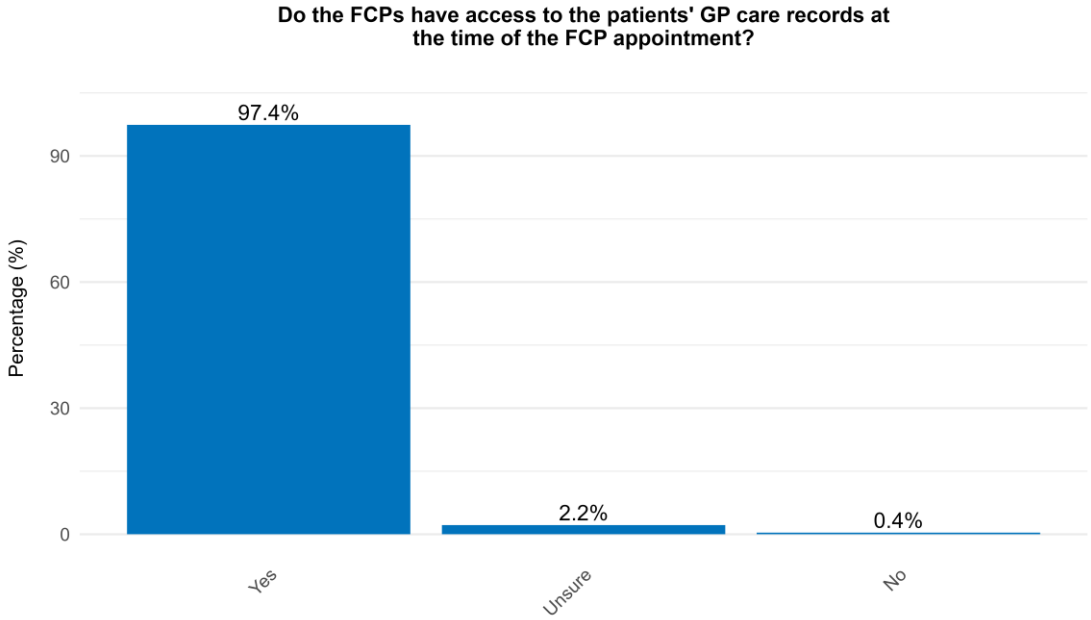
The most common appointment length was 20 minutes, used by 57.8% of services. A further 28.3% offered longer 30-minute appointments, while 9.2% of services offered appointments which were 15 minutes or less.



Independent providers of FCP services most commonly used 20-minute appointments, while directly employed FCPs were more likely to offer 30-minute appointments. The mean length of first FCP appointments was 21.1 minutes among independent providers, compared to 23.6 minutes across all other employment models.

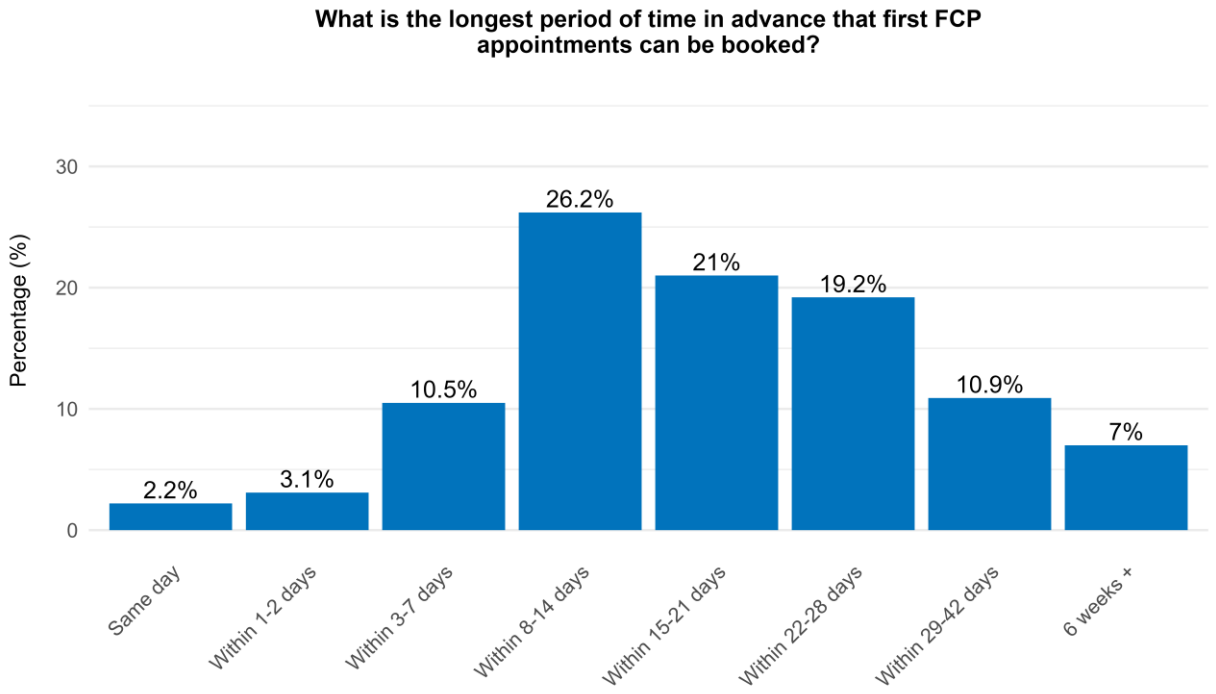


Almost all FCPs (97.4%) had access to patients' GP care records at the time of the appointment. Only one response (0.4%) reported that the FCP had no access to the patient record to support assessment and clinical decision-making.



Access

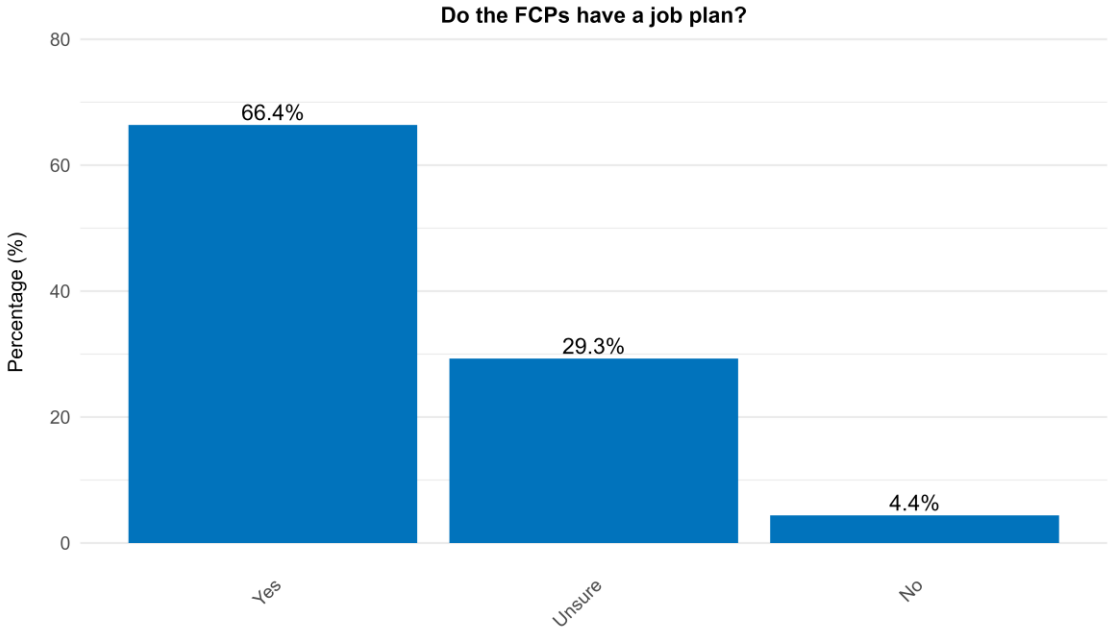
For advance booking of first FCP appointments, the most common approach was for patients to be booked up to 8-14 days in advance (26.2%) or up to 15-21 days in advance (21%). Some services only booked patients up to seven days in advance (15.8%), while others booked appointments up to 29-42 days in advance (10.9%). A further 7% of services booked first appointments more than six weeks in advance.



Future work may explore the reasons for variation in booking policies, including whether this reflects demand and capacity pressures or other influencing factors. Further evaluation could also consider the presence and type of triage processes used to determine the urgency of care for patients who may experience longer waits for their first FCP appointment.

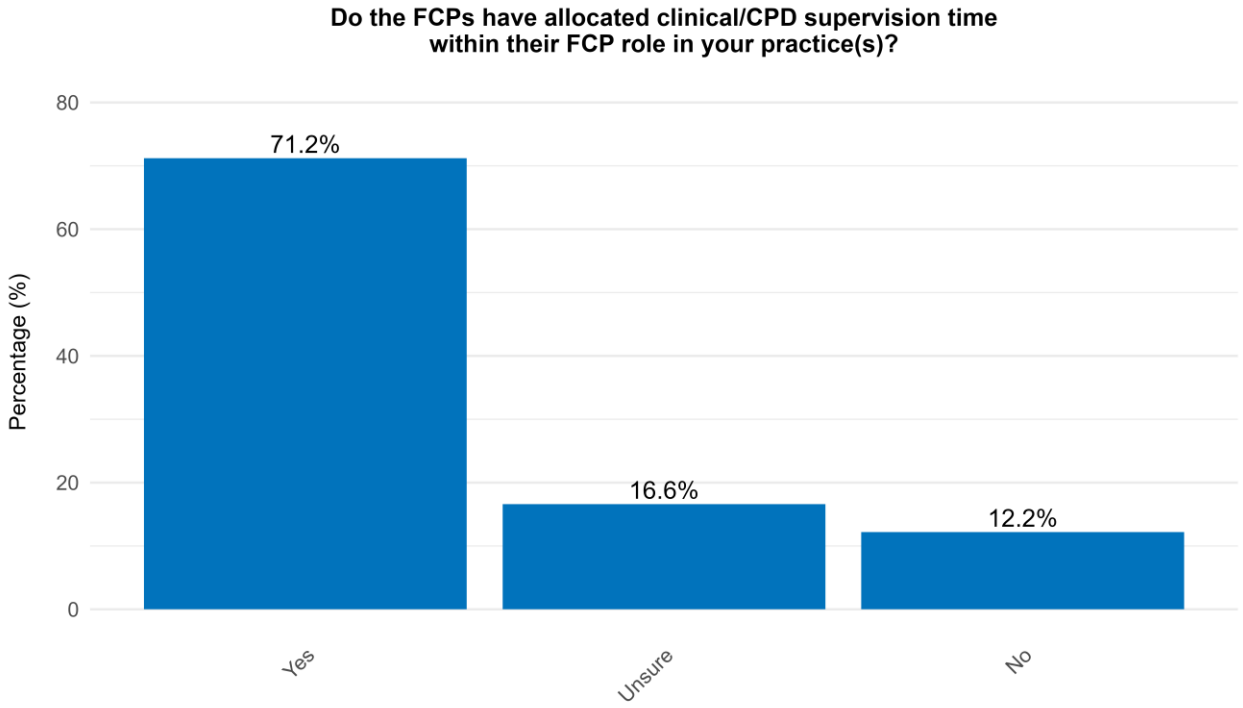
Supervision, job planning and governance

Overall, 66.4% of FCPs were reported to have a job plan, while nearly a third of respondents (29.3%) were unsure whether a job plan was in place.

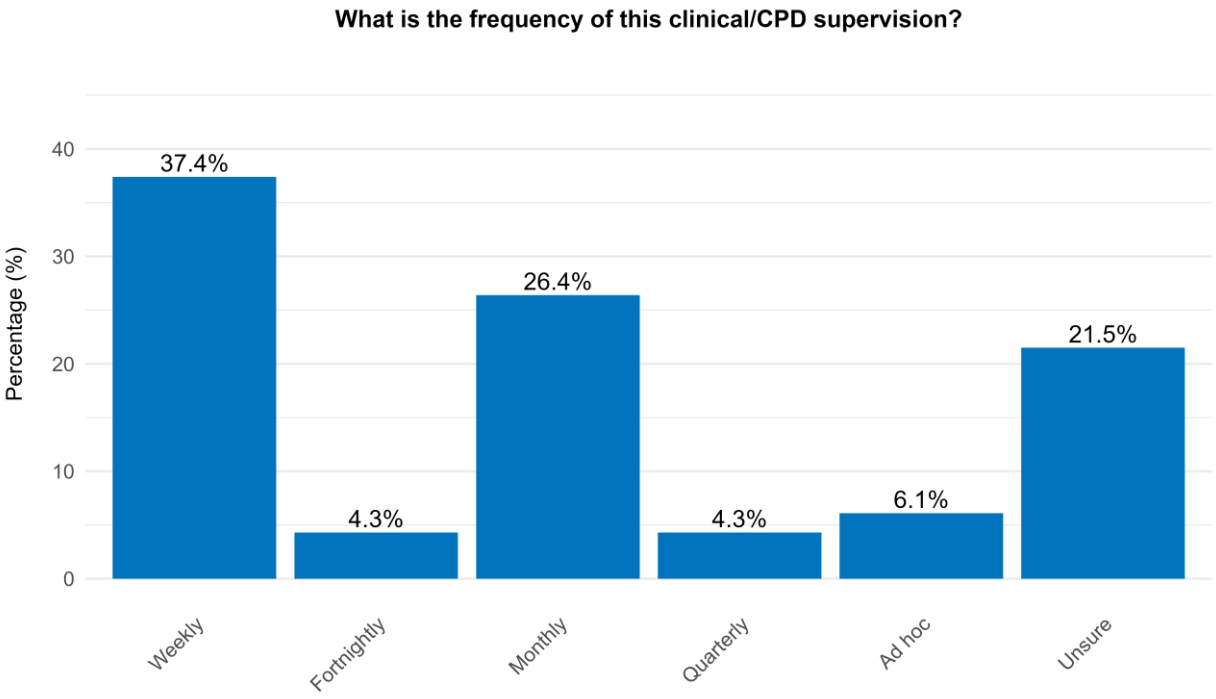


Clinical supervision

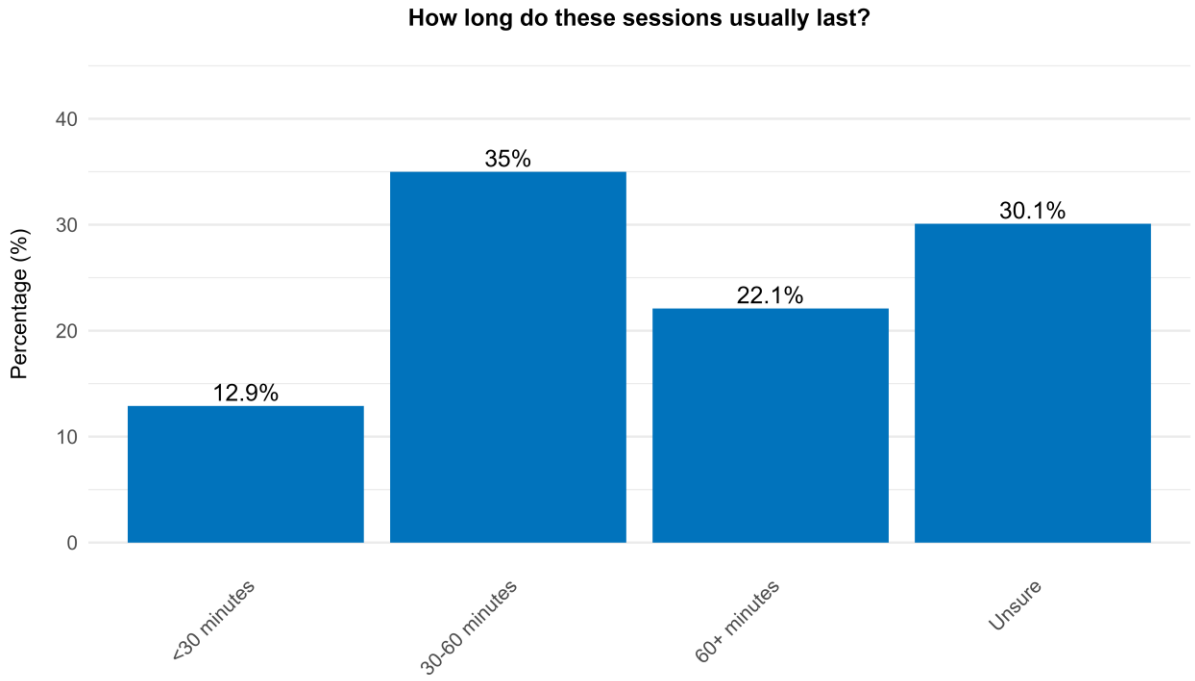
More than 12% of FCPs had no access to clinical or CPD supervision within their roles, while a further 16.6% of services were unsure whether this was included within the FCP job plan.



Among services reporting that job plans included clinical or CPD supervision for FCPs, supervision most commonly occurred on a weekly (37.4%) or monthly (26.4%) basis. However, more than one-fifth of services (21.5%) reported being unsure how frequently supervision took place.



Among services reporting access to supervision, 30.1% were unsure of the duration of these sessions. Where the length was known, the most common session duration was 30–60 minutes (35%), while 22.1% of services offered sessions lasting 60 minutes or longer.

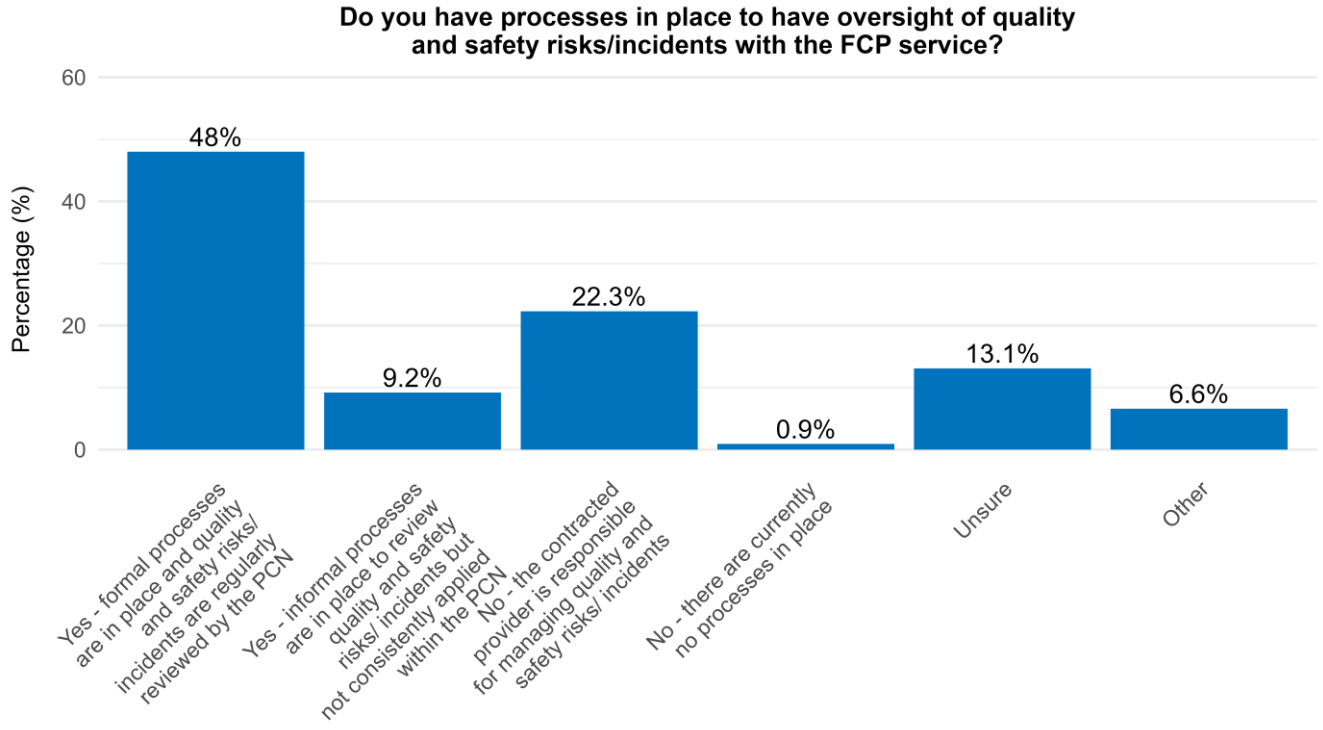


This evaluation did not seek to identify who provided supervision, whether the supervisors were appropriately trained and competent to undertake the role, or the perceived value and impact of supervision on the FCPs capability and development within their role.

Governance of quality and safety

Nearly half of respondents (48%) reported that formal processes were in place for monitoring quality and safety risks, with incidents reviewed regularly by the PCN. A further 9.2% indicated that informal processes existed, though these processes were not consistently applied across the PCN. In 22.3% of services, responsibility for quality and safety monitoring was held by the contracted FCP provider.

Outside of the scope of this work, further phases of the evaluation may explore the mechanisms by which concerns identified by FCP providers are shared with or escalated to the PCN or GP practice. Further engagement with cMSK services could also take place to understand how they monitored and fed back quality or safety concerns relating to FCP services or referrals into cMSK pathways of care.



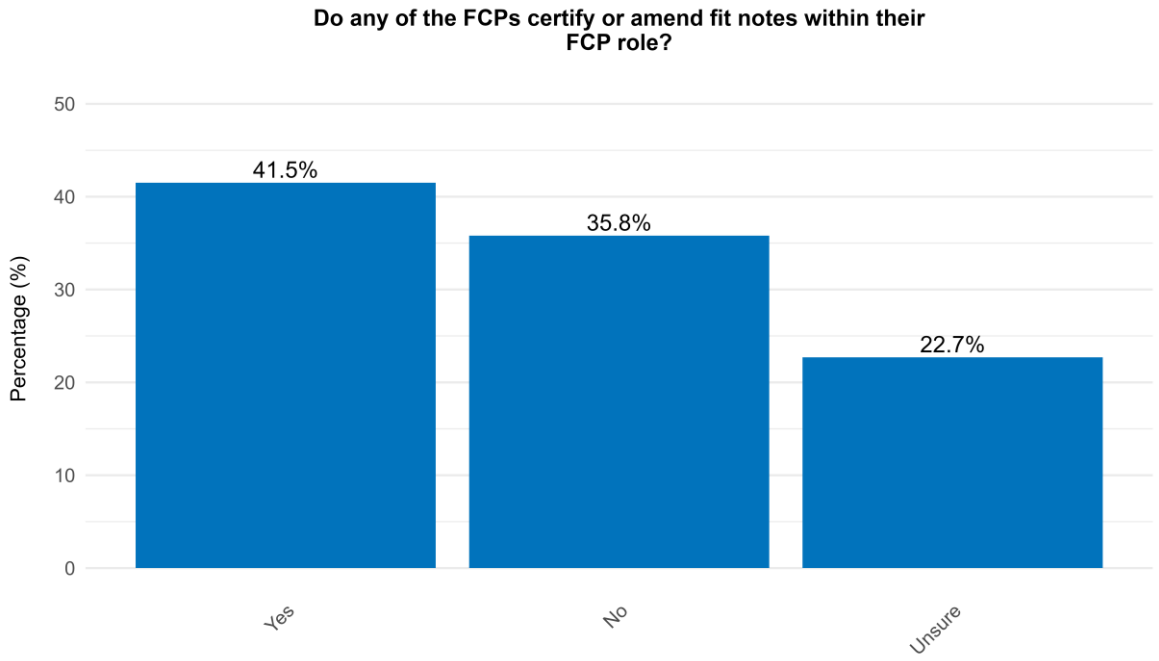
Scope of practice

The survey examined several additional skills outlined within the Network Contract DES as forming part of the key responsibilities for working as an FCP in primary care. It is recognised that these skills represent only a subset of the broader responsibilities of the role and do not represent the numerous other key responsibilities, such as supporting self-management, health prevention or promoting behavioural change. They were, however, considered valuable for providing an initial exploratory analysis of current FCP provision and the level of practice FCPs are working at – particularly as, in practice, these may be

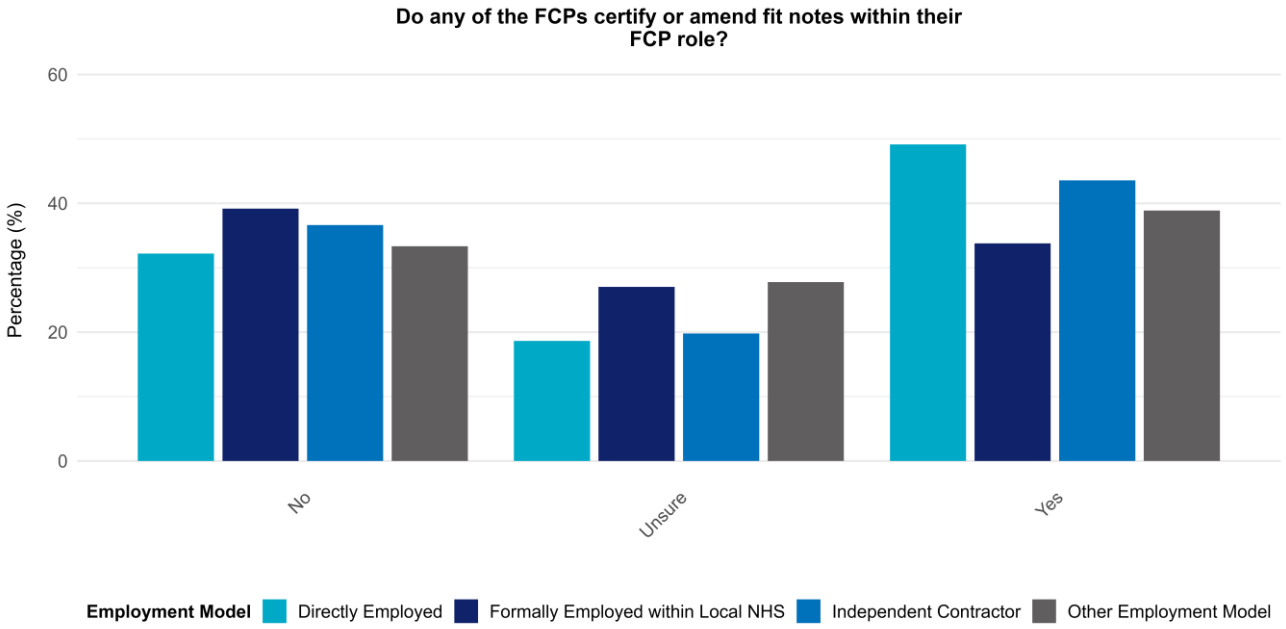
responsibilities that are tasked to GPs to undertake if the FCP does not have the capability or autonomy to complete independently.

Fit note certification

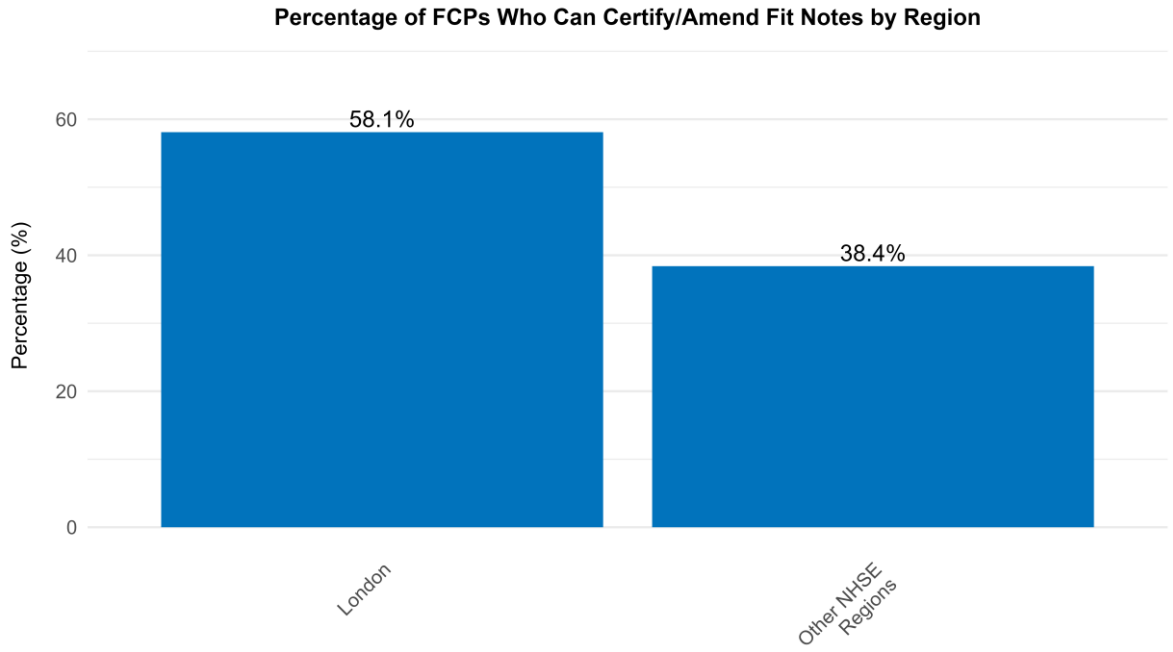
Overall, 41.5% of services reported having an FCP that could certify fit notes, while 35.8% stated that none of their FCPs could certify fit notes. A further 22.7% of respondents were uncertain whether any FCPs within their service were certifying fit notes. Further work may also explore reasons for this variation and examine the type or duration of fit notes being issued.



The results showed that FCPs in directly employed roles were more likely to certify fit notes, while services delivered through contracts with NHS providers were least likely to certify fit notes.



Regionally, FCP services in the London NHSE region were more likely to have clinicians certifying fit notes, with 58.1% of services having an FCP that was certifying fit notes in their FCP role compared to an average of 38.4% for other NHSE regions. The reasons for this variation are unclear.



AHP Health and Work reporting was used far less frequently in FCP clinical practice compared with fit note certification. Nationally, only 6.6% of services reported having at least one FCP who completed this type of report. This likely reflects the 2022 legislative change to Fit note guidance that enabled state registered physiotherapists to certify legally valid fit

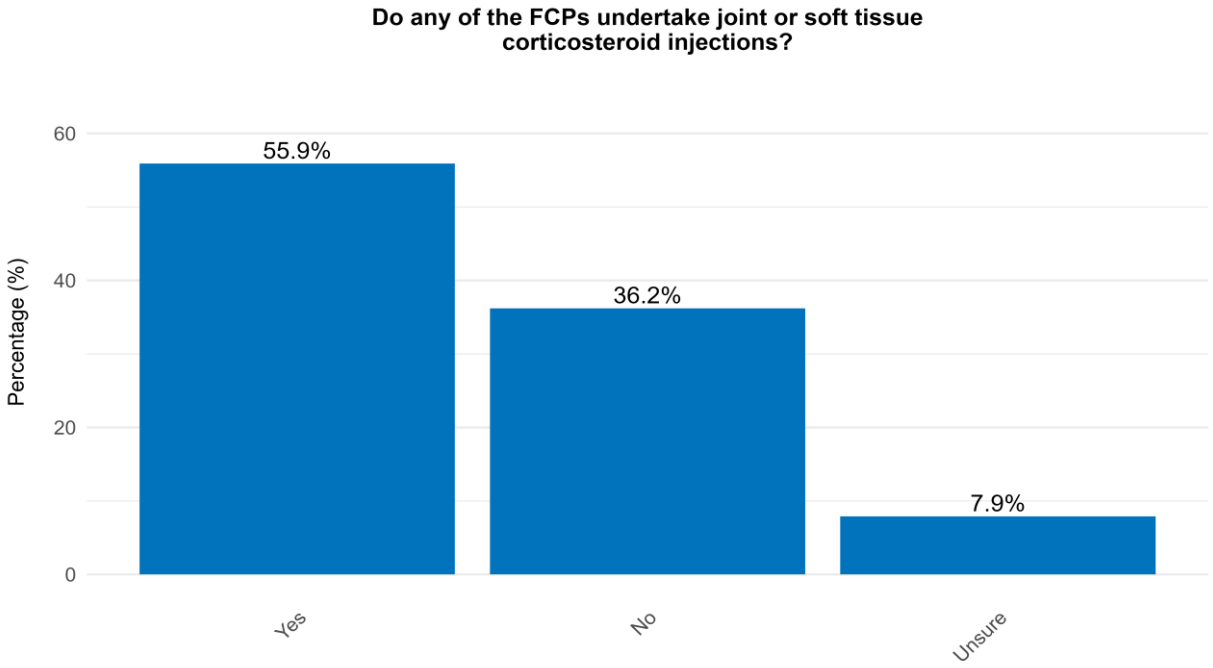
notes, reducing the need for FCPs to produce AHP Health and Work reports in comparison with certifying fit notes.

Access to employment support services

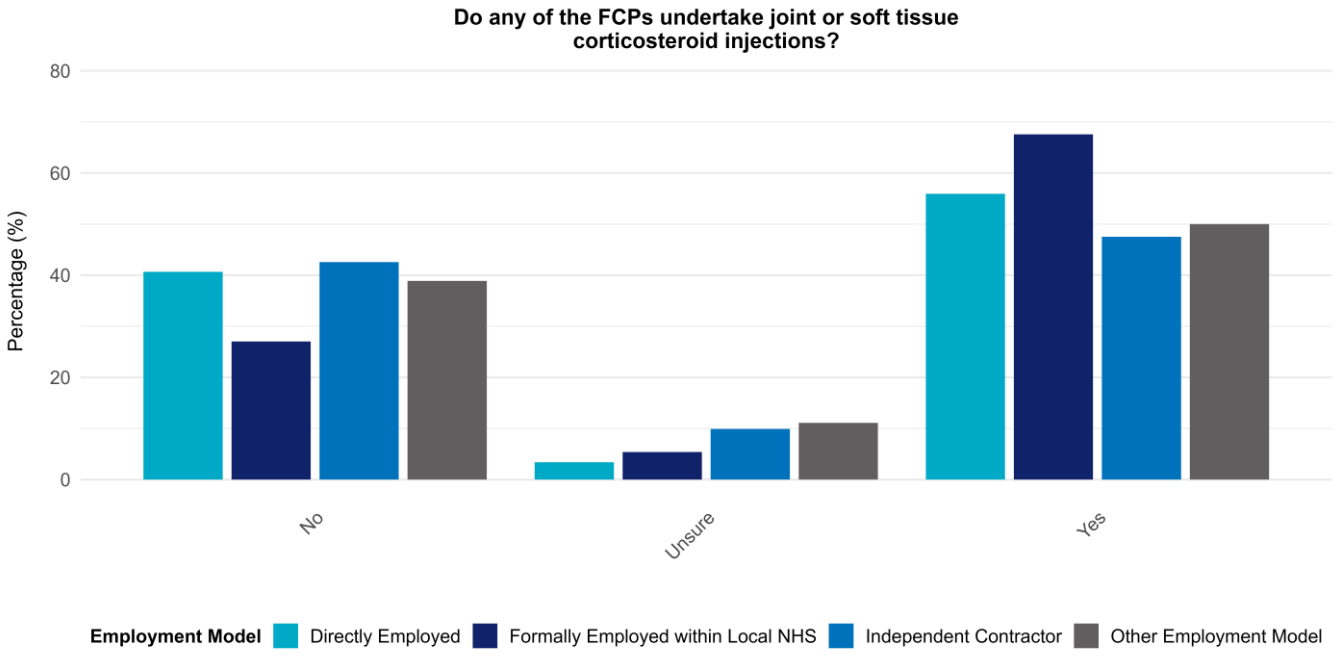
There was considerable uncertainty regarding FCP access to employment support services, with 35.5% of respondents unsure whether such access existed. A further 28.8% reported that FCPs had no access to employment services, while 35.4% indicated that access was available. Additional work may evaluate in further detail the type of employment support services such as Work Well that are accessible to patients following referral from primary care.

Injection therapy

Just over half of the services (55.9%) reported that at least one FCP within their practice undertook joint or soft tissue corticosteroid injections. Analysis did not indicate any association between undertaking injection therapy and the clinician's Agenda for Change pay band (where this information was available), as illustrated in the graph below.

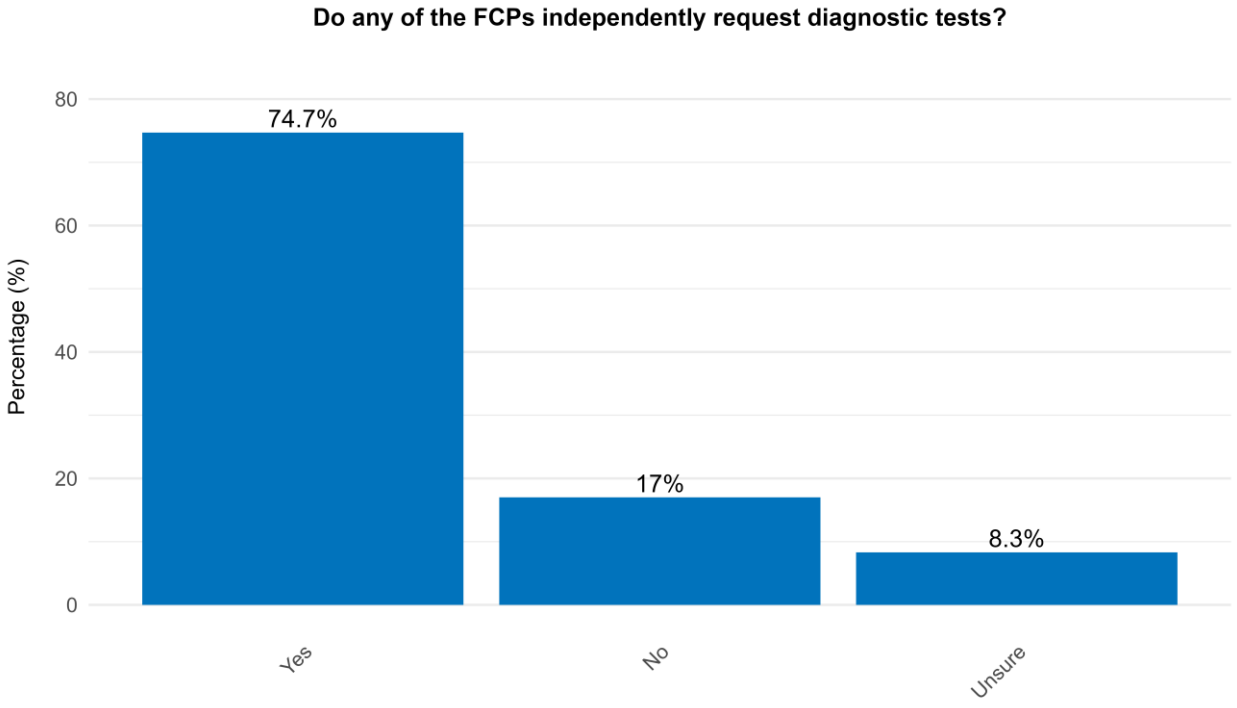


FCPs provided by local NHS services appeared more likely to undertake injection therapy within clinical practice, while those supplied by independent providers were least likely to do so.

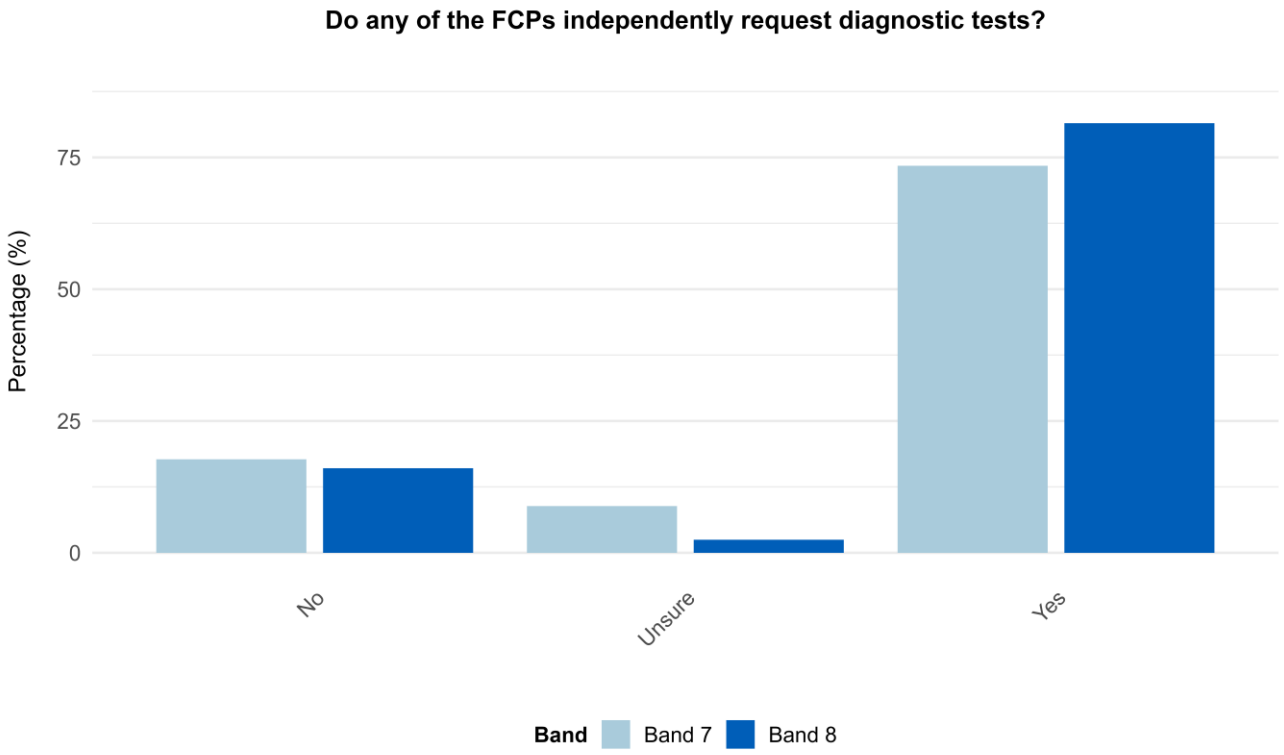


Diagnostic requesting

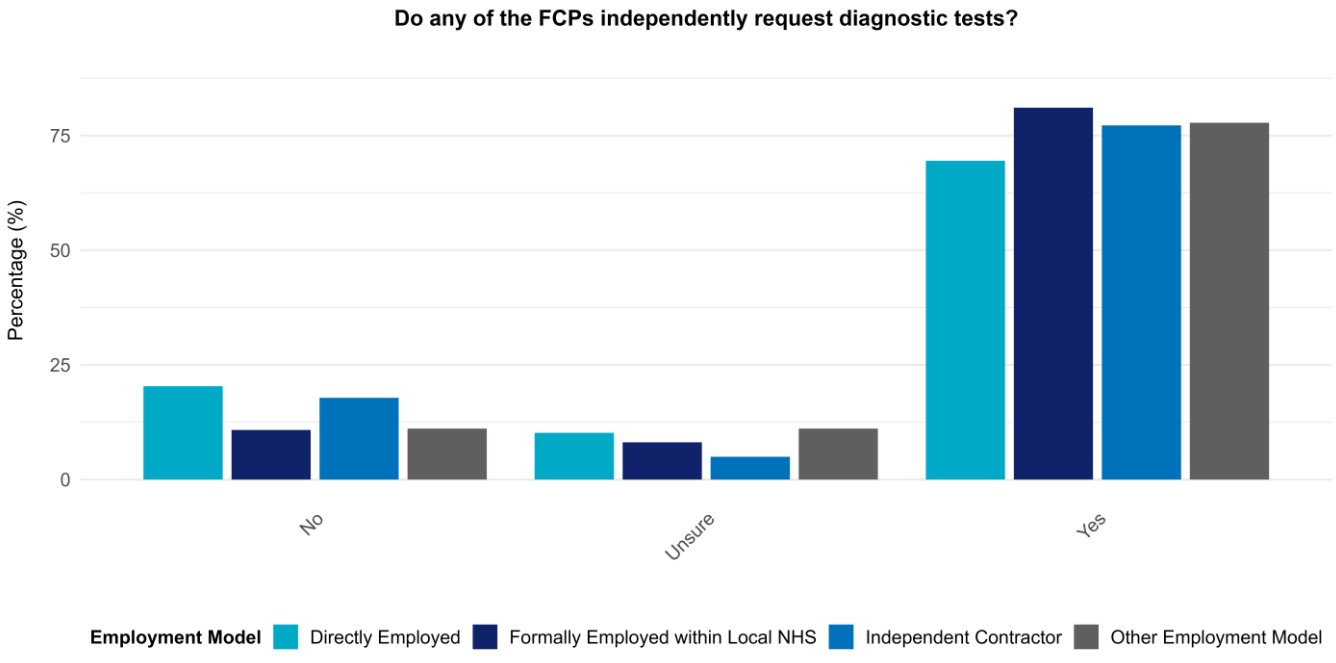
Overall, 74.7% of services reported having at least one FCP who could independently request diagnostic imaging.



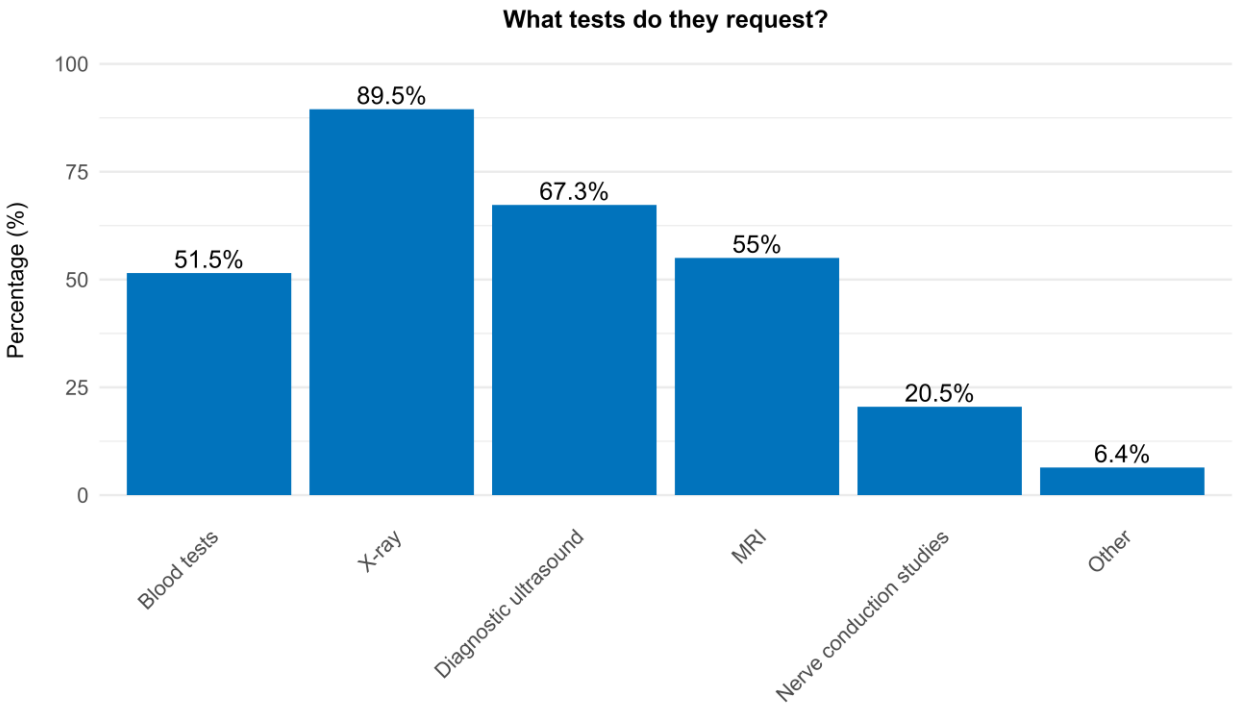
This appeared slightly more likely if clinicians were employed at band 8 level or above, compared to band 7 level clinicians.



FCPs provided by local NHS trusts were slightly more likely to request diagnostic tests independently, whereas directly employed FCPs were slightly less likely to do so.

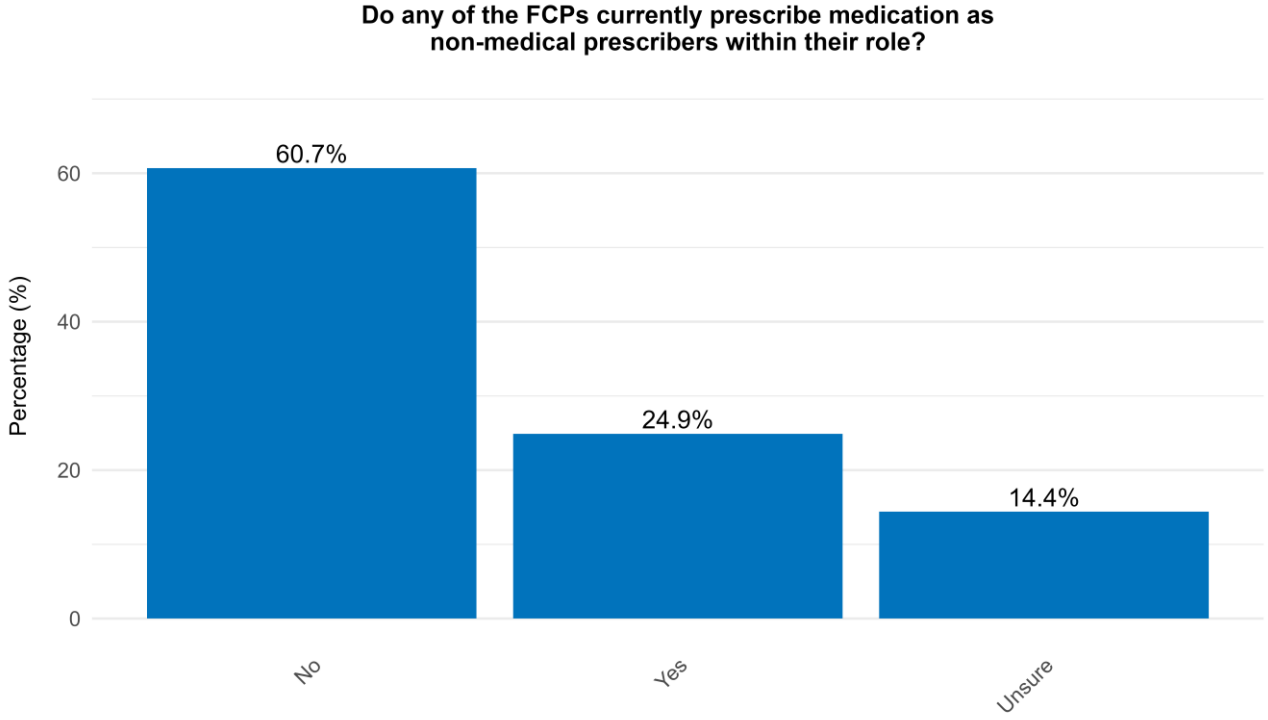


X-rays were by far the most requested diagnostic test (89.5%), followed by diagnostic ultrasound (67.3%) and MRI (55%). The survey did not explore the barriers or enablers influencing access to these investigations, nor the frequency with which they were requested within FCP services. This represents an area that may be considered for future work.

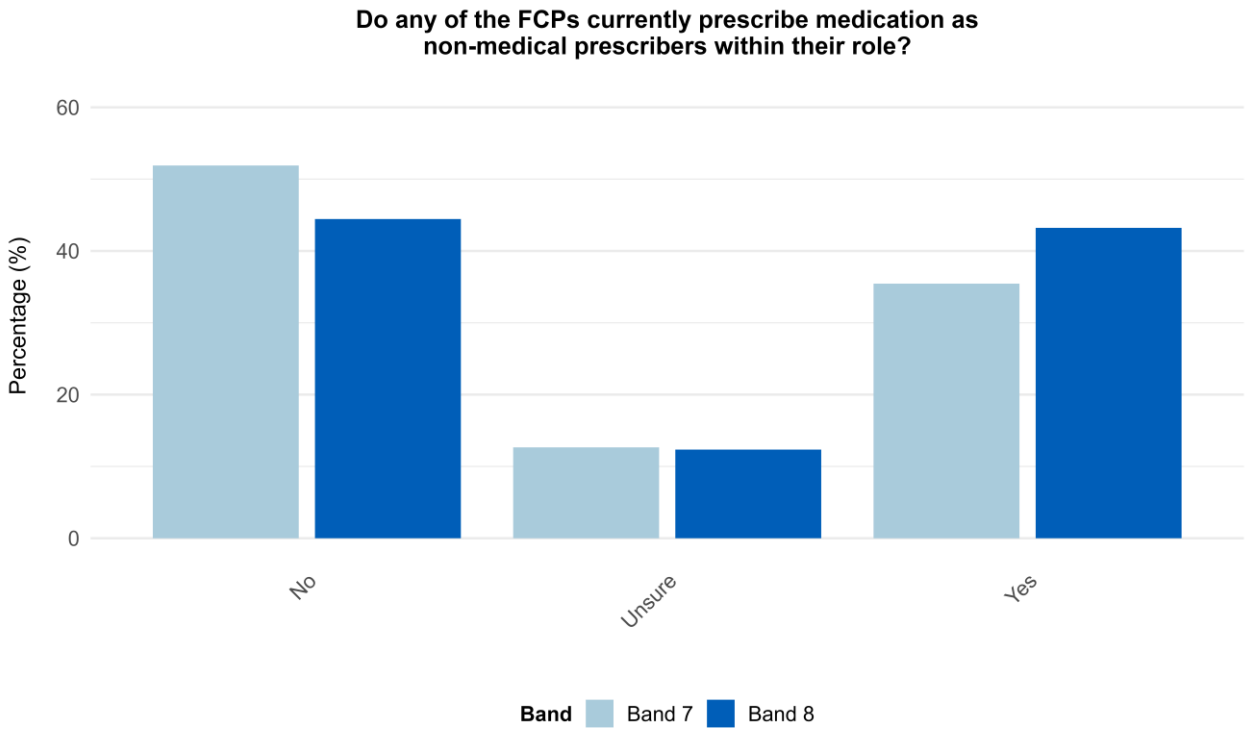


Prescribing

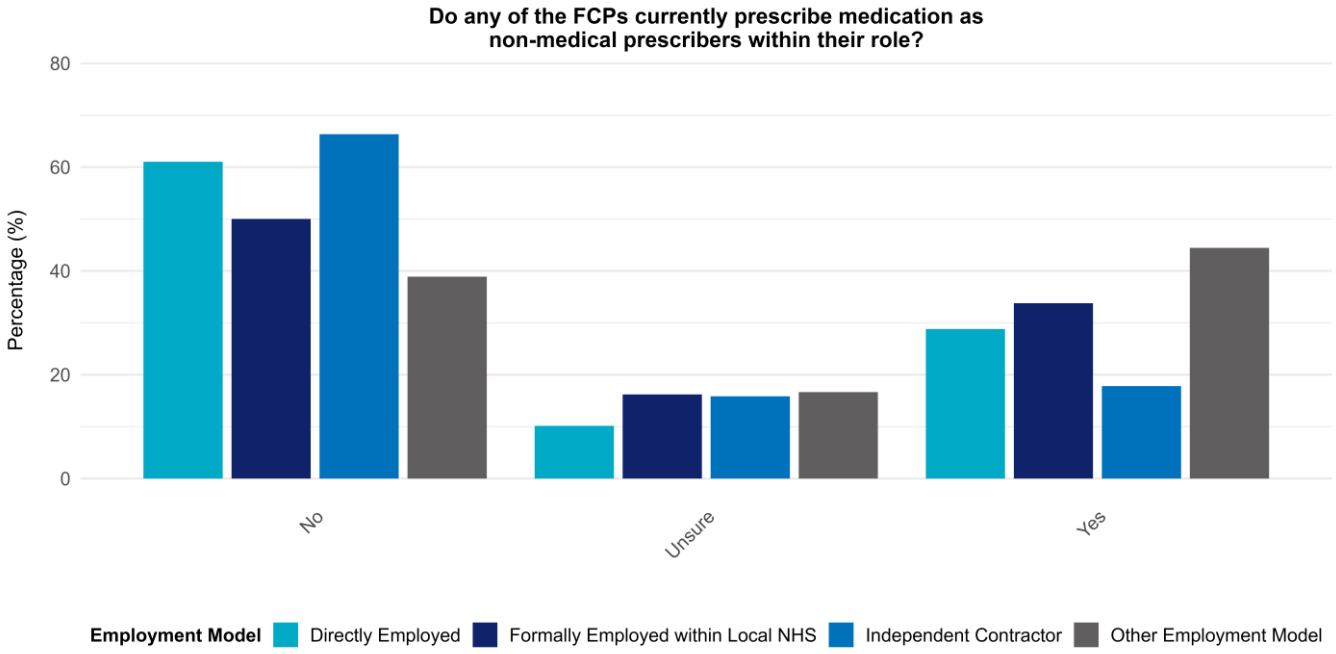
24.9% of FCP services had at least one FCP who was currently prescribing medication as a non-medical prescriber.



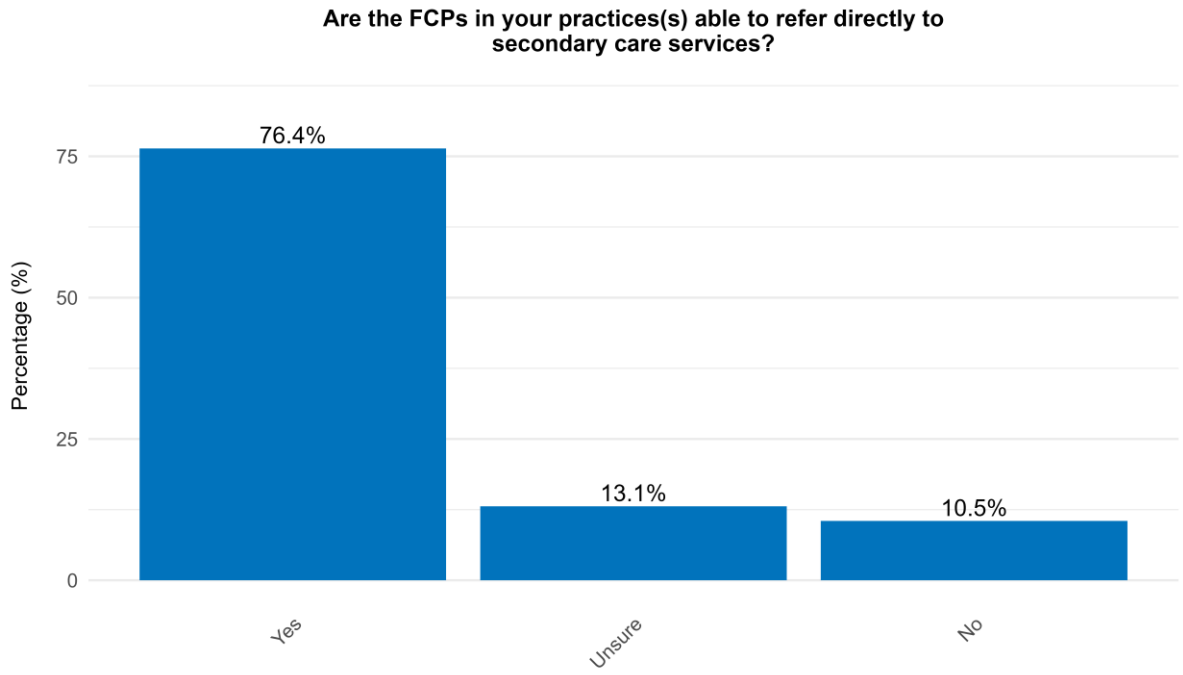
This was more likely if the FCP was employed at band 8 level compared to other pay scales.



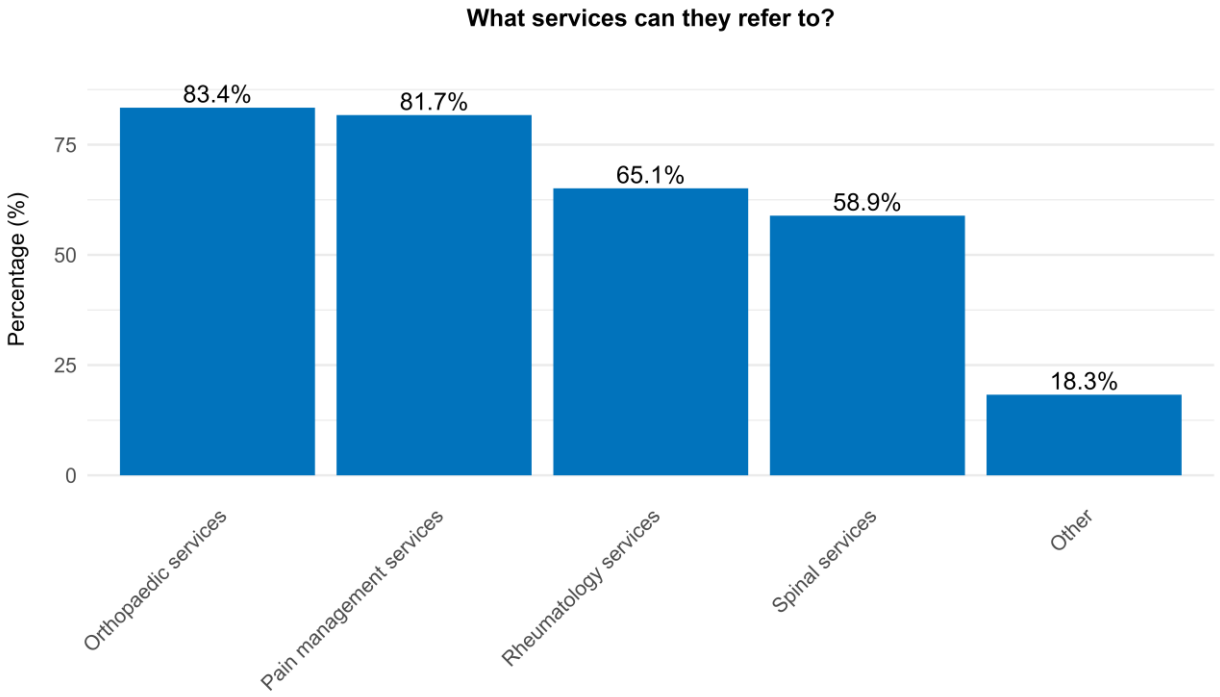
Non-medical prescribing within FCP services was also more common where FCPs were employed through alternative arrangements, such as an agreement with the local ICB or through provision by a local NHS trust. FCPs employed by independent providers were the least likely to be able to prescribe medication as non-medical prescribers.



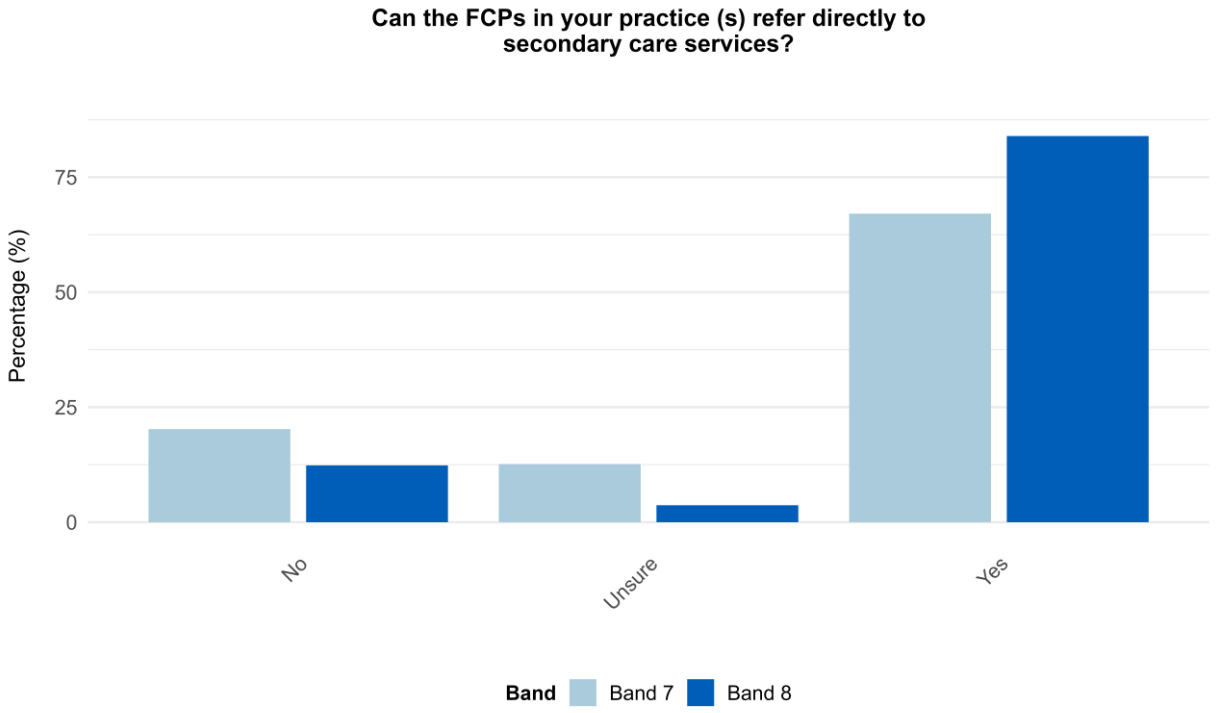
Secondary care referral access



As expected, orthopaedic services were the most common secondary care team to which patients could be referred (83.4%), followed by pain management services (81.7%). The survey did not establish whether the FCPs were able to access pre-referral guidance (A&G), or whether referrals were directed via the local cMSK triage service prior to onward referral.



Those working in band 8 roles were more likely to be able to directly refer patients to secondary care services than those working in band 7 level roles.



Patient Group Direction (PGD) authorisation

There was variation in who was reported to have responsibility for authorising patient group directions (PGDs), with relatively high levels of uncertainty, particularly when responding on behalf of a GP practice (40.4%) compared with PCN-level responses (25.3%). Patient group directions: who can use them - GOV.UK**.** Overall, combining PCT and GP practice responses, 43.9% of services reported PGDs were authorised at GP practice level, while over a third (33.9%) were unsure who held overall responsibility. PGD authorisation at other levels included 9.9% at PCN level, 5.8% via NHS employers, and 5.3% at ICB level.

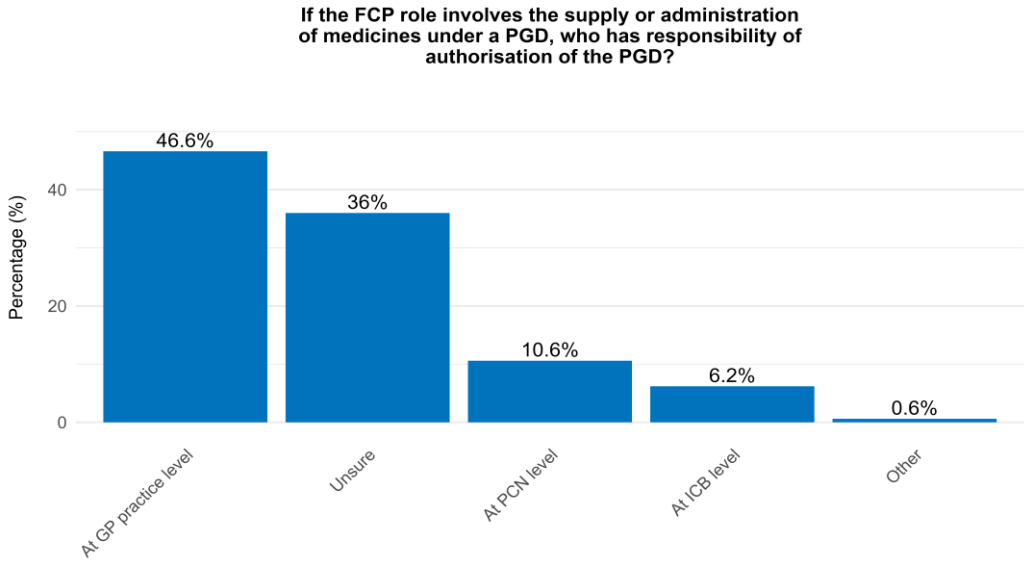
It is recognised that the organisations that can legally authorise PGDs for use in NHS or publicly funded services include:

- ICBs
- Local authorities
- NHS trusts or NHS foundation trusts
- Special health authorities
- NHS England

- UK Health security agency (Patient Group Directions in Complex Commissioning Scenarios.

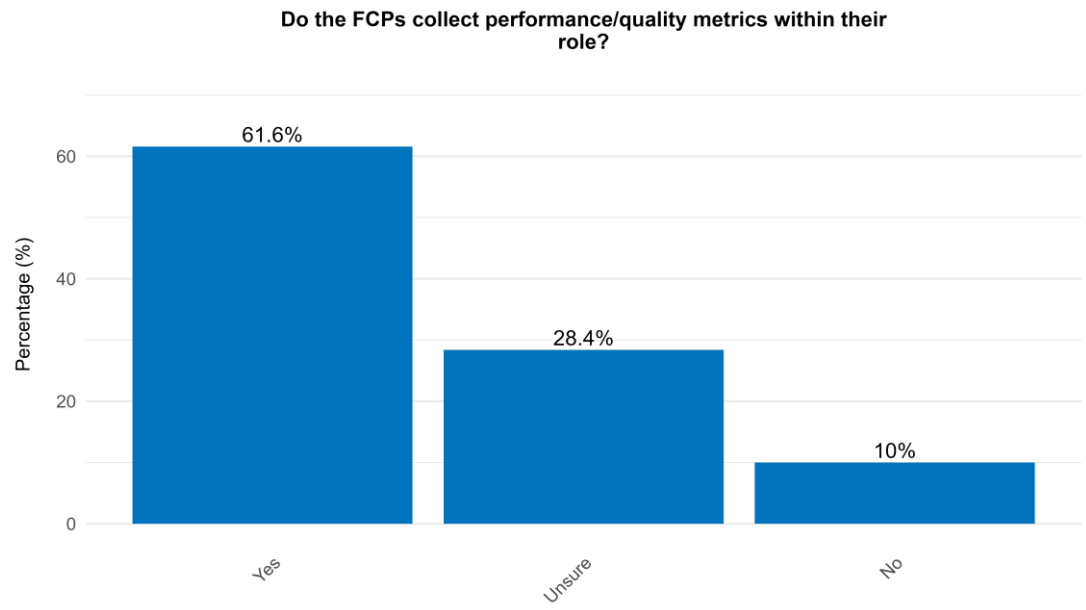
It is not possible in this phase of the evaluation to determine whether the observed variation in PGD authorisation reflects actual practice across FCP services or whether the respondents fully understood the question/subject matter.

The following graph demonstrates the variation in authorisation levels for PGDs captured within the FCP evaluation.

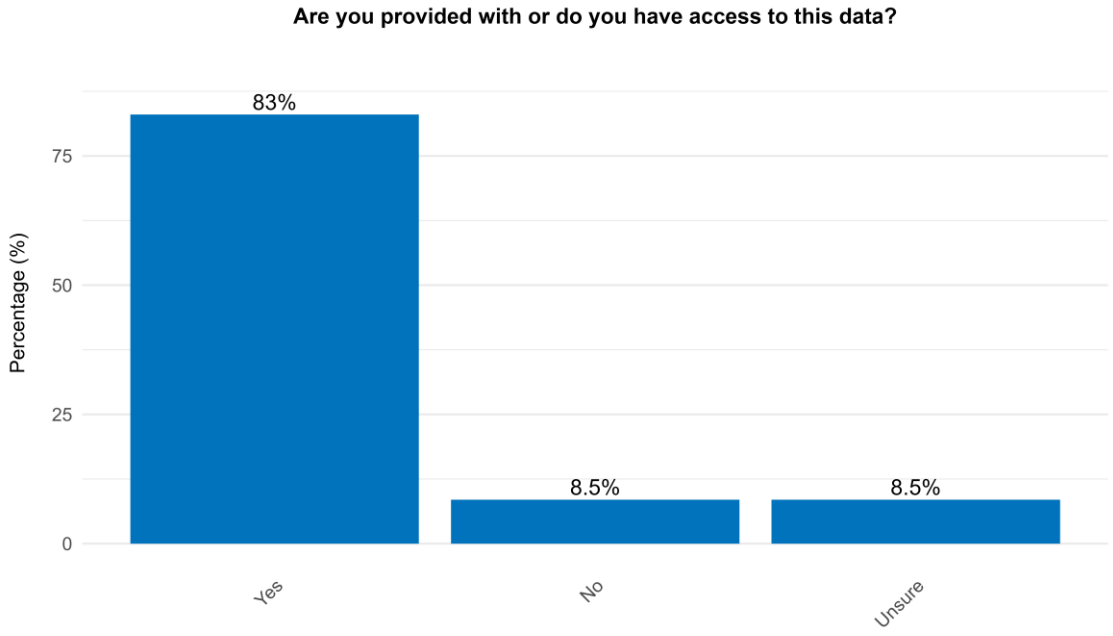


Performance measurement and patient feedback

61.6% of services reported collecting performance and quality metrics, while 28.4% were unsure and 10% stated that their FCP service did not collect any such measures. The review did not identify which specific metrics were collected, nor any associated benefits, challenges, or impact on service delivery. The frequency, method of collection and the impact of these metrics on FCP performance were also not established.

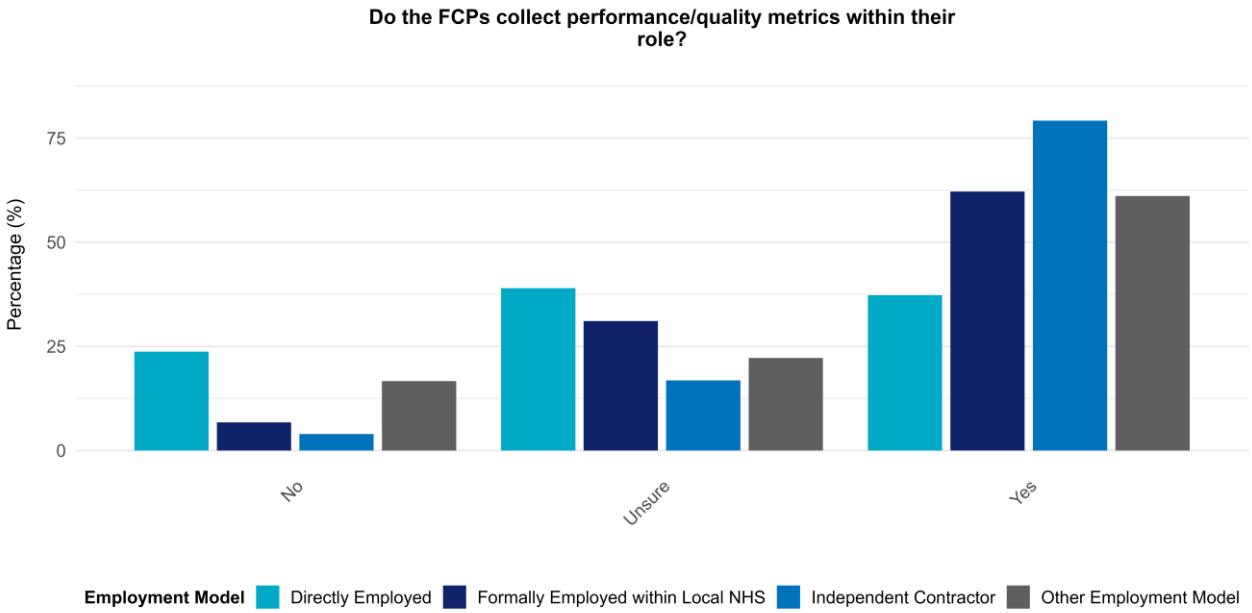


Overall, 83% of services either received or had access to these metrics, while 17% of respondents reported that they did not receive this data or were unsure whether it was available to them.



Among services employing independent providers of FCPs, 79% reported collecting performance and quality metrics, compared with 52% of services using all other employment models. The reasons for this variation are unclear. One possible explanation is that independently provided services may have more standardised approaches to performance data collection, supported by established portals or dashboards that facilitate data capture, visualisation and analysis.

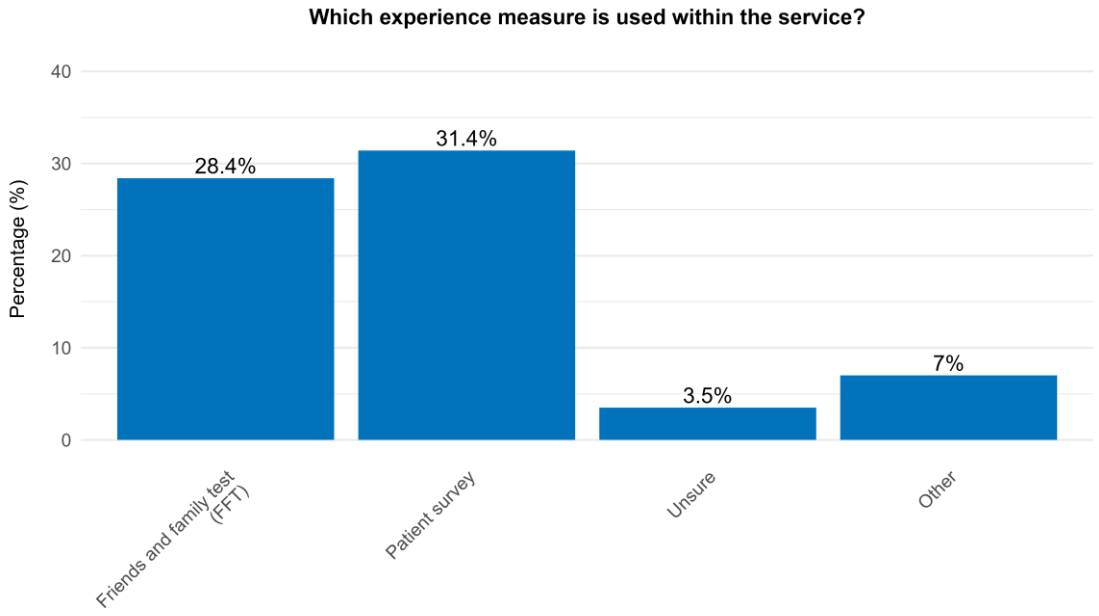
In contrast, other FCP services operating within primary care may work with more heterogenous systems, with less standardisation and fewer consistent mechanisms for collecting and analysing performance data.



Patient reported experience and outcome measure collection

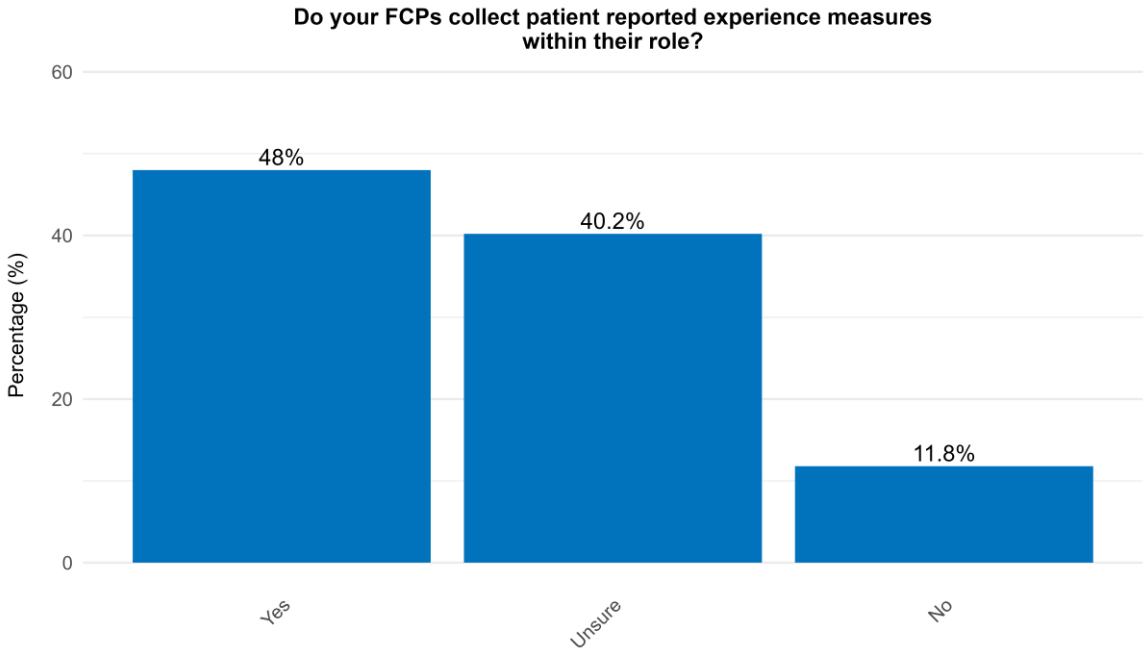
There were high levels of uncertainty (40.2%) regarding whether FCP services were collecting patient reported experience measures (PREMs) as part of their service delivery. Overall, 48% of services reported that they were collecting PREMs.

The following graph illustrates the types of PREMs used to capture patient experience.



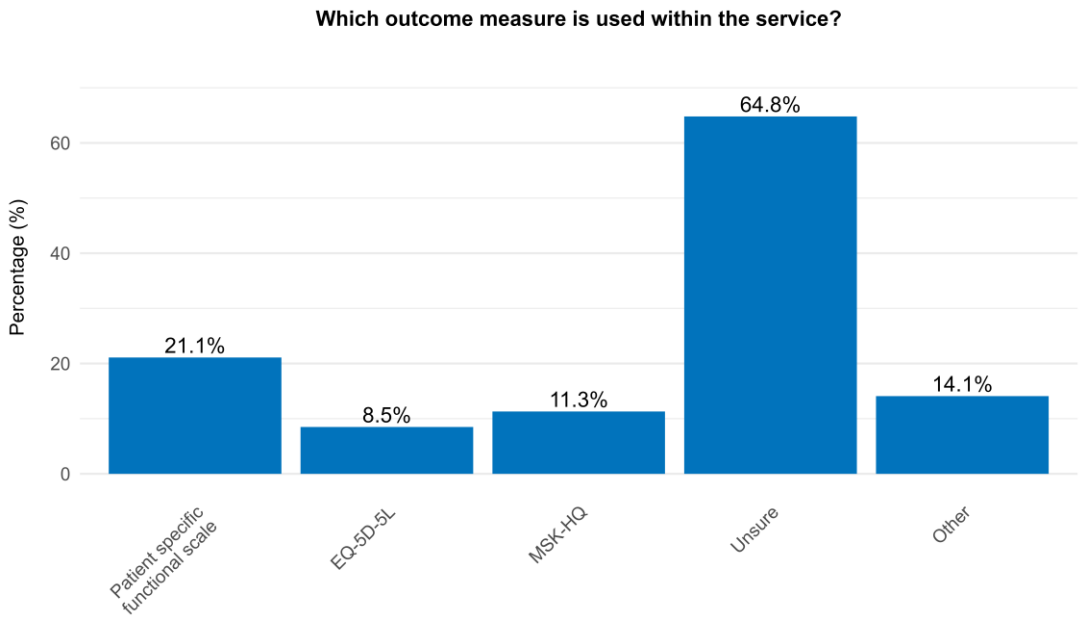
47.5% of GP practice responses were unsure whether any patient experience data was being collected, compared with 32% of PCN responses. The survey did not identify what data was collected, the method of distribution, return rates, or any associated findings from the responses.

The following graph shows the overall prevalence of PREM data collection within FCP services.



There were also high levels of uncertainty regarding the collection of patient-reported outcome measurement (PROMs) collection within FCP services. Overall, 52.4% of respondents were unsure whether their FCP service routinely collected PROMs, while only 31% confirmed that collection was taking place.

The outcome measures used within FCP service delivery were as follows:

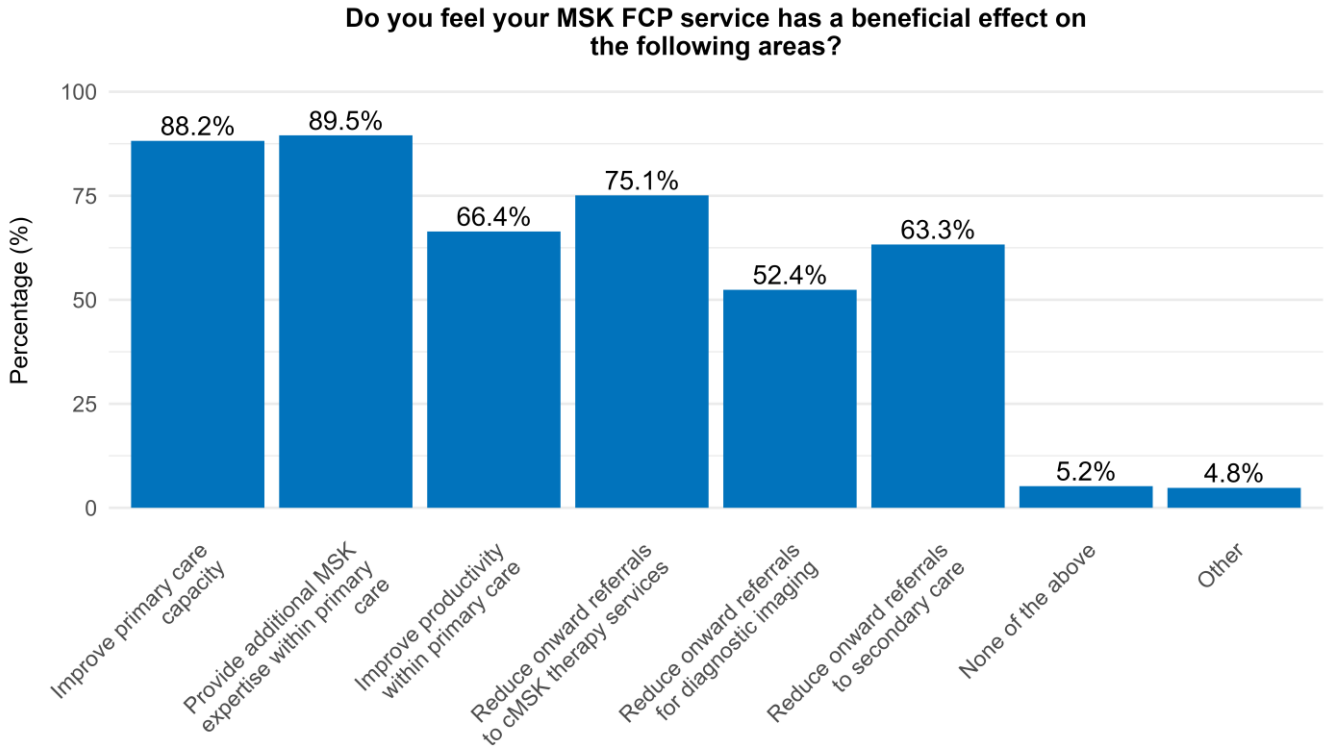


Overall, this survey did not explore the impact of the collected PREMs and PROMs data, nor the extent to which these measures are visible or provide value across the system when considering the commissioning of FCP services.

Perceived impact and future plans

Perceived impact of FCP services

Overall, respondents reported a positive perceived impact of FCP services within primary care. The majority (89%) felt that FCPs provided additional musculoskeletal (MSK) expertise, while 88% agreed that FCP services improved primary care capacity. Three quarters of respondents (75%) felt that FCP services reduced onward referrals to commissioned community MSK (cMSK) services, and 66% agreed that FCP services helped to improve productivity within primary care.

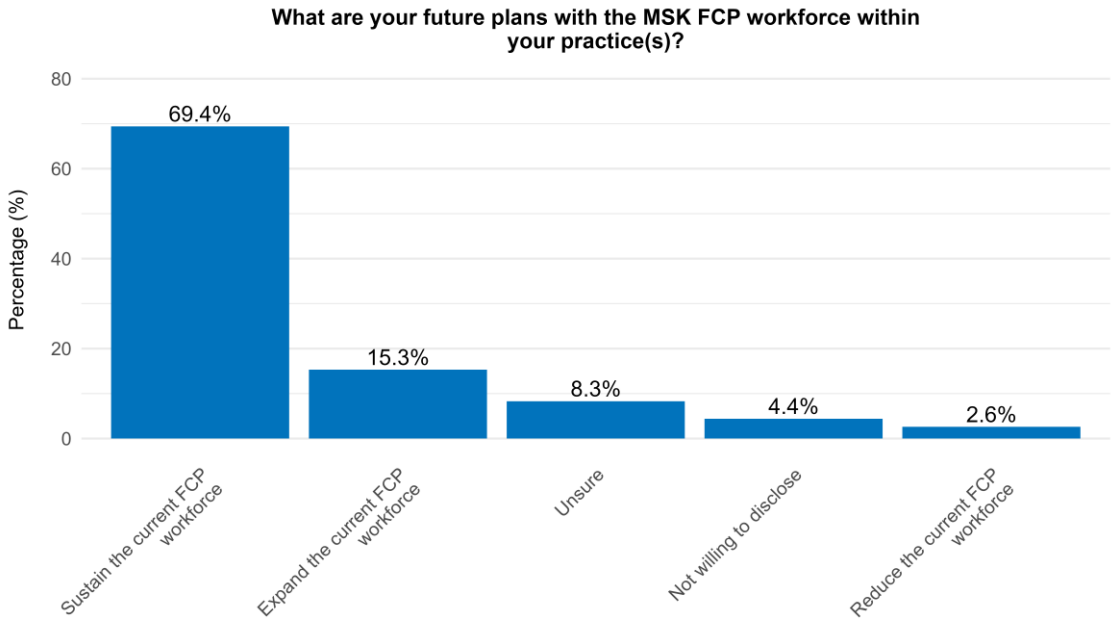


It should be noted that respondents were not required to provide any supporting evidence to justify their responses within this section of the survey. Instead, the survey presented a series of statements with which respondents could indicate agreement or disagreement. A small proportion of services (5%) reported that FCP did not achieve any of these return on investment outcomes within their service delivery.

Future plans

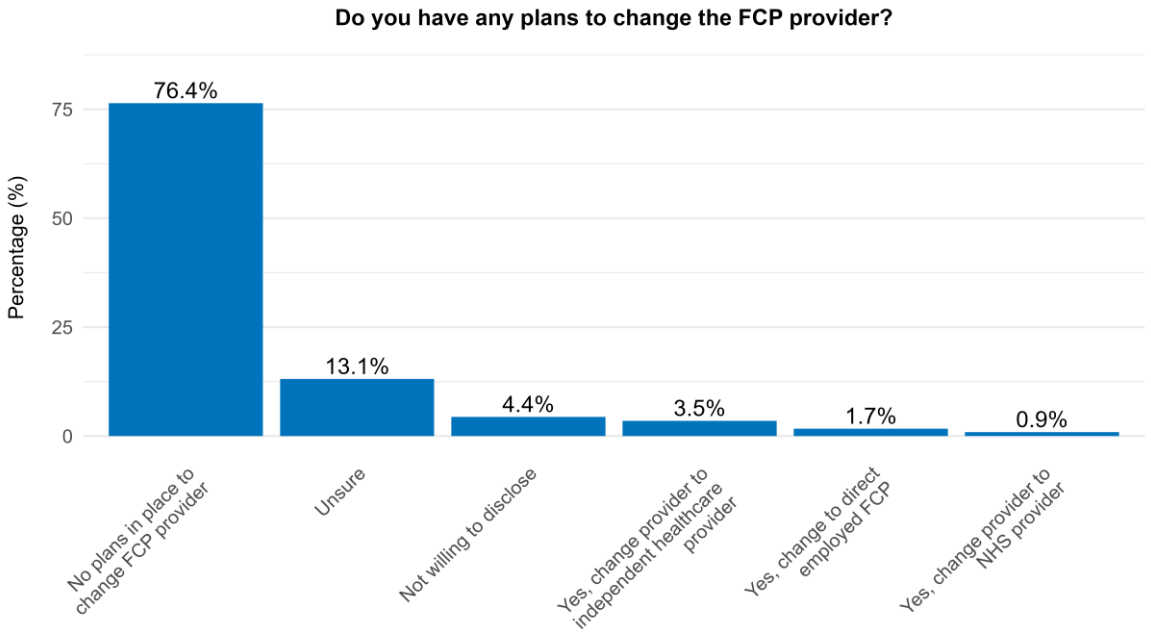
Most respondents indicated an intention to maintain their existing FCP workforce, with a further 15% indicating plans to expand. A small proportion of PCNs/GP practices (2.6%) anticipated a reduction in their FCP workforce.

Future phases of this evaluation could include the perspectives of PCNs or GP practices that do not currently commission an FCP service but are considering workforce development in this area. Such work could also examine the reasons for the absence of FCP provision and the factors influencing workforce planning decisions, including those affecting potential expansion or planned reductions in FCP services.



FCP provider change

Responses relating to potential changes in FCP provider arrangements indicate that the majority of services anticipate stability in the current provision.



Over 75% reported no plans to change their FCP provider type, while 13% indicated that they were unsure. A small proportion of services (3.7%) reported plans to change to an independent provider, with an even smaller proportion (1.7%) planning to move to directly employed FCPs.

Only two responses (0.9%) indicated plans to switch to an NHS provider. No additional information was collected regarding the reasons for these planned changes or the factors influencing the move between provider types. As a result, the findings indicate the anticipated changes in provider arrangements but do not provide insight into the underlying drivers of these intentions.

Additional comments on current or future FCP provision

Eighty-three responses were received to a free text question inviting additional comments on the current or future provision of FCP services. Responses were varied and reflected a mix of positive and negative views, covering a range of themes related to FCP service delivery.

The most commonly referenced themes included:

- patient expectations and experience
- overall positive impact/value
- integration, governance and provider communication
- funding/cost-effectiveness and management fees

- neutral/not applicable
- prescribing/diagnostics and direct access limits
- staffing capacity, cover and reliability
- access/availability and waits/booking.

The following table provides a selection of the examples from the free-text responses:

Theme	Comment
Patient expectation and experience	*We can offer a same day appointment to patients, but they are still reluctant to see a physio instead of a doctor, or if booked in advance will DNA as what they really wanted was medication. We utilise both an agency and the local acute trust team, however the acute staff can be very unreliable. Additionally, the same trust won't allow our FCPs to book x-rays and scans - it has to be done by the GP. They need direct access to book.*
Patient expectation and experience	*We have found they add to team knowledge and the patient experience, but GPs are as effective (outcome based) and cost the same (work faster) and are more flexible (can do more than MSK). Lack of clinical space has stopped us expanding the team.*
Patient expectation and experience	*The GPs think these roles are wonderful, the patients are booked in with the correct person with the expertise from the onset*
Positive impact and value	*An amazing service which has changed our service provision for the better, it is a key part of our service provision*
Positive impact and value	*Very lucky - both excellent. They are even taking part in new GP access model with contract change that came in October*

Positive impact and value	*MSK FCP in general practice has made a significant impact on capacity, so many people have MSK problems. Without these FCPs in general practice GPs would struggle to consult with all of the patients*.
Integration, governance and provider communication	*GPs see significant benefits for both patients and their own access to patients because that is increased. As a result, we have happy patients with the service closer to home. GPs will ask in real time for FCP guidance and information and there is definitely joint learning for both GPs and FCPs. The massive benefit on several occasions has been that the FCP identified what would have been sinister pathology and ensured a very quick pathway for the benefit of the patient. The FCPs longer appointment time allows time for better investigation than a normal GP appointment. The FCP is definitely part of the team here for both clinical and reception team communication with patients*.
Integration, governance and provider communication	*I think that with the outsourced option that we currently have they are not really part of the team - they don't come to team MDT meetings, and they are very restricted. We think employing our own will change this*
Funding/cost-effectiveness and management fees	*We decommissioned the service as it was not cost effective. As ARRS changed we could employ a GP instead. We would not employ them again as they just reproduce the local MSK service. The quality of care in the practice setting is also no better than an experienced GP.*
Funding/cost-effectiveness and management fees	*Each practice should have funding to provide at least 1-2 FCPs to support MSK FCP services. Patients are seen quicker, with less*

	increases in chronic conditions which will translate into reduced need for referrals to secondary care. Expanding the MSK FCP services to have sub-specialty areas in the community would reduce the pressures on secondary care.
Prescribing/diagnostics and direct access limits	*We are a single practice PCN and have 2wte of FCP MSK which is operating as both FCP and a Tier 2 service. I would not want to change anything. We have the lowest MSK referrals in the ICB and the highest conversion rate of referral to surgery within Orthopaedics*
Prescribing/diagnostics and direct access limits	*One local limitation is the refusal of the local trust to allow general practice-based FCPs to request x-rays despite years of lobbying - national encouragement would be helpful to support this.*
Staffing capacity, cover and reliability	*Helpful, but often appointments much more readily available with GP weeks ahead of FCP. Due to employment by PCN, limited clinics over school holidays due to annual leave and means bottlenecks throughout the year. Unfair on other GP staff.*
Staffing capacity, cover and reliability	*Brilliant service other than when illness/maternity leave occurs and the time to replace*
Staffing capacity, cover and reliability	*She is always fully booked, and patients have given positive feedback after seeing her*

Conclusion

This national FCP evaluation demonstrates substantial unwarranted variation across multiple aspects of FCP service delivery. While most primary care services report that FCPs provide valued musculoskeletal (MSK) expertise and contribute meaningfully to primary care capacity, the findings indicate inconsistent assurance of training completion and variability in scope of practice. This includes marked differences in access to, or delivery of, fit note certification, diagnostics, prescribing and job planned supervision.

The survey also identifies variation in appointment length, booking practices, hybrid working arrangements, and the collection and utilisation of performance metrics. Completion of patient-reported experience and outcome measures is similarly inconsistent. Governance arrangements vary, with some services relying on informal or unclear structures.

There is clear evidence of significant variation in the employment model for FCP provision. Although this evaluation did not assess the level or effectiveness of integration between FCP and broader MSK services, the findings reinforce the importance of FCP services collaborating with local MSK care systems, irrespective of provider type, to align with the actions set out in NHS England's *An improvement framework to reduce community musculoskeletal waits while delivering best outcomes and experience.*

The underlying reasons for the variation identified are not fully established and warrant further detailed investigation. Consideration of the future sustainability and growth of the FCP role is essential, recognising that unwarranted variation may pose risks to service quality, clinical safety, workforce sustainability, patient experience and the long-term credibility of the FCP model. The recommendations in this report are intended to support commissioners, providers, and oversight bodies in improving the consistency, effectiveness and safety of FCP services in England.

References

Care Quality Commission https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-106-primary-care-first-contact-practitioners-fcps

Department for Work & Pensions. Department of Health & Social Care Who can issue fit notes: guidance for healthcare professionals and their employers - GOV.UK.

Goodwin, R., Moffatt, F., Hendrick, P., Stynes, S., Bishop A. and Logan, P. (2021) Evaluation of the First Contact Physiotherapy (FCP) model of primary care: a qualitative insight. *Physiotherapy*, Dec;113:209-216. Available at: 10.1016/j.physio.2021.08.003. (Accessed 7th August 2025).

Hayward-Giles, S. (2025) First contact physiotherapy: challenges and opportunities. *Chartered Society of Physiotherapy. Frontline*, May 2025(2). Available at: https://www.csp.org.uk/frontline/article/first-contact-physiotherapy-challenges-opportunities. (Accessed1st August 2025).

Health Education England https://www.hee.nhs.uk/sites/default/files/documents/MSK%20July21-FILLABLE%20Final%20Aug%202021_2.pdf

NHS Digital Primary Care Workforce Quarterly Update - NHS England Digital

Henning, M., Henning, R. and Lynch G. (2024) First Contact Physiotherapy: A 4-Year Service Evaluation of UK Primary Care Data. *Musculoskeletal Care*, Dec;22(4): e1961. Available at:10.1002/msc. (Accessed 7th August 2025).

Medicines and healthcare products regulatory agency Patient group directions: who can use them - GOV.UK

NHS England https://www.england.nhs.uk/long-read/an-improvement-framework-to-reduce-community-musculoskeletal-waits-while-delivering-best-outcomes-and-experience/#actions-for-primary-care-services

NHS England NHS England » Changes to the GP Contract in 2026/27

NHS England https://www.england.nhs.uk/primary-care/primary-care-networks/

NHS England https://www.england.nhs.uk/wp-content/uploads/2025/03/PRN02067v-network-contract-des-contract-specification-2526-pcn-requirements-and-entitlements.pdf

Specialist Pharmacy Service Patient Group Direction use in Primary Care Networks – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Specialist Pharmacy Service Patient Group Directions in Complex Commissioning Scenarios

Stynes, S., Jordan, K.P., Hill, J.P., Wynne-Jones, G., Cottrell, E., Foster., N.E., Goodwin, R. and Bishop, A. (2021) Evaluation of the First Contact Physiotherapy (FCP) model of primary care: patient characteristics and outcomes. Physiotherapy. 113(2021) 199-209.

Walsh, N., Halls, R. Thomas., et al. (2024) First Contact Physiotherapy: An Evaluation of Clinical Effectiveness and Costs. *British Journal of General Practice* 74, no. 747: e717–e726. Available at: https://doi.org/10.3399/BJGP.2023.0560. (Accessed 7th August 2025).

Wood, L., Bishop, A., Goodwin, R. and Stynes, S. (2022). Patient Satisfaction with the First Contact Physiotherapy Service: Results from the National Evaluation Survey. *Musculoskeletal Care,* **20**, no. 2: 363–370. Available at: https://doi.org/10.1002/msc.1599. (Accessed 7th August 2025).

About the GIRFT programme

Getting It Right First Time (GIRFT) is a national programme designed to improve treatment and care by reviewing health services. It undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment, and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience, without the need for radical change or additional investment. While the gains for each patient or procedure may appear marginal, they can, when accumulated across an entire trust – and even more so across the NHS as a whole – deliver substantial benefits.

GIRFT is part of an aligned set of workstreams within NHS England. In Lord Carter's 2016 review of operational efficiency in acute trusts across England, Professor Tim Briggs was thanked for his clinical insights gained from visiting and reviewing elective orthopaedic surgery at 211 NHS providers. In the 12 months after the pilot programme, it delivered an estimated £30m-£50m savings in orthopaedic care – predominantly through addressing unwarranted variation and reducing average length of stay.

The programme has the backing of the Royal Colleges and professional associations and has a significant and growing presence on the Model Hospital portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency. The programme also works with a number of wider NHS programmes and initiatives which are seeking to improve standards while delivering savings and efficiencies.

The GIRFT model has now been applied in more than 40 different areas of clinical practice. It consists of five key strands:

- Data gathering – a broad data gathering and analysis exercise, generating a detailed picture of current national practice and outcomes.
- Peer reviews – direct clinical engagement via visits or virtual meetings between clinical leads and trust teams; an opportunity to examine trust behaviour in the context of the national picture, enabling teams to understand where they are performing well and what they can do better.
- National report and Academy resources – production of national reports that draw on data analysis and discussions with provider teams to identify opportunities for improvement, locally, regionally and nationally, alongside - clinical resources such as best practice pathways and guides.
- Support to deliver – the implementation phase where the GIRFT team supports trusts, commissioners and integrated care systems to deliver the improvements recommended.

- Research and development – GIRFT fellowships support resident doctors, nurses and allied health professionals to develop their research and clinical improvement skills, delivering research projects and GIRFT identified improvements in their host provider, system or region.

GIRFT and a greener NHS

Climate change is one of the greatest health threats and opportunities of the 21st century. The NHS is acting now to mitigate and adapt to this threat in order to protect the health of current and future generations. Doing so will not only protect the environment but will also bring many health, social and financial benefits. As the largest employer in the UK, contributing 4.6% of national emissions, the NHS is both part of the challenge and the solution.

Through its endeavour to improve the quality of care within the NHS by reducing unwarranted variation, GIRFT can play an important role in reducing the carbon emissions associated with care delivery. Through the GIRFT model, there is the opportunity to identify changes that will help reduce the NHS carbon footprint and therefore improve patient care now and in the future.

Glossary

ARRS	Additional role reimbursement scheme
AHP	Allied Health Professional
CAHPO	Chief Allied Health Professions Office
CPD	Continuing professional development
CQC	Care Quality Commission
CSP	The Chartered Society of Physiotherapists
FCP	First Contact Physiotherapist
GP	General Practitioner
ICB	Integrated Care Board
ICS	Integrated Care System
JWHD	Joint Work and Health Directorate
MSK	Musculoskeletal
MSK CDP	Musculoskeletal Community Delivery Programme
PCN	Primary Care Network
PGD	Patient Group Direction
PMA	Practice Managers Association
PREMS	Patient reported experience measures
PROMS	Patient reported outcome measures

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Ian Jones	Director, The Practice Managers Association

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Appendix 1

FCP Evaluation Questions

What is the name of the region in which your practice(s)/PCN is located? (Use this information page if you're not sure - https://www.england.nhs.uk/system-and-organisational-oversight/system-directory/)

What is the name of the ICS in which your practice(s)/PCN is located? (Use this information page if you're not sure - https://www.england.nhs.uk/system-and-organisational-oversight/system-directory/)

Please enter the 5 digits of your PCN code after the initial letter 'U'. (E.g., if your PCN code is U12345, please type in 12345) Use the following link to search for your PCN code if required: https://www.odsdatasearchandexport.nhs.uk/

Are you answering on behalf of your GP practice(s) or the PCN overall?

GP practice(s)
PCN

What is your job role?

Practice manager
PCN Lead
Other (please specify):

What is the AfC pay band(s) (or equivalent pay scale) of the FCPs working in your practice(s)? Please select all that apply.

Band 6
Band 7
Band 8a
Band 8b

Unsure
Other (please specify):

What is the employment model for the FCPs working in your practice(s)? Please select all that apply.

Directly employed by general practice/PCN
Contract with independent healthcare provider
Formal agreement (MoU, SLA or contract) with a local NHS musculoskeletal (MSK) provider
Other (please specify):

Are any of the FCPs working within your practice(s) also working within the local community MSK (cMSK) therapy service alongside their FCP role?

Yes
No
Unsure

What support is provided to the FCPs not working within the local cMSK therapy service to improve integration between these services? Please select all that apply *

Peer support
Clinical supervision
Work shadowing
Attendance at cMSK professional development sessions
Access to cMSK service pathway documents
Direct referral access to cMSK therapies or triage services
None of the above

Unsure
Other (please specify):

***Once an initial review of the responses to this question took place, it became clear that the question had been misinterpreted. The responses were therefore not evaluated fully and are not included within this initial report.**

Are you aware of the CQC regulatory guidance on the educational requirements for working in FCP roles?

Yes
No

Have all of the FCPs working in your practice(s) completed "stage 1" of the FCP roadmap to practice? The FCP Roadmaps to Practice are guidance documents which set out nationally agreed education and training standards for AHPs moving into FCP roles. Stage 1 is completed before the FCP starts work in primary care.

Yes
No
Unsure

Have all of the FCPs working in your practice(s) completed "stage 2" of the FCP roadmap to practice? The FCP Roadmaps to Practice are guidance documents which set out nationally agreed education and training standards for AHPs moving into FCP roles. Stage 2 is completed once the FCP is working in primary care.

Yes
No
Unsure

If any of the FCPs do not have plans in place to complete the FCP roadmap, do you have mechanisms in place to assure that your FCPs have the appropriate education, training and capabilities to be working at the advanced level of practice required for an MSK FCP role?

Yes

No
Unsure
N/A

What mechanisms do you have in place?

What is the typical length of a first FCP appointment in your practice(s)?

15 mins
20 mins
30 mins
Unsure
Other (please specify):

What type of FCP appointments do you offer? Please select all that apply.

Face-to-face
Phone
Video
Patient's home
Unsure

What is the longest period of time in advance that first FCP appointments can be booked?

Same day
Within 1-2 days
Within 3-7 days
Within 8-14 days

Within 15-21 days
Within 22-28 days
Within 29-42 days
6 weeks +

Do the FCPs have access to the patients' GP care records at the time of the FCP appointment?

Yes
No
Unsure

Do the FCPs have a job plan?

Yes
No
Unsure

Do the FCPs have allocated clinical/CPD supervision time within their FCP role in your practice(s)? (NB: This is separate to on the day clinical support)

Yes
No
Unsure

What is the frequency of this clinical/CPD supervision?

Weekly
Fortnightly
Monthly
Quarterly
Ad hoc
Unsure

How long do these sessions usually last?

<30 minutes
30-60 minutes
60+ minutes
Unsure

Do any of the FCPs certify or amend fit notes within their FCP role?

Yes
No
Unsure

Do any of the FCPs write AHP health and work reports within their FCP role?

Yes
No
N/A

Unsure

Do the FCPs have access to refer to any employment support services?

Yes
No
Unsure

Do any of the FCPs undertake joint or soft tissue corticosteroid injections?

Yes
No
Unsure

Do any of the FCPs independently request diagnostic tests?

Yes
No
Unsure

What tests do they request? Please select all that apply.

Blood tests
X-ray
Diagnostic ultrasound
MRI
Nerve conduction studies

Other (please specify):

Do any of the FCPs currently prescribe medication as non-medical prescribers within their role?

Yes
No
Unsure

If the FCP role within your practice(s) involves the supply or administration of medicines under a Patient Group Direction (PGD), who has responsibility for authorisation of the PGD?

At ICB level
At PCN level
At GP practice level
NHS employer
Unsure
Other (please specify):

Are the FCPs in your practices(s) able to refer directly to secondary care services?

What services can they refer to? Please select all that apply.

Orthopaedic services
Pain management services
Rheumatology services
Spinal services
Other (please specify):

Do the FCPs collect performance/quality metrics within their role?

Yes
No
Unsure

Are you provided with or do you have access to this data?

Yes
No
Unsure

Do your FCPs collect patient reported experience measures within their role?

Yes
No
Unsure

Which experience measure is used within the service? (Tick all that apply)

Friends and family test (FFT)
Patient survey
Unsure
Other (please specify):

Do your FCPs collect patient reported outcome measures within their role?

Yes
No
Unsure

Which outcome measure is used within the service? (Tick all that apply)

Patient specific functional scale
EQ-5D-5L
MSK-HQ
Unsure
Other (please specify):

Do you have processes in place to have oversight of quality and safety risks/incidents with the FCP service?

Yes - formal processes are in place and quality and safety risks/ incidents are regularly reviewed by the PCN
Yes - informal processes are in place to review quality and safety risks/ incidents but not consistently applied within the PCN
No - the contracted provider is responsible for managing quality and safety risks/ incidents
No - there are currently no processes in place
Unsure
Other (please specify):

Do you feel your MSK FCP service has a beneficial effect on the following areas? Please select all that apply.

Improve primary care capacity
Provide additional MSK expertise within primary care
Improve productivity within primary care
Reduce onward referrals to cMSK therapy services
Reduce onward referrals for diagnostic imaging
Reduce onward referrals to secondary care

None of the above
Other (please specify):

What are your future plans with the MSK FCP workforce within your practice(s)?

Expand the current FCP workforce
Sustain the current FCP workforce
Reduce the current FCP workforce
Unsure
Not willing to disclose

Do you have any plans to change the FCP provider?

Yes, change provider to independent healthcare provider
Yes, change provider to NHS provider
Yes, change to direct employed FCP
No plans in place to change FCP provider
Unsure
Not willing to disclose

Do you have any further comments on the current or future provision of MSK FCP services within your practice(s)?

Did you require any support to complete this questionnaire?

Yes
No

Who provided you with the additional support to complete this questionnaire?

FCP
FCP Provider
Other (please specify):

What sections of the questionnaire did you require additional support with? (Please tick all that apply)

Pay band / employment model
Employment / integration with local community MSK therapy services
Roadmap stage 1 / 2 completion
FCP job plan / supervision structure
Fit note / AHP job plan certification / employment service support
PGD sign off
Performance / quality metric collection
Patient reported experience / outcome measure collection
Oversight of quality / safety
Other (please specify):

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