"ROCK THE BOAT
BUT DON'T FALL IN"
Between June 2014 and June 2017, a feedback loop had formed around the Musculoskeletal (MSK) Physiotherapy interview show The Physio Matters Podcast and its surrounding social media. Having a podcast in common often helped the 20,000+ clinicians, patients, educators and policy-makers to involve themselves in discussions, even around topics infamous for causing conversation breakdown.

Chews Health, the Manchester-based healthcare company responsible for the podcast, partnered with Newcastle-based healthcare company Connect Health to host an event that they hoped would channel this energy. Fifty invitees discussed a variety of topics central to contemporary MSK practice at the inaugural event ‘Reasoning, Responsibility and Reform’. The event was a huge success and interest beyond the room was clear from the immediately trending hashtag #TheBigRs, which the resultant movement has subsequently been known as.

A further invitational event in May 2018 saw one hundred innovators in the field look to identify mechanisms for change as they explored the question of whether a reformative agenda was emerging from the discussions on and offline. Following this event and a further 150-strong conference in November 2018, it was clear that there was momentum behind the movement. The collective was also privileged to have the involvement of many great leaders, five of which were selected to head up individual Working Groups made up of ten volunteers for a bold new project.

The five Working Groups consisting of clinicians, patients, students, educators and policy-makers sought to identify what reforms would best facilitate improvements in MSK patient outcomes. They did so across the topics of Evidence, Governance, Education, Excellence and Influence.

#TheBigRs, a previously unused hashtag was seen by 34.1 million social media users in one week in 2018, turning the heads of senior civil servants, Members of Parliament, major company CEOs and, most importantly, many hopeful MSK patients. #TheBigRs has come to represent Reform by way of discussion, persuasion and consensus rather than legislative force. It is a truly inclusive grass-roots movement involving a diverse group of people with the common goal of reforming MSK practice for the betterment of patient care.

Coinciding with the launch of the Manifesto for Reform, #TheBigRs movement has been incorporated into a non-profit company and will operate from October 2019 onwards as the think tank MSKReform (MSKR).

Policy priorities and 2020’s action group leaders are to be voted for by MSKR members as part of an innovative community portal at www.mskreform.org.uk

**WHAT NEXT?**

JOIN NOW TO HELP SHAPE THE FUTURE OF MSK PRACTICE. BECAUSE IF NOT US, THEN WHO? AND IF NOT NOW, THEN WHEN?

**OUR STORY**

**WHAT NEXT?**

**WHY ARE WE DOING THIS?**

**FIVE GIANT CHALLENGES - A CLEAR CASE FOR CHANGE**

- **Fourth largest area of NHS spending at 4.7bn (PA)**
- **Whilst passionate, the organisations that stand up for MSK health are often disjointed and lack a consensus of vision**
- **MSK DISORDERS ARE THE SECOND BIGGEST CAUSE OF DAYS LOST IN WORK**
- **The highest percentage of total years lived with disability is 22.7%**
- **Low public awareness of MSK**

INTRODUCTION

I am delighted to introduce the MSKR Manifesto for Reform, the product of an innovative two-year project, which I feel demonstrates grass-roots support for a reformative agenda in MSK practice.

The MSKR Manifesto for Reform is a culmination of two years of work contributed to by over 200 interesting, unique individuals who are willing to make a stand for reformation in the industry that has been sluggish to adapt to the contemporary challenges that MSK practice faces. Simple reforms could position MSK care where it deservedly belongs: at the heart of wider healthcare innovations.

When reading this Manifesto, I invite you to ask yourself the following question on a regular basis: ‘If we were to enact these policies, would MSK practice improve?’ If yes, I hope you’ll join our movement. If no, I hope you’ll help us to refine it.

This Manifesto is a consensus of opinion which lays out ideas as points of principle. It has a declared focus on why we need reform and what reforms we propose. The pages of instruction and hours of transcripts detailing how we can enact these reforms are not contained in this already lengthy document. The MSKR contributors are famed for being people of action so there has been no shortage of planning and strategy. If you would like specific detail regarding next steps, please get in touch as you are asking just the right questions.

You’ll read of a ‘royal we’ throughout the Manifesto so allow me to introduce you by way of thanks to the incredible people who have made this innovative project come to life:

I would like to thank my ever-patient team at Chews Health who continue to both support and challenge me and my mad ideas with an amazing combination of professional tact and good humour!

To my co-authors Emma, Paula, Reena, Matthew and Ashley it has truly been an honour to work with you on this project. Your vision and leadership inspired this document and having witnessed how you’ve brought your chapters together, I will forever aspire to emulate your expertise.

To our Working Group and event contributors, the time and effort you have committed to this project will go down in history and I hope that this Manifesto does you proud.

To the leadership team of our sponsors Connect Health, thank you for your belief, encouragement and understanding. Few organisations could have kept up with such a dynamic project.

To MSKR Deputy Director, Felicity Thow: your attention to detail is as incredible as your patience. (This, my friend, may well be our best co-creation since my undergraduate dissertation.) And finally,

To you, our readers. Thank you for your time in reading this work which I have so enjoyed bringing together for you. I hope you find it persuasive enough to consider signing your name in support and joining the movement at MSKReform.org.uk

A significant development over the course of #TheBigRs project has been the collective realisation that our analysis and suggested reforms are applicable beyond the initial target of MSK Physiotherapy. I have been pleased to hear from professionals and patients from a wide variety of backgrounds who have contributed to the realisation that MSK practice is in fact the target. The policies detailed in the MSKR Manifesto for Reform are widely applicable across disciplines but at times concentrate on MSK Physiotherapy as a best test case. As it stands, Physiotherapists are the largest provider of MSK care in the UK and I feel we are best placed to lead MSK reforms providing we remain outward looking and inclusive with patients’ best interests at the heart of our decision making.

Throughout my career I’ve been accused of ‘rocking the boat’, a metaphor suggesting agitation, disruption and challenge of the status quo. I’m far from offended by this but I have long reflected on how this expression is so often used to describe me and the projects I’m involved in so allow me to indulge the metaphor.

If I’m in a boat, I am blessed with an incredible crew. We have a destination in mind but the sea is inherently rough, the engines and other low-effort options have failed and the winds are against us. If my boat is rocking, it’s because we’re paddling so damn hard.

Agitation, disruption and irritation are secondary consequences, not primary intentions. We do not profess to be reinventing the wheel and we recognise and credit the giants of our industry whose shoulders we are stood on to be here today. But we do speak with confidence in saying that the MSKR Manifesto for Reform is the best effort of many passionate clinicians, patients, educators, researchers and policy makers to demonstrate consensus in a time of disagreement; unity in a time of division and bravery in a time of cowardice.

The actions to be taken from this work do not fall on one specific organisation or stakeholder group. The suggested reforms are evidence-informed, pragmatic and implementable but require a combination of mass support and specific lobbying to achieve. We call upon all stakeholder groups to move forward with the proposed reforms that they are best placed to implement and to support the wider cause to ensure a balanced distribution of responsibility.

If I was looking for signatures from people who agreed with 100% of this Manifesto, I wouldn’t even get my own. This is an authentic collaboration with adjustments and compromises laced throughout. We welcome challenge, invite your critique and look forward to refining this work together for future editions. But for now, please ask yourself:

IF WE WERE TO ENACT THESE POLICIES, WOULD MSK PRACTICE IMPROVE?

Jack Chew
MSKR Director
Evidence-based practice (EBP) is a process of care centred around three pillars:

1. The patient’s values and preferences
2. Clinical experience and expertise.
3. Applicable scientific evidence.

Modern day EBP strives to optimise safer, more consistent and cost-effective care that is patient-centred.

The value of EBP within clinical practice is something consistently recognised as important by Physiotherapists and other MSK practitioners but there still appears to be wide variation in its implementation.

EBP should depend on relatively equal weighting of all three of the above pillars. Patterns in practice of individual clinicians working autonomously have been shown to be strongly influenced by their experience, even when robust contrasting evidence on effectiveness is well publicised.

While there are certainly advantages to autonomous practice, an individual clinician’s experience will be subject to inherent bias and could therefore lead to suboptimal provision of care and unwarranted clinical variation.

Potential barriers to embracing the remaining two pillars (patient values and scientific evidence) have been reported to include insufficient time within a standard clinical workload, lack of clinical appraisal skills, and difficulty in understanding evidence on effectiveness, which is fully available online as an open access download.

While there are certainly advantages to autonomous practice, an individual clinician’s experience will be subject to inherent bias and could therefore lead to suboptimal provision of care and unwarranted clinical variation.

The rationale for this work was to consider the ideals of EBP and how to implement it in the world of MSK care. This chapter is a summary of the fully referenced, mixed-methodology study that was triangulated with published literature and information from public-facing forums and events, which is fully available online as an open access download.

MSKR’s Reforming Evidence Working Group have carried out a broad analysis of the perceived issues affecting EBP. This chapter proposes changes to the MSK industry’s relationship with evidence and comprises a set of policies addressing the following key themes:

- To support an evidenced-based culture
- To reduce unwarranted variation in clinical practice
- To address measurement and accountability
- To narrow the clinical-academic divide
- To enhance patient-centred decision-making

DEVELOPING AN EVIDENCE-INFORMED CULTURE

It has been reported that the culture within an organisation is essential for implementation of EBP. By promoting an EBP culture we can reduce the use of treatments with low efficacy whilst engaging in research to better our future practice. We cannot achieve this if the tools to build this culture are blunted by managerialism or hidden by layers of bureaucracy.

‘Managerial priorities are mainly regarding waiting times and clinical capacity. Improving individual clinical effectiveness is given low priority. Audit of clinical practice and time for professional development are not carried out on a regular basis.”

MSKR SURVEY RESPONDENT

MSKR advocate a roll out of the Oxford EBP framework with each clinician’s involvement evidenced in personal appraisals and integrated into performance measures. Based on the framework used in Oxford by Karen Barker, EBP Culture in the workplace can be achieved by enabling all staff to be actively involved in research but at different levels of engagement. This could be in one of three strands:

- Actively involved in research
  - for example NIHR fellowships/research schemes/charitable funds, split posts shared between research and clinical practice, involvement in National guideline development.
- Actively supporting research
  - for example supporting colleagues or being involved in portfolio work.
- Demonstrating EBP
  - for example being involved in critically appraised topics, evaluating research or guidelines in an area of clinical specialism, demonstrating how this has changed practice through audit or service evaluation.

MSKR will encourage universities to grant full literature access to a named research champion in all services employing 20 or more clinical MSK staff*. It has been demonstrated that MSK professionals prefer to use their colleagues as a source of information, with a trusted individual that is accessible. We feel that this will reduce the oft-stated barrier of poor literature access for clinicians and patients.

*MSKR recommends that smaller MSK services collaborate to meet the threshold of 20 clinicians. The figure 20 has been selected as it is felt to be a pragmatic one that is implementable based on the current number of UK MSK services and university schools teaching MSK disciplines.
In order for MSK care to be patient-centred, some variation in healthcare provision should be expected due to the inevitable differences in individual patient needs. Unwarranted variation in healthcare provision is the consequent use of these outcomes to provide both clinicians and the patients they offer, and also that they know how to apply that evidence to me - a unique individual.”

JOLETTA BELTON, PATIENT CONTRIBUTOR

In order to reduce unwarranted variation, we propose more widespread adoption of the synthesised evidence through Clinical Practice Guidelines (CPGs) to form the building blocks of our understanding of the efficacy of treatments. Guidelines have been criticised for being overly prescriptive and if used judiciously in conjunction with individual critical thinking, they can enhance patient care. To achieve this, MSKR will conduct a publicity campaign to MSK practitioners across the UK using a roadshow, podcasts, social media influence and by having a meaningful presence at professional forums and conferences.

MSKR will promote the need for additional NICE guidelines relating to MSK disorders. Currently there are very few NICE guidelines relating to MSK care. NICE recognise that MSK is an area for future development and MSKR will therefore work with NICE to keep this area high on their agenda through already established links to bring about changes for better MSK healthcare. To improve translation of best practice, one suggestion is that guidelines are developed in an easy to digest way to provide busy clinicians with quick and effective resources. One such way would be to develop ‘guidance at a glance’ documents in which recommendations can be condensed to a single side of paper. Current and somewhat underutilised resources such as NICE’s Clinical Knowledge Summaries could be more widely adopted.

MSKR propose increased use of knowledge translation strategies. Knowledge translation strategies have been shown to be effective in improving EBP if they are developed and implemented at a local level. Communities of good practice can develop and have already formed around the MSKR movement and others. In these groups a number of individuals with shared interests collaborate to address issues around EBP.

On review of the literature for universal MSK outcome measures, MSKR recommend the PSFS (Patient Specific Functional Scale) and MSK-HQ questionnaires. MSKR support Clinical Audit Awareness Week (CAAW) and pledges to produce specific MSK service audit resources as well as examples of MSK service audits to coincide with CAAW on an annual basis. We are delighted to be able to support an established and successful system and advocacy framework. Free resources are available from the Clinical Audit Support Centre (CASC) aimed to help define a topic, decide on metrics, capture data, set the standard, feedback the findings, create actions and measure the impact. We feel that this work should involve all staff within a service thus creating an EBP culture whilst developing the skills required for regular audit, comparison and wider sharing of data.

NARROWING THE CLINICAL-ACADEMIC DIVIDE

Barriers exist for clinicians wishing to access research. It could be argued that there is little responsibility or incentive for clinicians to be actively involved in research in many NHS and private MSK providers across the UK. This is for a number of clinical disciplines, such as Medicine, where responsibility to be involved in research has long been established.

MSKR advocate for the development of more clinical academic posts across the UK. Split posts (where an employee is employed in part by one organisation, such as an NHS Trust, to fulfil clinical responsibilities and in part by another organisation, such as a university, to fulfil research/teaching commitments) are proposed as a means of improving clinician involvement in research. As outlined earlier in this chapter, the benefits of co-operative contracts and closer links between institutions are numerous. Additionally it is in the best interests of all stakeholders for those with an aptitude for and interest in clinical practice and research to work across both roles.

MSKR propose the development of an up to date directory of resources for MSK funding streams. A significant challenge facing any aspiring researcher is the acquisition of funding. A live directory of resources could help establish the types of funds that are available from a variety of organisations. This directory will include brief descriptions of funds available, eligibility criteria, closing dates, website links and recommendations from previously successful applicants.

MSKR support the proliferation of open access journals and will lobby for a reformed business model to improve clinicians’ access to evidence. When applying for research funding we propose that funding for publication within an Open Access journal should be considered as a required step and in turn, researchers should submit to an Open Access journal as a preferred option. We also recognise the challenges faced by small specialist journals who rely on subscription funding which is why we will lobby for a reformed business model across the sector to better distribute resources in a fair manner. This conversation is long overdue and MSK professionals could lead the line on improving access due to the cross-over appeal of the discipline.

PATIENT-CENTRED DECISION-MAKING

Modern healthcare reforms place patient-centred decision making at the heart of the service. Clinicians must be able to align research skills, clinical reasoning and communication skills to offer patients informed choices about their management in a way that reconciles with the person’s values. Our qualitative analysis findings suggest that brief patient contact time as well as inconsistencies in training are barriers to creating an environment conducive to consolidating the evidence base with patient-centred decision making. This is in line with literature findings and resulted in suggestions for further training within a biopsychosocial framework incorporating critical thinking, communication and ‘soft’ skills, to facilitate good clinical practice.

‘The only way evidence can be incorporated successfully into care is to know the individual who is being treated and to understand that their story, their experiences are important data too’

JOLETTA BELTON, PATIENT CONTRIBUTOR

MSKR propose accessible mechanisms for patients to contribute to service audits and research projects relevant to their condition, circumstances and interests. It is becoming increasingly commonplace for patients and the public to be involved in research project developments and guideline development. It is less common to involve clinicians in patient and public involvement in research implementation, local service changes and local commissioning pathways. We advocate involving patients in all stages of research and its implementation.

MSKR support the integration of patients into decision-making structures in order to improve patient-centred care and governance in MSK services. Whilst a step in the right direction, we fear that integration of the patient voice in research planning and design is still too often taken to mean that care would involve top-to-bottom integration of public stakeholders whose experience interacting with the MSK industry has provided many of the prerequisites for expertise. MSKR therefore support the development of roles such as the Patient Director within the Sussex MSK Partnership.

In conclusion, we propose an integrated approach to evidence-based practice, which when coupled with a patient-centric perspective will ensure the best outcome for the patient and public.
“Listening to patient stories and reading qualitative literature gives us insights into what living with musculoskeletal conditions is like, what helps, and what doesn’t from the patients’ point of view, which can lead to more relevant research questions and successful clinical approaches.”

JOLETTA BELTON, PATIENT CONTRIBUTOR

EVIDENCE

“What matters to me as a patient is that my clinician knows the evidence for the conditions they treat and the treatments they offer, and also that they know how to apply that evidence to me - a unique individual.”

JOLETTA BELTON, PATIENT CONTRIBUTOR
CHAPTER 2
REFORMING CLINICAL GOVERNANCE
“We should aspire to a system through which we’re accountable for continuously improving the quality of professionals and services by creating an environment in which excellence in clinical care will flourish.”

JACK CHEW, MSKR DIRECTOR

Much like the kitchen in a restaurant, the underlying governance structure that supports an industry can be the cornerstone of success - or the cause of catastrophic failure. Only dishes prepared with precision, skill, planning and teamwork win critical acclaim. When food of this standard is sent out into the restaurant, it is the culmination of a process of development that cannot be seen on the plate, but without which standards would vary.

When aiming for success, one has to first avoid failure. Food poisoning of one individual is a major negative event, food poisoning of several is worse, food poisoning across several restaurants who share a supplier is worse still. In this example there might only be one safety error each time, but the point in the chain where the error occurs is relevant to the scale of the consequences. Let’s take this further and consider the agencies that are responsible for upholding the legal food safety standards and those who investigate incidents such as in this example. Imagine the scale of food poisoning that could occur if the regulations were lax and the investigations complacent. The differences between critical acclaim and catastrophic failure are the systems that govern safety and excellence.

When equivalent safety and quality errors are made in MSK practice, the consequences are often less overtly obvious and certainly less measurable but seldom less significant. Additionally, in the food industry example, a market force will exert itself due to the reputational damage caused by a food poisoning incident. In MSK practice most errors are more subtle, public expectation is less defined and long-term outcomes are less likely to influence public behaviour than short-term consequences; therefore market forces are unlikely to positively drive standards.

Initially coming to prominence in the NHS following the Bristol heart scandal in the 1990s, Clinical Governance was proposed as a system through which health service organisations are accountable for continuously building on the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

We live in a high-trust society in which there is an implicit assumption that the governance systems beneath the industries on which we rely are SAFE CREDIBLE UNIVERSAL REGULATED ASPIRING TO IMPROVE

We further assume that professionals within any system are held accountable to the same standards. When we take a closer look at both our MSK systems and the constituent MSK staff, are they fit for purpose? Or is MSK reform indicated?

Clinical Governance may not be at the top of a clinician’s agenda, may not resonate with all professionals and may not be a subject consistently taught as part of the undergraduate curriculum yet it is key to continuous quality improvement, which is important for all levels of patient care.

Clinical Governance needs to become an integral part of a clinician’s toolkit and a key component of every clinical service and clinician’s life. By doing this, it will underpin everything we do, become part of the clinical service process and not be seen as additional or challenging. It should be an integral part of setting up in private practice.

Physiotherapists make up a significant percentage of the UK MSK workforce and are recognised by the general public to be a trusted profession for the assessment and treatment of MSK conditions. MSK Physiotherapy is therefore a good test case for the following question:

Is the existing Governance of MSK Physiotherapy and Physiotherapists fit for purpose?

Physiotherapists play a crucial role in the treatment of MSK disorders and yet there is huge variation in support for delivering high quality care and best practice from both NHS and private providers.

This variation is not only confusing intra-professionally but also to our key stakeholders and has been identified as a barrier to providing consistent high value care.

The responsibility for ensuring the quality and safety of healthcare services lies with all involved. MSKR advocate for appropriate distribution of this responsibility to avoid an over-reliance on organisational governance where it exists and the hopeful complacency regarding individual clinician competence when it does not.

Although both the Health and Care Professions Council (HCPC) and the Chartered Society of Physiotherapy (CSP) set standards to ensure its registrants/members undertake safe and effective practice, there is a lack of validation, monitoring and inspection of services and individuals that leaves Physiotherapy practice open to under-regulation.

The current processes allow individuals to interpret the standards and regulations freely, which in turn allows large scope for misinterpretation.

MSKR recognise that a synergy between bottom-up and top-down contributions is the essential mechanism for any reform. Clinicians aspire to be better in services that aspire to be better.

This chapter will therefore suggest policies to:

Provide public assurance that all MSK services in the UK are continuously providing high quality care.

Provide public assurance that every MSK clinician they encounter is safe, competent and continuously delivering high-quality care.

CREATING ROBUST SYSTEMS

In the field of MSK care, systematic approaches to the promotion of quality improvement are far from ubiquitous. There are certainly organisations that have embedded Clinical Governance into their delivery model but there does not appear to be a mechanism for spreading best practice to other organisations or indeed a compelling external driver to mandate or promote this.

“As a patient I feel totally reliant on the clinical governance systems and the regulatory bodies to ensure safe and quality of care for me. I live in hope that the systems are good.”

TINA PRICE, PATIENT CONTRIBUTOR

MSKR recommend that Physiotherapists be included in the CQC list of registrants required to be registered under the regulated activity of “Treatment of disease, disorders or injury”. The independent regulator of health and social care is the Care Quality Commission (CQC), whose role is to register health and adult social care service providers in England and to inspect whether or not standards are being met. The CQC does not require Physiotherapists to be registered with them for the regulated activity of “Treatment of disease, disorders or injury”. On the contrary, Physiotherapists are currently listed as being out of the scope of the Health and Social Care Act 2008 for this regulated activity. This means that any standalone treatment services run by Physiotherapists are not required to register and therefore will not be inspected by the CQC. Physiotherapists who are licenced to prescribe medication and/or deliver injection therapy procedures are also currently not required to register with the CQC or the HCPC.

MSKR will lobby for legislation change to the Health and Social Care Act 2008. MSKR recommend that this is also extended to other MSK professionals whilst also recognising the category challenges involved in this. Osteopathy, Podiatry and Occupational Therapy are the fellow Allied Health Professions with significant MSK workforces. On a pragmatic level, extending this policy to these disciplines in the first instance would perhaps encounter fewest barriers.
MSKR advocate for the development of an accreditation process from which MSK services can aspire to a quality standard mark. MSKR acknowledge and support examples of voluntary accreditation schemes such as SEQOHS (Safe, Effective, Quality Occupation Health Service), which provide independent and formal recognition that occupational health services are competent in delivering services that meet SEQOHS standards. SEQOHS accreditation is recognised and respected as a badge of quality. We currently have no such MSK accreditation scheme in the UK and so MSKR will work with partners across disciplines to produce a respected kite mark for MSK services.

MSKR propose that all providers of MSK services mandate governance training into their induction programmes and ongoing mandatory training. MSKR support the integration of Clinical Governance education in every level of MSK courses. Clinical Governance frameworks as a method of promoting clinical governance are, in most instances, the responsibility of the provider organisation to implement. A ‘systems’ approach embedded within service design aims to support and influence clinical behaviour and standards of care. These frameworks are designed to support the individual clinician delivering patient care but is the individual clinician devoid of responsibility with regards to Clinical Governance? This should not be the case. In the reverse instance, services without robust Clinical Governance frameworks are, in theory, completely reliant on the conscientiousness of individual clinicians. Clinical Governance education should therefore begin in undergraduate training and thereafter be integral to professional career-long learning.

MSKR advocate for the development of a National MSK Clinical Governance framework which is applicable to all who practise in the MSK speciality. The design of any MSK service should enable every staff member within the organisation to understand and contribute to service issues, processes, safety and clinical quality. The culture that would underpin this is key and should be one of positivity, openness and no blame, whilst also being professional, challenging and promoting responsibility and accountability. It is clear that all services offering MSK care should be operating within a robust Clinical Governance framework to drive quality improvement. This framework should ideally have universal applicability across the varying MSK sectors, including NHS services, private MSK organisations, individual practitioners, occupational health providers and sporting organisations. The setting of MSK services can vary hugely but the operational standards, accountability, safety and responsibility towards improvement should show consistent baseline competence and an aspiration towards advancement of quality. MSKR and its partner organisations are well equipped with the knowledge and workforce to create a blueprint of best governance practice.

CREATING ACCOUNTABLE CLINICIANS

1. We felt the HCPC continual professional development audit process didn’t particularly prove that I am a safe or effective Physiotherapist. There was a requirement to write about how the evidence submitted proved you were providing an effective service. Luckily, I had a large amount of evidence to submit, but to be honest I could have made it up. All that the process proved was that I can gather some documents together and write about them in a way that met an arbitrary pass/fail threshold- recently audited Physiotherapist.

The public not only need assurance that providers and services are safe and consistently delivering high-quality care, but also should be confident that the therapists involved in their care are properly trained, qualified and competent, will treat them with dignity and respect, not mistreat or harm them and will endeavour to continuously deliver high-quality care.

The HCPC are the statutory regulators for sixteen health and care professions including Physiotherapists. For a Physiotherapist to remain on the HCPC register, they go through a re-registration process in order to demonstrate their adherence to the standards set by the HCPC.

This re-registration process occurs every two years and the current requirements are:

A signed professional declaration by the Physiotherapist that they have read and will comply with the standards of proficiency, conduct, performance and ethics and that they have read and will comply with the standards for CPD.

2.5% of Physiotherapy registrants are randomly selected and audited against the following CPD standards.

The HCPC views the CPD standards and audits for registrants as a robust process for determining continued fitness to practise. The justification is that the sixteen professions regulated by HCPC are of low risk to the public and so the requirements are based on right-touch regulation principles - the minimum regulatory force required to achieve the desired result. However, the HCPC acknowledge that whilst registrants carry low risk of poor competence they have a high incidence of unprofessional behaviour. Unprofessional behaviour is largely addressed by the HCPC through their Fitness to Practise investigations and reliance on concerns being raised by members of the public, employers, the police and other health care professions.

We feel it is reasonable to expect that a regulatory body that publicly recognises its registrants are at high risk of unprofessional behaviour should diligently manage its fitness to practise thresholds and processes. However, this does not appear to be the case. The HCPC is regulated by the Professional Standards Authority (PSA) who publish an annual review of the HCPC’s performance. In the Performance Review 2017/18 and 2018/19 there were six standards that the HCPC were failing to meet in the area of fitness to practise. A stand-out failing highlighted by the PSA is the inconsistent and often inappropriately high threshold for investigation of a fitness to practise case. Since 2006 it has been compulsory to undertake CPD as part of re-registration but as aforementioned, the process selects relatively few registrants to self-report their activities whilst encouraging the masses to participate in CPD CPD audit and the self-declaration assessment. Both of which form the basis of continuing to practise, are entirely based on self-assessment and lack external validation of the evidence submitted. This makes the process unreliable and open to possible fabrication of submitted evidence. The lack of third party adjudication also increases the risk that registrants self-certify themselves as meeting minimum standards when they do not. This approach does not safeguard patients or facilitate the identification of dependency-based medicine into practice. nor does it take into account the variation in quality and applicability of CPD courses in MSK practice.

Within the audit itself, it is possible that MSK Physiotherapists could be grossly under-represented and also that many clinicians will go through their careers unaudited.

55,560 Physiotherapists are currently on the HCPC register.

2.5% of registrants are selected to submit their CPD profile, which includes Physiotherapists from all specialties within the profession.

54,171 practitioners left unaudited every 2 years.

In 2016 the Department of Health (DoH) commissioned a study to answer the question: “What is the evidence for assuring the continuing fitness to practise of Health and Care Professions Council registrants. Based on its Continuing Professional Development and audit system?”

The following recommendations were made to the DoH by the comprehensive study:

- To review the HCPC Continuing Fitness to Practise system with regard to aligning the HCPC system with existing parallel systems of staff appraisal. This would ensure congruency and increase the robustness of a system currently based entirely on self-assessment. We anticipate this would increase public confidence.

- To further clarify for the benefit of registrants that the primary aim of the HCPC CPD Standards is to drive up the quality of practice and not to identify poor performance.

- To consider creating an online facility to enable registrants to log CPD activity and support an audit-ready philosophy.

The HCPC should consider contacting employers when registrants are invited to be audited, and request that time be provided to ensure registrants have time to compile their CPD profile.

To request that as a standard, all CPD profiles should be validated by a line manager or include third party evidence.

To limit the number of times a registrant can be asked for additional evidence to meet the HCPC CPD Standards.

Consider providing qualitative feed-forward advice following audit submission.

The HCPC should advise employers that an appropriate level of protected time should be provided within working hours for CPD.

The HCPC should advise on the best use of protected CPD time to offer the best return on investment. Perhaps due to the current political climate here in the UK, it would seem that this study has not made the impact it should have.

We believe it is time to resurrect some of these recommendations and start making the necessary changes to fully validate our regulation process in order to give the public the assurance it should provide.
MSKR propose a phasing out of the current CPD audit process for Physiotherapists and HCPC registered MSK professions. Illing and colleagues in 2016 made recommendations regarding improvements to the existing CPD portfolio audit process. MSKR instead deem the existing model to be unfit for purpose, therefore working on improvements would be futile in solving the problems identified. MSKR will work with its partner organisations and the PSA to identify which regulatory body has a re-registration process closest to best practice. The General Medical Council (GMC) and the General Osteopathic Council (GOC) are examples of profession-specific bodies with direct PSA relationships in contrast to professions such as Physiotherapy and Podiatry which are answerable to the PSA via the HCPC. A working group is indicated to investigate how this direct relationship influences the upholding of quality standards.

MSKR recommend a mandatory annual appraisal as a requirement for all MSK Practitioners, which will include agreed supporting evidence aligned to HCPC (or subsequent regulator) standards. MSKR advocate to aligning the re-registration process with an appraisal system similar to that of the GMC, which involves a nominated (trained) appraiser and supporting evidence.

GMC revalidation is not without its flaws, but demonstrates the essential requirements for such a system to be effective, namely a skilled appraiser, a relationship with registrants based on trust and resources to help professionals and organisations use the process fruitfully.

MSKR recommend that all annual appraisals should be uploaded onto a HCPC (or subsequent regulator) database to ensure compliance assurance. The digital infrastructure upgrade required for this is minimal, yet the improvements in accountability it would bring are significant. Services, clinicians and patients would benefit from an efficient system of mandated reflection and justification of practice to a peer.

MSKR propose that for re-registration, the HCPC should audit 2.5% of a registrant’s submitted appraisals against compliance standards. This is a minimum number based on the current percentage in use. For pragmatic reasons, our policy does not increase the workload of the regulator and compared to other professions such as Medicine (100% every five years) this proposed percentage is very low.

MSKR propose that each HCPC Fitness to Practise audit should include a declared percentage of registrants from a variety of settings and be represented by a percentage from each of the 48 counties in England. An uneven distribution of registrants called for continuing professional development audit by therapy discipline, care sector and geographical location is assumed based on the low number of audited therapists. To understand whether this is a factor that requires correction, we first need better transparency from the HCPC as to how many clinicians from each of the aforementioned demographic categories are revalidated under the current system.

CONCLUSION

Encouragingly, the HCPC, the DoH and the PSA are aware of the need to review and reform the ‘Continuing Fitness to Practise’ process. The DoH has proposed a new cycle of reform in the regulation of healthcare and undertook a consultation into the role of the current nine health regulators entitled ‘Promoting Professionalism, Reforming Regulation’. Their rationale was in part to raise the profile of regulation in the public eye and improve public trust in healthcare professionals in the wake of publications like the Francis Report.

Under pressure from MSKR and others organisations, the HCPC and PSA have adopted the language of reform. The following series of consultation papers make for interesting reading as they corroborate many of MSKR’s findings and proposals:

- PSA ‘Rethinking Regulation’ (2013)
- PSA ‘Regulation Rethought - Proposals for Reform’ (2016)
- DoH ‘Promoting Professionalism, Reforming Regulation’ (2017)
- PSA ‘Right-touch Reform’ (2017)
- HCPC Consultation on HCPC Registration Fees
- DoH ‘Government response to consultation - Promoting Professionalism, Reforming Regulation’ (2019)

Respondents suggested a wide variety of options for reconfiguring the regulatory bodies. The most frequently suggested model (75 responses) was to reduce the current set of regulatory bodies to three separate bodies covering doctors - nurses - all other professionals.

The second most frequent suggestion (68 responses) was to extend the remit of HCPC. Responses ranged from amalgamating the smaller professions under HCPC to HCPC becoming the single regulatory body for all regulated professions.

The UK and Devolved Governments believe that a case can be made for fewer regulatory bodies, but acknowledge that more work is needed before bringing such a proposal forward. The UK and Devolved Governments will consider how best to develop proposals to reconfigure the professional regulation landscape. Any proposals to reconfigure the regulatory bodies will be subject to public consultation.


GOVERNANCE

“AS A PATIENT I FEEL TOTALLY RELIANT ON THE CLINICAL GOVERNANCE SYSTEMS AND THE REGULATORY BODIES TO ENSURE SAFE AND QUALITY OF CARE FOR ME. I LIVE IN HOPE THAT THE SYSTEMS ARE GOOD…”

TINA PRICE,
PATIENT CONTRIBUTOR
CHAPTER 3
REFORMING CLINICAL EDUCATION
Unsurprisingly, every conversation on the topic of reform visits the subject of Education. Through education, consensus is formed and, just as this Manifesto intends, a reformative agenda can emerge and be enacted. Since the very first #TheBigRs event in November 2017, round table discussions on all things ‘education’ have been central to the MSKR movement and yet this has not been without controversy. Whilst not distinct from each other, the following educational themes consistently emerged:

- Patient education
- Undergraduate education
- Clinical education
- Postgraduate education
- Continued professional development
- Public education

As discussed at length in Chapters One and Four, evidence-informed practice has led us to especially value patient-centred care, holistic biopsychosocial reasoning and interpersonal communication skills. The only feasible mechanism to educate the MSK workforce on these and other key factors is through patient exposure coupled with reflection, a process best known as clinical education. Clinical education has long been highly regarded across healthcare and we recognise that we are far from the first group to highlight it as a priority. We are however seemingly uniquely concerned by the lack of urgency to improve consistency and appropriately universalise clinical educational standards.

The patho-anatomical and patho-kinesiological models of diagnosis are failing to capture the complexity of the current population and the structural and physiological mechanisms of what were assumed to be ‘corrective’ interventions continue to be challenged. Whilst even biomedical models and methods required practice-based clinical education for their application, there are far more inherent ‘rights and wrongs’ and binary yes or no answers in these systems that better lend themselves to classroom and textbook education. MSK professionals need exposure to contemporary MSK practice and the time to reflect on what they encounter throughout their career, particularly in the current climate of pain knowledge.

For these reasons, our Working Group prioritised clinical education and used a variety of mixed methodologies to identify problems, forge consensus and propose solutions. There is a long history of practice-based clinical education across the MSK professions, but the most integrated with frontline public healthcare is that of Physiotherapy student placements.

Clinical education and the supervisory process it involves is an important component of pre-registration Physiotherapy education.

Student Physiotherapists in the UK are required to undertake at least 1000 hours of clinical placements, which provides the opportunity for students to apply their academic knowledge and skills as well as develop their professional social skills, both necessary prerequisites for their career as a Physiotherapist. Despite universal acknowledgement of their importance, securing clinical placements for students has become increasingly difficult in recent years. In a contemporary healthcare environment where clinical staff are challenged by increased workload demands as well as an ageing and more medically complex population, there are many factors for a department to consider before offering a student placement. This can lead to inconsistency and inequality in students’ learning experiences as well as varying standards of clinical teaching and levels of motivation among clinical educators. Furthermore, several additional factors have been cited as potential influencers of the success of a clinical placement:

- Attitudes of the student
- University preparation
- Self-confidence in fulfilling the clinical educator role
- The student-clinician relationship

Placements are an essential component of training and a fundamental means of developing a graduate from a layperson to an entry-level professional. Placements are incredibly rich experiences that place into context the many hours spent in the classroom and behind a desk studying. However, every placement for every student is a heterogeneous experience as demonstrated by this account of two very different placements by one of our student contributors:

**A TALE OF TWO MSK PLACEMENTS**

**Placement 1**

Although I was a very junior Physiotherapy student, I came to realise that my educator’s clinical reasoning was linear and formulaic. Patients had either a ‘weak core’ or ‘weak glutes’ and this was presented as the root of their problems.

**Placement 2**

This time my clinical reasoning was constantly discussed throughout my placement: they cared about why I thought something, not just what I thought. It was clear that my educators were current with the evidence base as they would email me relevant papers, podcasts and other resources before discussing them with me.

**CLINICAL EDUCATION QUALITY**

A selection of UK Physiotherapy students were asked to reflect on what factors make for a good MSK clinical educator? Their answers were bold, but did not surprise our Working Group:

- ‘They don’t really have to be the most competent nor experienced Physiotherapist’
- ‘They need to be comfortable with the unknowns of MSK presentations and admit it’
- ‘They should encourage a person-centred, BPS approach’
- ‘They are comfortable discussing and using current evidence to guide decisions’
- ‘They should encourage questioning’
- ‘Although they may be trained in particular treatments or have biases, they should still engage in critical discussions surrounding these and be flexible around/understanding of different approaches to different patients/presentations/conditions’

When reflecting on the thoughts of their peers and following wider discussions with the patients, academics, and clinicians in the Working Group, our student contributors posed the following hypothetical question that then drove several of this chapter’s policies:

- ‘Wouldn’t it be nice if your next educator was as good as your best educator?’

MSKR propose a clinical educator online learning resource to support clinical educators offering MSK placements. The 2017 HCPC Standards of Education and Training stipulate that clinical educators must undertake regular training, which is appropriate to their role, the learners’ needs and the delivery of the teaching outcomes of the programme. Each UK University provides clinical educator training to ensure educators have the relevant knowledge, skills and experience to support safe and effective learning. There is significant variability however in how this is delivered as no universal standard exists currently.
MSKR propose that the MSK placement learning resources referred to above and the model for creating them have the potential to be shared with other professions including:

Other MSK professions
(Osteopathy, Chiropractic, Sports Rehabilitation etc)

Other disciplines within Physiotherapy
(Neurology, Respiratory, Paediatrics etc)

Other Allied Health Professions
(Occupational Therapy, Speech and Language therapy, Dietetics etc)

Medicine

MSKR advocate for a respected MSK educator credentialing process to be developed.

The CSP previously launched the Accreditation of Clinical Education (ACE) scheme in 2004. Developed in collaboration with all UK Higher Education Institutions (HEIs), the scheme offered standardisation of the quality of training for clinical educators and allowed a Physiotherapist’s calibre as a clinical educator to be recognised formally. The scheme was discontinued because it did not gain a strong level of currency within the profession and was considered a distraction from a more strategic approach to practice-based learning. MSKR is confident that the aforementioned clinical educator resources could be delivered online or through the use of a blended learning approach.

CLINICAL EDUCATION QUANTITY

We feel that improving MSK placement quantity is a priority, but would struggle to argue that a poor placement is worse than no placement at all. In the UK, the MSK professions are growing rapidly due to rising numbers of university places, exemplified by a 41% rise in Physiotherapy places over four years. Developing more practice-based learning opportunities is a priority to meet future workforce demands and yet significant barriers exist that are stalling progress.

MSKR propose a promotional campaign which highlights the positive impact of student placements on productivity of MSK services.

Models such as Connect Health’s 2:1 educator system have shown it is possible to run student placements that maintain or even increase capacity. This productivity increase is not at the cost of patient and student satisfaction feedback, which remains high and stable throughout the placements. MSKR will develop and promote the business case for productive MSK placement models and provide resources via our online clinical educator resource.

MSKR advocate a universal code of conduct detailing the responsibilities of HEIs, clinical educators, students and service providers before, during and after student placements.

It is a challenge to appropriately manage expectations for MSK placements when, as suggested, the variation in quality is so significant. The largely undiscovered roles and responsibilities of all involved parties in clinical education add further difficulty. For example, what is explicitly expected of the student, the educator, the university and the service provider? Every placement has its own unique features that are most often covered in a local induction and discussed internally early in a placement. However, a significant number of responsibilities could be made universal across MSK placements and distributed fairly and explicitly between the four main parties. For example, we propose a local induction, which is expected by the student and delivered by the clinical educator in time allocated by the service provider. We feel that expectations and responsibilities such as the constituent parts of an induction should be declared and signed to in a universal code of conduct. This would provide clarity over what is expected of each involved party on a placement and offer a point of reference in case of disputes, thus reducing misunderstandings that can often compromise a placement experience.

THE GRADUATE SKILL GAP

In a young and ever-evolving discipline like MSK, there are few traits more important than a commitment to life-long learning. The idea that clinical education stops after a student’s final placement is of course nonsense, but for those wishing to specialise in MSK practice as a graduate, the quality of learning opportunities varies significantly.

The realities of the UK health economy including an ageing and ailing population, an intergenerational inactivity crisis and a struggling NHS with demands exceeding its budget have contributed to depleting education budgets and decreased mentoring time. Pockets of good practice exist whereby services are providing high quality teaching and mentoring to aspiring MSK professionals but there is no scope as yet for those practices to become a blueprint for universal quality.

Preceptorship: “A period of structured transition for each newly-qualified healthcare professional during which he or she will be supported by a preceptor to: develop his or her confidence and competence as a professional; refine skills, values and behaviours; and to continue his or her journey of life-long learning.”

Health Education England, 2018

Providing support to health professionals through preceptorship has long been advocated as a way of improving care and workforce retention and some healthcare professionals already benefit from well-established schemes: the strongest evidence of benefit existing in the nursing profession. Benefits of preceptorship extend to all stakeholders including the individual practitioner, preceptor, employer, the service user and the profession itself.

Across the MSK professions, UK HEIs currently have no responsibility to their alumni following graduation. Whilst this is not necessarily different to most degree courses, as has been mentioned previously in this document, the MSK industry is currently in a major transformative period and a graduate cannot be expected to be a thoroughly competent MSK clinician after just three to four years of undergraduate study—only part of which is MSK focused. We can find no evidence that UK tuition fee increases and the removal of universal tuition fee bursaries for certain MSK professions (Physiotherapy, Podiatry, Occupational Therapy) have led to improved student experience, learning outcomes or employability.

We feel that an extended duty of care from HEIs to their graduates is the most cost- and resource-efficient method of adding value to degrees in MSK disciplines.

MSKR propose a formal, universal preceptorship pathway for graduates aspiring to MSK Excellence.

As ever, we advocate for developed and distributed responsibility and so propose the ‘Triad of Responsibility’ model for post-graduate MSK preceptorship. A model which involves three key stakeholder groups committing time and other resources to pursue MSK excellence beyond registration via clinical education.

Whilst it is out of the scope of this Manifesto to present in detail the proposed MSKR preceptorship model, we feel it is important to outline some of the shared responsibilities and prospective rewards for HEIs, service providers and graduating clinicians.

MSKR recognise the varied early-career routes that can lead to MSK specialisation from immediate MSK private practice roles to rotational NHS roles and Physiotherapy apprenticeships. To account for this variety we propose that the MSKR preceptorship programme be made available for two years within the first four years post-graduation.

‘The principles of preceptorship can also be applied to any qualified and experienced healthcare professional transitioning to a new setting, or returning to practice after a career break.’

HEALTH EDUCATION ENGLAND, 2018
MSKR propose a process for MSK professionals who have been long graduated to complete the credentialing element and engage with the mentoring component of the preceptorship programme detailed in the previous policy.

We would argue that the MSK industry is in a state of transition with many long-assumed causes of pain, injury and disability being re-evaluated and many long-assumed influencers of recovery being challenged. A way in which MSK professionals who aspire to clinical excellence can achieve this through a recognised process of clinical education is long overdue. Existing models such as those developed by the Musculoskeletal Association of Chartered Physiotherapists (MACP) and Institute of Osteopathy (IO) for example should be reviewed in-depth to identify successes and limitations. MSKR would like to work with these professional bodies and other partner organisations to universalise a mark of MSK competence that is appropriately detached from single MSK disciplines and interventional modalities.

“One of the biggest challenges I faced transitioning from a student to a newly-qualified Physio was that I felt I had to ‘prove’ my competence to my colleagues as they had such varying expectations of newly-qualified Physios. I believe this was mainly because in the current education system there is such a range in quality and abilities of newly-qualified Physios that at the very start you have to prove your competence until you have gained the trust of your colleagues. However, following this initial period you are then ‘let loose’ and this can seem somewhat overwhelming as it often means you can feel unsupported whilst also often being given unrealistic caseloads with few teaching opportunities to consolidate knowledge and skills.”

NEW GRADUATE PHYSIOTHERAPIST

EDUCATION

“I FELT I HAD TO ‘PROVE’ MY COMPETENCE TO MY COLLEAGUES AS THEY HAD SUCH VARYING EXPECTATIONS OF NEWLY-QUALIFIED PHYSIORS. I BELIEVE THIS WAS MAINLY BECAUSE IN THE CURRENT EDUCATION SYSTEM THERE IS SUCH A RANGE IN QUALITY AND ABILITIES OF NEWLY-QUALIFIED PHYSIORS”

NEW GRADUATE, CONTRIBUTOR
Clinical Excellence is our aspiration in MSK Practice but it is difficult to define and in so doing we risk limiting the creative edge of the profession or promoting an expertise model lacking evidence-informed validity. However, we believe that a definition of Excellence is worth pursuing to minimise variation in practice, which creates confusion for clinicians and more importantly for patients.

Reforming Clinical Excellence has been a popular table discussion at MSKR events, a popular theme for online debate and the most popular Manifesto Working Group with many more applicants than spaces. However, for the reasons outlined above, it is perhaps the most challenging topic to channel into this format.

In MSK practice, both evidence and experience lead us to hold subjective assessment findings in high regard. In much the same way, the opinions of the large volume of clinicians, thinkers and patients that have shared their subjective takes on what constitutes Clinical Excellence should be valued and respected. If something is important enough it should be included, regardless of whether it suits the format that this Manifesto has assumed.

“A reduction in all types of unwarranted variation will increase value for individual patients and for populations, ensuring that the right people are given the right care in the right place at the right time.”

MATTHEW CRIPPS, DIRECTOR OF RICHGATE, NHSG ENGAND

Similar concerns to those mentioned above regarding ‘best practice’ and Clinical Excellence are often voiced in discussions surrounding the popular term ‘unwarranted variation’. This term has been thoroughly discussed at every MSKR event to date, as well as across a wide variety of healthcare settings. Despite the best efforts of many, conversations consistently break down when attempts are made to quantify and qualify the term ‘unwarranted’.

In MSK practice, several diagnostic frameworks, treatment modalities and reasoning heuristics have become wedded to people’s identity and sense of self. The fear therefore that their modalities and reasoning heuristics have become wedded to variation in practice. Which creates confusion for clinicians and more importantly for patients.

Clinical Excellence is our aspiration in MSK Practice but it is difficult to define and in so doing we risk limiting the creative edge of the profession or promoting an expertise model lacking evidence-informed validity. However, we believe that a definition of Excellence is worth pursuing to minimise variation in practice, which creates confusion for clinicians and more importantly for patients.

Perhaps the most well-known use of the term Clinical Excellence is as part of the original title for UK special health authority. NICE (National Institute of Clinical Excellence) NICE produce condition-specific guidelines through a rigorous process of evidence reviews by multidisciplinary experts. As mentioned in Chapter One of this Manifesto, relatively few MSK conditions have NICE guideline recommendations and yet even if they did, few would argue that Clinical Excellence in MSK practice is best demonstrated by the letter adherence to guidelines.

Certain characteristics, skills, attitudes, habits and values appear consistently in conversations around Clinical Excellence and their antonyms appear frequently in conversations around poor practice. Whilst MSKR do not profess to have refined a methodology that fully resolves the aforementioned issues, we do not feel comfortable with the current absence of any statement of values to aspire to.

MSKR are willing to state:

Our take on the core values recognised in Clinically Excellent practitioners

How these values are supported by the policies in adjacent chapters of this Manifesto

Further specific policies, which we feel will optimise the chances of achieving consistent Clinical Excellence across MSK practice.

DEFINING EXCELLENCE

Part of our chapter details ten attributes that we feel are most recognisable in Excellent MSK Clinicians. These attributes are promoted and reinforced by the policies detailed in previous chapters of this Manifesto and so are internally referenced. We feel that these policies will hold clinicians accountable to these attributes; thus promoting Excellence.

MSKR propose that Clinical Excellence is delivered by clinicians who value:

Patient-centred care

Excellent clinicians recognise that patient needs, patient goals and patient outcomes should be central to care. They afford patients uninterrupted time to articulate their story and work with them to identify meaningful and personalised goals. Complexity is inherent to pain because complexity is inherent to people. Excellent clinicians embrace this complexity and seek to ensure that all aspects of care are in the patient’s best interest and that options are thoroughly clarified and decisions sufficiently reasoned.

MSKR policies to assist patient centred care

Outcome measure use [Ev9]

Guidelines [Ev6]

A holistic biopsychosocial model

Excellent clinicians recognise and account for holistic factors affecting a patient’s symptoms. A biomedical model of care that is concerned exclusively with pathology of structure or system is inadequate for a contemporary understanding of MSK practice. Adoption of a biopsychosocial patient care model that acknowledges a wider variety of specific and non-specific contributing factors to symptomology is a necessary step forward in order for MSK practice to remain cohesive with the evidence base. We add the word ‘holistic’ to this term as a reminder that Excellent clinicians do not reduce a patient’s experience to biological, psychological or sociological factors. Only a holistic all-encompassing model that recognises and values all possible contributing variables is in line with our take on Clinical Excellence.

MSKR policies to promote a holistic biopsychosocial model

Inclusion in best practice guidelines [Ev6]

Protected learning time [Ev2]

Communication skills

Excellent clinicians seek to hone their communication skills in order to better articulate their thoughts to patients, colleagues and beyond. Whilst Excellent clinicians over the decades have sought to optimise their communication skills to optimise outcomes, we argue that contemporary MSK practice involves a level of patient engagement far beyond that of past healthcare generations. When we perceived that tissue integrity was strongly correlated to symptoms and that the success of our manual techniques was related to our ability to positively influence scar tissue, how well we communicated with patients seemed to matter less. Now, an honest answer to the infamous ‘why does it hurt?’ question is often so counter-intuitive to a patient that the conversation becomes a negotiation. Excellent clinicians are collaborative but persuasive. They exude credibility not by dictating a plan but by identifying common ground and communicating a coherent, scientifically robust route to the goals set by the patient.

MSKR policies to assist communication skills

Skills training for educators [Ed1]

Communication abilities monitored in appraisals [Cov8]

CHAPTER FOUR

ASPIRING TO CLINICAL EXCELLENCE

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MANIFESTO FOR REFORM
EMPOWERMENT

Excellent clinicians trust patients to make informed decisions once the patient is fully equipped to make choices about their care. As MSK patients are themselves best placed to understand how their symptoms are impacting their life and how they can influence that, a likely common goal is for them to be able to self-manage their condition. Excellent clinicians identify when it is appropriate to lead and when to stand shoulder to shoulder with patients and be led at different stages of the recovery journey. This integrated model of patient empowerment is central to a quality therapeutic alliance as it demonstrates respect and trust between clinician and patient.

MSKR policies to promote patient empowerment:
- Consistent use of outcome measures [Ev9]
- Universal appraisal [Gov8]
- Clinical reasoning

Excellent clinicians value clinical reasoning over algorithmic decision-making. They recognise the need to hold a diagnosis under review over the course of treatment so that further information can influence care in real time. Differential diagnoses would be frequently considered, as would all factors that could be making the symptoms and/or prognosis atypical. Excellent clinicians reason between treatment methods by considering the desired mechanisms of effect, the supporting evidence, the compatibility with patient needs and other complex variables. Quality clinical reasoning is embodied and encompasses all of the aforementioned attributes of Clinical Excellence.

MSKR policies to promote clinical reasoning:
- Preceptorship training [Ev5] which aims to build skills post-qualification
- Access to journals/guidance throughout career [Ev12]
- Protected learning time [Ev2]
- Oxford EBP scale within appraisals [Ev1]
- Excellence programme [Ed6]
- Evidence-informed care

Excellent clinicians value scientific enquiry and stay up to date with the MSK evidence base. They endeavour to use reliable and validated examination techniques as well as treatment methods that have been demonstrated to help patients reach their goals in clinical research. In the likely absence of definitive research that suggests an indicated care plan for an individual patient. An Excellent clinician delivers patient-centred care that is informed by evidence⁶⁸. Evidence-informed clinicians do not rely on specific guidance and compliance with diagnostic criteria but deliver care that is plausible in terms of what is scientifically known within MSK and overlapping fields of study.

LIFELONG LEARNING

Excellent clinicians consolidate their knowledge but do not assume that they know most of what is to be known in MSK practice. The confidence that a Mathematician or Physicist might have about the base reality and the coherence of rules would be blind arrogance in the still developing and changeable landscape of MSK practice.

MSKR policies to assist lifelong learning:
- Annual appraisals throughout career [Gov8]
- Access to journals [Ev12]
- Protected learning time [Ev2]
- Formal preceptorship programme [Ed6]
- Universal post-grad opportunities [Ed7]

REFLECTIVE PRACTICE

Excellent clinicians recognise the need to pause and reflect on the care they deliver, their development and the balance of their broader skill set. Reflective practice assists self-awareness, which in turn often enhances the approachability and humility of the clinician.

MSKR policies to assist reflective practice:
- Submitted reflections for annual appraisals [Gov8]
- Protected learning time [Ev2]
- Online learning resource for clinical educators [Ed1]
- Critical thinking

Excellent clinicians recognise the variety of options available to them and their patients at any given moment. Therefore the ability to think critically, rationally, objectively and where necessary, sceptically about a topic or decision is a valuable asset.

MSKR policies to assist critical thinking:
- Access to journals [Ev12]
- Best practice guidance availability [Ev6]
- Preceptorship programme [Ed5]
- Shared Decision-Making

Excellent clinicians understand that their broad professional expertise is different to the narrow personal expertise of each individual patient. The lived experience of each patient is relevant to their presentation and journey to recovery, therefore understanding it as best possible is paramount. Excellent clinicians respect the patient’s expertise and allow the decision-making process to be an equal partnership in working towards set goals⁶⁹.

MSKR policies to enhance shared decision-making:
- Outcome measure use in all MSK patients [Ev9]

As discussed in the introduction to this chapter, it is deemed by some to be controversial to even point out the attributes of Excellent clinicians. However, even if we simply examine the direct opposites of our top ten attributes, they go a long way towards describing the characteristics we might recognise in ‘poor’ MSK clinicians without merely stating the more obvious adjectives such as ‘unsafe’, ‘incompetent’ and ‘unprofessional’.

ACHIEVING EXCELLENCE

We hope that our attempts to define Clinical Excellence move the conversation forward in an area that too often stalls due to conflicts over small differences. Even if this non-exhaustive set of attributes was to be fully embraced and promoted, we feel that further reforms would still be required to achieve Clinical Excellence. MSKR feel that the enacting of the following four key policies would lead to a higher consistency of Excellent care and would support the reforms outlined in the preceding chapters.

MSKR proposes a central, digital library of best practice guidance for common MSK presentations that are efficiently peer-reviewed for quality, clarity and brevity. As acknowledged in the first chapter of this Manifesto, best practice guidance is a pragmatic synthesis of the available evidence applied to real-world clinical contexts. Every day, patients present to MSK clinicians with some version of the question; ‘what is the best way to get this/ me better?’ Understandably, few would accept the answer ‘We don’t know yet, the science is still very young’, but for most MSK conditions, especially in terms of dose response, patient profile and timing, this would be an honest one.

If we accept that Clinical Excellence can and does exist and that it is delivered by clinicians whose attributes match the list detailed above, best practice guidance created by collaborations between clinicians we consider to be excellent would be of value. The strongest argument that we have encountered against such guidance is based on the fear that this becomes recipe-like, non-critical and risks being under-reviewed.
Some feel that we risk replacing old dogma with new dogma that will be equally difficult to replace. We recognise this risk but argue that if this was the case, the contributing clinicians would not meet the above criteria and would not therefore be excellent by MSKR’s definition, namely failing to demonstrate critical thinking, evidence-informed care, shared decision-making and prioritising clinical reasoning over recipes.

MSKR feel that the enacting of this policy would promote Clinical Excellence by improving public and professional access to high quality evidence-informed guidance.

Some feel that we risk replacing old dogma with new dogma that will be equally difficult to replace. We recognise this risk but argue that if this was the case, the contributing clinicians would not meet the above criteria and would not therefore be excellent by MSKR’s definition, namely failing to demonstrate critical thinking, evidence-informed care, shared decision-making and prioritising clinical reasoning over recipes.

With this in mind, many therapists across disciplines have embraced human complexity and made the primary rationale of treatment to scale an individual’s function from where they are at this given moment in their life to where they wish to be post-treatment. Quality rehabilitation accounts for the commonalities of basic human needs such as breathing, eating, sleeping, reproducing, washing, moving and working, combined with the diversity of each individual’s requirements and goals.

MSKR plan to work with partner organisations across all professions and disciplines to promote graded functional rehabilitation as a vital feature of health and social care.

MSKR propose a promotional campaign to highlight the unifying nature of functional rehabilitation as a core component of healthcare.

In the many discussions about MSK Clinical Excellence throughout this project, we have consistently noticed the commonalities between contemporary best practice across therapy disciplines. MSKR contributors working in the fields of physiotherapy, occupational therapy, psychology, massage therapy, osteopathy, chiropractic, rehabilitation medicine, and other related disciplines will never be able to ignore the significant contribution of rehabilitation to the modern health system. Rehabilitation is not only an essential component of healthcare but also a cornerstone of Clinical Excellence.

MSKR propose a review of the term ‘Chartership’ as used in Physiotherapy and of the criteria required to qualify for Chartership.

Chartership status originates from Royal Charters issued to professional bodies by the monarch on the advice of the Privy Council. Over a thousand professional organisations have been granted chartered status since their inception in 1290; however fewer than 80 charters allow for individuals who meet certain standards to use the prefix ‘Chartered’ ahead of their professional identity as a self descriptor. For example, the Royal College of Chiropractors received a royal charter in 1202, yet there is no such title as ‘Chartered Chiropractor’.

In 1920 King George V granted a Royal Charter to ‘The Chartered Society of Massage and Medical Gymnastics’, the organisation known since 1944 as The Chartered Society of Physiotherapy (CSP). The CSP also have an ‘individual Chartership designation’ granting it the ability to award chartered status to individual members.

In the UK the prefix ‘Chartered’ is considered a mark of professional competence awarded to an individual as a relevant distinction to its non-chartered form. The two most common examples encountered in Britain are Chartered Accountants and Chartered Surveyors.

Chartership in these disciplines requires:

**An undergraduate degree**

Three years in-trade experience

A submitted report of professional competencies

A pass grade for Chartership examinations

A unanimous decision by a panel of peers to grant Chartership

Routine revalidation by monitored appraisal of CPD activity

Payment of membership organisation fees

Use of the term ‘Chartered Physiotherapist’ requires:

An undergraduate degree

Payment of membership organisation fees

This inconsistency in requirements seems to be a legacy problem that other Chartered institutions have sought to correct for. For example, the Institute of Physics (2001) and the Royal Science Council (2004) recognised in the early 2000s that a higher minimum standard must be set for the ‘Chartered’ prefix in their fields. The organisations decided that Masters level study; three years post-graduate experience and routine revalidation through proof of CPD would form the new entry-level criteria. Individuals who did not meet these standards at the point of revalidation could not use the prefix. The Privy Council granted amendments to the entry level for use of the title ‘Chartered Physicist’ in 2001 and use of the title ‘Chartered Clinical Scientist’ in 2004.

Interestingly, the Privy Council itself recognises that the set entry level for Chartership should be consistent so as to not devalue the use of the prefix. The Privy Council office kindly provided the following quote:

‘Privy Council policy is that the criteria for individual Chartered Status should be broadly similar across the professions, e.g. Chartered Accountant, Chartered Engineer, Chartered Surveyor etc. Charters and Chartered titles have traditionally been linked to academic qualifications and most modern Chartered bodies that intend Individual Chartered status as a robust professional qualification set the entry level at Masters degree level (or equivalent in skills and experience) and re-evaluate holders on a regular basis to ensure continued professional competency and development, with only practicing professionals allowed to hold the designation.’

The Privy Council Office

MSKR propose a review of the use of the term ‘Chartered’, primarily due to the concern that its use may be misleading the public. In fact, some of the strongest voices in favour of this policy were from MSKR’s patient contributors.

Patients do not know what ‘Chartered’ in relation to Physiotherapy means, but ‘Chartered’ as it's used generally implies a credible distinction. To learn that it is a title you can essentially buy completely undermines the credibility of the whole profession. Chartership surely needs to mean something or not exist. As it stands it’s not an accurate description of a professional’s status, it’s an embarrassment to the profession and it’s misleading the patients it’s meant to reassure.

Sam Williams. Patient Contributor

MSKR propose that a Bachelor of Science (BSc) undergraduate degree or accepted international equivalent combined with accreditation through the Professional Standards Authority (PSA) would be sensible minimum standards. Beyond this, the specifics of a vacant MSK role should be detailed thoroughly in each personal specification with a view to a candidate being recruited based on individual competence.

We feel that this policy will raise standards and promote Clinical Excellence by disrupting the complacency that can appear in the absence of competition. It is in all of our best interests for the very best person for the job to be in post through as efficient a means as possible.

We recognise the challenges that a movement to change the terms of a Royal Charter might face. Not least the collaboration required to engage our non-MSK Physiotherapy colleagues, who would also need to be consulted. This is why MSKR calls for a thorough review, which involves and includes all relevant organisations that are interested in raising quality standards to achieve Clinical Excellence.

MSKR advocates for all MSK job roles to be accessible by professionals who can demonstrate that they meet the criteria outlined by the role, regardless of profession. As our organisation name suggests and this Manifesto has outlined, MSKR feel that the MSK industry at large and the constituent MSK professions must do more to improve the quality and consistency of the care delivered to the public. We do however recognise that the professional organisations representing MSK clinicians care deeply about the patients we all seek to help but that shortcomings do occur despite current best efforts.

We have found no evidence that Clinical Excellence is consistently recognisable in any qualification, sub-speciality or professional identity. We have instead noted that individuals of all professional backgrounds have the capacity to be Clinically Excellent and safely also the capacity to emulate poor practice. No professional organisation has demonstrated a quality assurance standard that has helped its members stand out consistently from their MSK peers of different stripes, nor has any specific qualification type stood out as worthy of promotion in this document.

Instead we propose that in light of the increasing societal burden of MSK conditions, it is in the public’s best interest for MSK job roles to be accessible by professionals who can demonstrate that they meet the criteria outlined by the job specification, regardless of profession. Considering the increasing evidence of comorbid and other contributory health factors affecting MSK care, a minimum qualification standard and minimum regulatory standard is important to ensure clinical safety. MSKR propose that a Bachelor of Science (BSc) undergraduate degree or accepted international equivalent combined with accreditation through the Professional Standards Authority (PSA) would be sensible minimum standards. Beyond this, the specifics of a vacant MSK role should be detailed thoroughly in each personal specification with a view to a candidate being recruited based on individual competence.

We feel that this policy will raise standards and promote Clinical Excellence by disrupting the complacency that can appear in the absence of competition. It is in all of our best interests for the very best person for the job to be in post through as efficient a means as possible.
The best person for the job may well be someone from a profession not immediately associated with that post, for example:

The best person for a Band 5 (Junior) MSK Primary Care Physiotherapist role might be a

Sports Rehabilitator (BSc)

The best person for a Band 7 MSK Lower Limb Extended Scope Podiatrist role might be a:

Physiotherapist (BSc)

The best person for a Band 8a MSK First Contact Practitioner role might be an

Osteopath (BSc)

We are certainly not the first organisation to advocate for competency-based recruitment and we recognise that some organisations are ahead of the curve on this policy, however it remains common practice for MSK job adverts to explicitly state a profession when others could realistically be considered. MSKR recognise the embryonic nature of some of the policies in this Manifesto but this is not one of them. Forward thinking service providers and their local public are already reaping the rewards of this change. If we lose dated assumptions and ask the correct questions of existing recruitment structures, we can raise standards by simply redacting a title on job adverts.

"Putting a profession’s interests over the public’s interest is the equivalent of putting party over country or country over humanity. Inter-professional tribalism in MSK is needless and counter-productive, so let’s instead build a multi-disciplinary coalition around shared values and reform MSK practice for the better.”

JACK CHEW, MSKR DIRECTOR

This chapter lays out the criteria we believe are indicative of Excellent practice and suggests mechanisms by which this can be established and sustained for the benefit of our patients and our professional pride and integrity.
The MSKR Manifesto for Reform makes a clear case for change and details specific policies to bring this about. Change however relies on the ability of these ideas to influence people. We are aiming to make a persuasive case that influences individuals who then in turn influence their friends, colleagues, teams, services, organisations and so forth. Throughout the development of this Manifesto and at all previous MSKR events, a frequent concern has kept us thinking pragmatically: ‘It’s all well and good in theory but how can we influence that change?’

We feel that patient care can be positively influenced by reforming the ways in which the MSK industry seeks to influence clinicians and exerts its influence through the media. As the previous chapter discussed at length, unwarranted clinical variation is an issue in MSK practice, but how might we best influence the clinicians concerned and make a persuasive case to change behaviours? If the care delivered is varied, is it any wonder that the media representation of MSK practice and pathology is also varied? Why wouldn’t inconsistent messages from clinicians and inconsistent messages in the media contribute to the huge variety of pain beliefs among the people who subsequently become MSK patients? Whilst we do not have a valid method to identify just how causal this inconsistency is on society’s perception of MSK issues, if we wish to aspire to accuracy then surely we can improve the ways in which we look to influence opinion.

This chapter therefore details policies in these three overlapping areas:

- Influencing Clinicians
- Influencing Media
- Influencing Patients

**CLINICIANS**

MSKR proposes a trusted communication infrastructure for private, professional discussions with accountable users and administrators. Adoption of evidence-based practice in MSK health is challenging due to a number of documented factors including poor access to information, limited appraisal skills and ever-increasing service demands. Additionally, MSKR recognises that there are barriers with regards to inter-professional communication, platform inclusivity and varied representation, all issues that can surely be improved in an age of connectivity and digital expansion.

MSK clinicians work in a variety of environments across the UK such as NHS services, private clinics, sports clubs and in patients’ homes in the community. The lack of appropriate communication infrastructure for those interested in consolidating MSK best practice through discussion and resource sharing. A mode of communication increasingly used by those interested in MSK practice is social media. Platforms such as Facebook, Twitter and Instagram offer health professionals an accessible place to communicate with peers, researchers, educators and patients across the MSK industry. By design these platforms are inclusive and open access but do so by being fully public and potentially too exposed to be appropriate for some clinical discussions. Several MSKR member organisations have developed closed platforms such as iCSP (Interactive Chartered Society of Physiotherapy) to offer their members the opportunity to connect with each other online away from public visibility. These closed platforms are exclusively for members of specific professions and therefore inherently exclude patients and other MSK-interested individuals of different backgrounds. They also suffer from the same issues as social media in that they permit anonymity and therefore cannot always be considered accountable platforms.

MSKR recommends a communication infrastructure that appropriately corrects for these issues. The MSKR digital community platform is being developed with a brief which specifically states that the forum and resource library is to be inclusive, accountable and appropriately sheltered.

**MEDIA**

MSKR will develop and support a credible network of media-trained MSK experts available to journalists, producers and broadcasters. Frontline MSK clinicians know just how easy it is for the best laid rehab plans to be derailed by a newspaper article or TV advert. A classic example being a treatment plan involving patient engagement in active care with sustained commitment over a period of months and education to change the patient’s perception of what the problem is. The patient then encounters an anecdote broadcast in the media highlighting a much simpler, though not necessarily evidence-supported solution to their problem that could be administered passively.

Whilst this is a great indication of the versatility of MSK care, we hold concern that this has the potential to foster slided forms of practice which can stifle critical thinking in favour of practices based on convention, marketing and anecdote. This in part may account for the high levels of unwarranted clinical variation seen across MSK practice and discussed thoroughly in the previous chapter.

A frequent point expressed at MSKR events has been the lack of appropriate communication infrastructure for those interested in consolidating MSK best practice through discussion and resource sharing. A mode of communication increasingly used by those interested in MSK practice is social media. Platforms such as Facebook, Twitter and Instagram offer health professionals an accessible place to communicate with peers, researchers, educators and patients across the MSK industry. By design these platforms are inclusive and open access but do so by being fully public and potentially too exposed to be appropriate for some clinical discussions. Several MSKR member organisations have developed closed platforms such as iCSP (Interactive Chartered Society of Physiotherapy) to offer their members the opportunity to connect with each other online away from public visibility. These closed platforms are exclusively for members of specific professions and therefore inherently exclude patients and other MSK-interested individuals of different backgrounds. They also suffer from the same issues as social media in that they permit anonymity and therefore cannot always be considered accountable platforms.

MSKR will host quarterly update sessions for journalists and other media personnel in which developments and insights in the field of MSK practice will be shared and accurate stories promoted.

Those interested in MSK reforms have their work cut out to change deep-rooted societal perceptions around pain and injury. It is therefore important to identify ways in which we can improve the quality and consistency of public MSK messaging in the media.

MSKR will respond with a press release within 48 hours to news stories related to the MSK field. This is to ensure that an expert take on the matter is made available as a supportive or counter-narrative. Some heartening news is that medical and academic professionals are among the most trusted in the UK whilst journalism and broadcasting professionals are among the least. Whether or not these ratings are deserved is a topic of much debate but it could be argued that whilst this trust-distrust ratio exists, any chance to get MSK voices heard in the media would have significant reward, especially if a trusted expert opinion was seen to oppose an untrusted journalistic one.
It has long been noted in the literature that health care professionals have a considerable and enduring influence on the beliefs of patients they encounter. It is important, therefore, that clinicians are mindful of their language in the consultation room but also in the public sphere, especially as patients are increasingly using more direct sources to access news. For example, currently more than half of UK adults use social media as their primary source of news and over 65% of 18 to 35 year olds consider ‘online’ resources to be their primary source of news.

Many have hoped that patient information websites will provide the remedy to misinformation, however these are not without their problems. A 2019 systematic review by Ferreira and colleagues studied 79 public-facing websites from six English-speaking countries and found that only 43.28% of their recommendations for low back pain could be considered accurate. This is worryingly low, especially for a condition with far greater expert consensus than most other MSK conditions.

MSKR advocate the involvement of patients as equal partners in all MSK projects, organisations and research studies.

“I had Physio, I had Chiro, I had surgery but I still somehow had nobody to work with. I was on my own trying to figure out how much to do and when to exercise but you just can’t do it on your own.”
ADRIAN MCGREGOR, PATIENT CONTRIBUTOR

Throughout this Manifesto we have proposed a model of supporting patients to lead their care and empower them to manage their MSK conditions. For too long patient voices have been absent from discussions and so MSKR support patient partnership projects such as the Patient Director role within the Sussex MSK Partnership and the Patient Editor role at the Journal of Orthopaedic and Sports Physical Therapy.

“Rather than researchers informing patients and clinicians about a condition and instructing patients how to behave, engaging in a way that promotes sharing and understanding of a patient’s unique lived experience can mean that patients, clinicians, and researchers answer key clinical questions together.”

PATIENTS AS PARTNERS IN RESEARCH: IT’S THE RIGHT THING TO DO (2019)

MSKR propose further promotion of first-person patient advocacy and the sharing of public experiences within MSK care. Patients are the best narrators of their own stories and are therefore a powerful and under-utilised resource for helping others better treat and manage MSK problems. A shared language to suit a layperson may be necessary in some instances, however MSK patients have individual agency and so should be treated with the respect and dignity they deserve. In many instances, patients whose journeys have led them to study their MSK condition and the contributing factors affecting their experience have a better understanding of the MSK evidence base and its application than many clinicians.

“When you live in pain and you read something about how pain works, you try to fit your personal pain experiences into what you are reading - or at least I do - and when you just can’t fit your experience in than this can lead to confusion, frustration and despair, or at least it has for me.”
TINA PRICE, PATIENT CONTRIBUTOR

This chapter proudly states a number of policies that we feel will better influence clinicians, the media and therefore patients to improve healthcare outcomes in MSK practice. These policies seek to refine and then broadcast messages and so rely heavily on the policies of the previous four chapters to raise standards. Failure to co-ordinate the action that will follow this Manifesto could lead to high quality clinical reforms that are not shared widely and therefore do not influence wider system change. Or worse, an amplification of unreformed, low quality practice which would be rightly met with frustration by all stakeholders.

Let’s look to mitigate this from the very start. MSKR shall remain open and inclusive to all interested parties by inviting partnership with any MSK organisation and allowing membership of any individual regardless of background. MSKR shall pursue the policies in this Manifesto as prioritised by the voting membership with thoughtful, pragmatic activism.
CONCLUSION

“The MSKR Manifesto for Reform is the best efforts of many passionate clinicians, patients, educators and policy makers to demonstrate consensus in a time of disagreement, unity in a time of division and bravery in a time of cowardice.”

JACK CHEW, MSKR DIRECTOR

A final reminder of our core question: ‘If we were to enact these policies, would MSK practice improve?’ We believe so and look forward to working with you on the action plans that can make that happen. For too long there has been a lack of clarity over what MSK reformers stand for and for too long there has been a place for unfair critics to misrepresent our goals. The MSKR Manifesto for Reform certainly won’t (and shouldn’t) end the arguments that rage on across these topics, but it does offer a point of reference for those who are interested in changing MSK practice for the better.

Even best efforts to be thorough were bound to leave us wondering if there’s any stone unturned or a discussion point unexplored. This Manifesto for Reform sought to offer an answer to the complex problem of inherent complexity! The Working Group and chapter themes emerged from early discussions at MSKR events as these were the key areas in which reform was felt to be most needed. It is our opinion that several important things need to change simultaneously. Namely, the MSK industry’s relationship with Evidence, the underlying clinical Governance structures, the delivery of clinical Education, the sense of what clinical Excellence looks like and the way in which we seek to exert Influence on wider society. We hope that we have justified these priorities in this document but we know that these categories are not exhaustive!

An interesting challenge faced by the authors of this Manifesto is that all five chapters struggled to avoid overlap with their counterparts. For example, every policy is informed by evidence and seeks to influence change primarily through education! Various models, diagrams and formats have been explored and so we hope that this style and layout has been readable and enjoyable. Having realised that overlap was inevitable but that a degree of categorising was necessary, we were very fortunate to work with versatile and understanding contributors whose cooperation has been amazing to witness.

In producing this document, our team of contributors have faced a great deal of opposition, yet very little of it has been coherent. A great example of this is the accusation that the MSKR movement is simultaneously utopian, radical and blinkered whilst being bland, samey and broad.

We hope that you’ve found this work persuasive and can recognise that the proposed structure of MSKReform as a grass-roots MSK think-tank is one worth supporting. Without mass membership, this Manifesto is the high watermark of #TheBigRs project. If you want to see us promote these ideas widely and lobby for their implementation then join the movement today.

BECAUSE IF NOT US, THEN WHO?
AND IF NOT NOW, THEN WHEN?
EVIDENCE

Developing an evidence-informed culture

1. MSKR advocate a roll out of the Oxford EBP framework with each clinician’s involvement evidenced in personal appraisals and integrated into performance measures.

2. MSKR will aim for all MSK service providers to ensure at least 5% of clinical staff's working week is for protected learning time - approximately two hours full-time equivalent - to be annualised and stated in job descriptions.

3. MSKR propose a move to cooperative contracts between universities and service providers for each MSK service employing 20 or more clinical staff.*

4. MSKR will encourage universities to grant full literature access to a named research champion in all services employing 20 or more clinical MSK staff.*

Reducing unwarranted variation in clinical practice

5. MSKR will promote the need for additional NICE guidelines relating to MSK disorders

6. MSKR propose increased use of knowledge translation strategies

7. The MSKR evidence working group will be available for consultation with MSKR spokespeople, journalists and members of the public interested in wider promotion of best practice.

Measurement and Accountability

8. MSKR advocate mandating the universal use of patient-orientated outcome measures in UK MSK healthcare.

9. MSKR support Clinical Audit Awareness Week (CAAW) and pledges to produce specific MSK service audit resources as well as examples of MSK service audits to coincide with CAAW on an annual basis.

Narrowing the Clinical-Academic divide

10. MSKR advocate for the development of more clinical academic posts across the UK.

11. MSKR proposes the development of an up to date directory of resources for MSK funding streams.

12. MSKR support the proliferation of open access journals and will lobby for a reformed business model to improve clinician’s access to evidence.

GOVERNANCE

Creating Robust Systems

1. MSKR recommend that Physiotherapists be included in the CQC list of registrants required to be registered under the regulated activity of “Treatment of disease, disorders or injury”.

2. MSKR advocate for the development of an accreditation process from which MSK services can aspire to a quality standard mark.

3. MSKR propose that all providers of MSK services mandate governance training into their induction programmes and ongoing mandatory training.

4. MSKR support the integration of Clinical Governance education in every level of MSK courses.

5. MSKR advocate for the development of a National MSK Clinical Governance Framework which is applicable to all who practice in the MSK specialty.

Creating Accountable Clinicians

6. MSKR propose a phasing out of the current continuing professional development audit processes for Physiotherapists and HCPC registered MSK professions.

7. MSKR recommend a mandatory annual appraisal as a requirement for all MSK Practitioners, which will include agreed supporting evidence aligned to HCPC (or subsequent regulator) standards.

8. MSKR recommend that all annual appraisals should be uploaded onto a HCPC (or subsequent regulator) database to ensure compliance assurance.

9. MSKR propose that for re-registration, the HCPC (or subsequent regulator) should audit 2.5% of a registrant’s submitted appraisals against compliance standards.

Patient centred decision making

10. MSKR propose accessible mechanisms for patients to contribute to service audits and research projects relevant to their condition, circumstances and interests.

11. MSKR support the integration of patients into decision-making structures in order to improve patient-centred care and governance in MSK services.

EXCELLENCE

Defining Excellence

1. MSKR propose that Clinical Excellence is delivered by clinicians who value:

   i. Patient-centred care
   ii. A holistic biopsychosocial model
   iii. Communication skills
   iv. Empowerment
   v. Clinical reasoning
   vi. Evidence-informed care
   vii. Lifelong learning
   viii. Reflective practice
   ix. Critical thinking
   x. Shared decision-making

Achiving Excellence

2. MSKR propose a central, digital library of best practice guidance for common MSK presentations that are efficiently peer reviewed for quality, clarity and brevity.

3. MSKR propose a promotional campaign to highlight the unifying nature of functional rehabilitation as a core component of healthcare.

4. MSKR propose a review of the term ‘Chartership’ as used in Physiotherapy and of the criteria required to qualify for Chartership.

5. MSKR advocates for all MSK job roles to be accessible by professionals who can demonstrate that they meet the criteria outlined by the role, regardless of profession.

INFLUENCE

Influencing Clinicians

1. MSKR proposes a trusted communication infrastructure for private, professional discussions with accountable users and administrators.

Influencing Media

2. MSKR will develop and support a credible network of media-trained MSK experts available to journalists, producers and broadcasters.

3. MSKR will respond with a press release within 48 hours to news stories related to the MSK field. This is to ensure that an expert take on the matter is made available as a supportive or counter-narrative.

4. MSKR will host quarterly update sessions for journalists and other media personnel in which developments and insights in the field of MSK practice will be shared and accurate stories encouraged.

Influencing Patients

5. MSKR advocate the involvement of patients as equal partners in all MSK projects, organisations and research studies.

6. MSKR propose further promotion of first-person patient advocacy and the sharing of public experiences with MSK care.
JOIN THE MOVEMENT

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