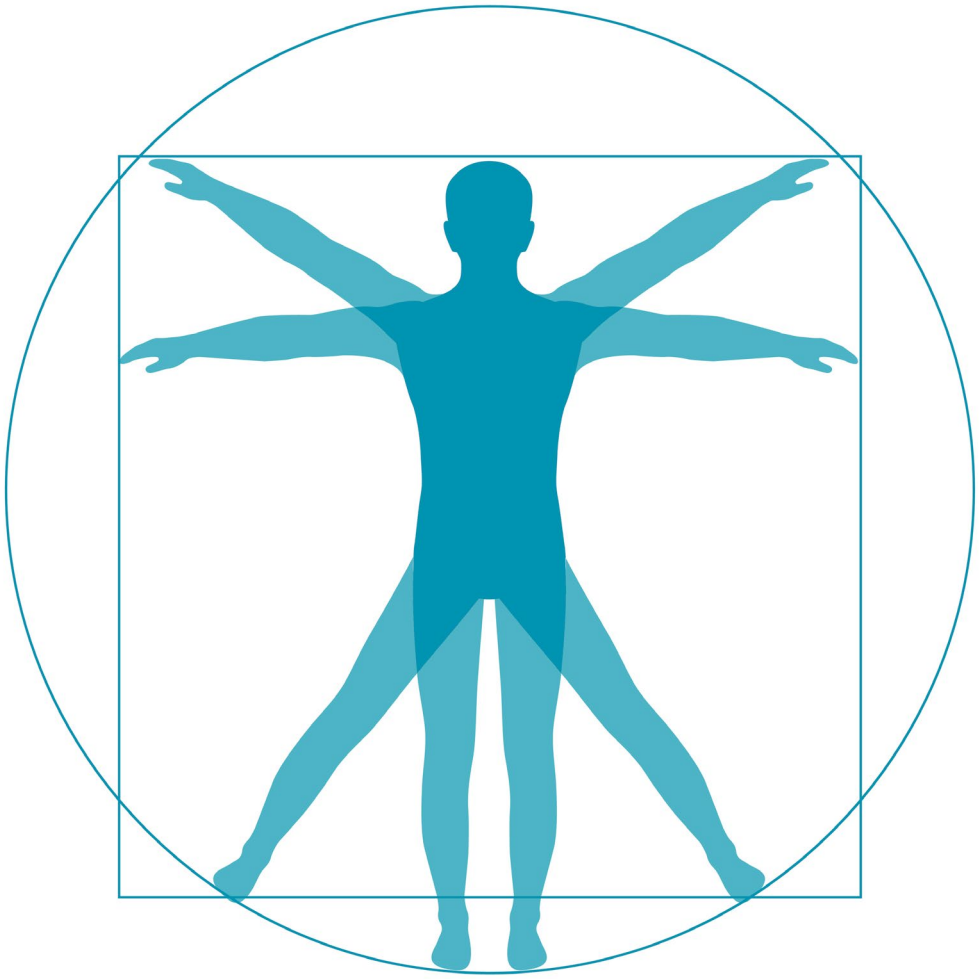

Musculoskeletal core capabilities framework for first point of contact practitioners

Skills for Health

Public Health England

ARMA Arthritis and Musculoskeletal Alliance

NHS England

NHS Health Education England

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The project management group included representatives of the following organisations:

- Arthritis Action
- Arthritis and Musculoskeletal Alliance (ARMA)
- British Society of Rheumatology
- Chartered Society of Physiotherapy
- Health Education England
- Institute of Osteopathy
- National School of Occupational Health
- NHS England
- Public Health England
- Royal College of General Practitioners
- Royal Cornwall Hospitals NHS Trust
- Skills for Health
- University of Exeter
- University of Leeds
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- British Association of Prothetists and Orthotists
- British Health Professionals in Rheumatology
- British Institute of Musculoskeletal Medicine
- British Orthopaedic Association
- British Society for Rheumatology
- Chartered Society of Physiotherapy
- College of Paramedics
- College of Podiatry
- Faculty of Sport and Exercise Medicine
- MSK:UK
- National Rheumatoid Arthritis Society
- NHS England
- Primary Care Rheumatology Society
- Royal College of Nursing Rheumatology Forum
- Royal College of Occupational Therapists
- Royal Pharmaceutical Society.

Finally, we are grateful to the many other clinicians and service users who provided comments and feedback on the framework and particularly the 74 respondents to the wider online consultation survey.

Further detail of how the framework was developed is presented in **Appendix 1**.

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

Foreword

The delivery of high quality musculoskeletal (MSK) care and successfully meeting the increasing demands on healthcare services relies on developing a skilled and well-integrated multidisciplinary workforce. This capability framework aims to ensure that the range of health professionals who provide care for people with MSK problems are equipped to consistently deliver person-centred care, can play a full role in helping to manage problems appropriately at the first point of contact and help towards achieving better outcomes across the system.

The first point of contact is important to ensure that potential emergencies are recognised and that the next step in the pathway occurs seamlessly and as efficiently as possible. Working in a team and sharing challenges, first contact MSK practitioners can ensure the person with an MSK problem gets rapid access to the right support.

By making it clear what capabilities are required we hope the framework will encourage training and development to increase the number of practitioners from different professions to fulfil this vital role. Importantly, this is not about creating a new MSK workforce, but is about recognising existing capabilities within practitioners' scope of practice and ensuring services are delivered consistently by multi-professional teams.

The statement of core capabilities offers employers, clinicians, regulators, primary care training hubs, commissioners and practitioners themselves clear definitions against which to improve and assure, and offers the public assurance of the capabilities of the wider primary care team.

This framework also offers the opportunity to modernise skill sets and to ensure that person-centred approaches are central to service transformation for example skills to support shared decision-making, health coaching, social prescribing and prevention; working in partnership with people to maximise early recovery, support self-management and enable people to stay active and independent.

The framework has been developed by representatives from the whole MSK sector, and includes feedback from several focus groups with people with lived experience of MSK problems, collaborating on an issue we all agree is important. Implementation of this framework will enable assurance of patient safety, help to deliver the benefits of earlier intervention and support the national service changes within primary care and beyond. We believe that this will make a real difference to health outcomes for people with MSK problems and we commend the framework to you.

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Professor Peter Kay

National Clinical Director for Musculoskeletal Services, NHS England

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Chief Allied Health Professions Officer (England), NHS England

Introduction and background

Health Education England and NHS England commissioned the development of this Musculoskeletal (MSK) core capabilities framework in order to support the improvement of services, placing skilled MSK practitioners earlier in patient pathways. The aim is to ensure expert diagnosis, prevention, supported self-management advice, early treatment and onwards referral, where needed, is available to anyone presenting with an MSK condition. It meets the needs and wishes of people with MSK conditions, identified through focus groups.

Many health professionals (such as GPs and physiotherapists) will already be working in accordance with these capabilities, while for others the capabilities will provide a framework for continuing professional development. The framework sets out a standard for consistent, safe and effective practice across a range of practitioners working as part of a multi-professional team. This includes a range of settings, including primary and community care, emergency care or occupational health services. This framework supports the implementation of the NHS England-supported first contact practitioner model of care into service delivery.

MSK conditions are the single biggest cause of the growing burden of disability in the UK[1]. Much of the disability is avoidable. They have an enormous impact on the quality of life for millions of individuals in the UK with the third worst quality of life impact after neurological conditions and mental health, as reported in the NHS GP survey (2015). MSK conditions account for 30% of GP consultations in England[2] and are associated with related co-morbidities, including diabetes, depression and obesity. They account for £4.76 billion NHS spending each year[3]. Early management keeps people at work or enables them to return to work more quickly, reduces downstream treatment needs and optimises recovery. This framework will help healthcare professionals to address some of these challenges.

Drivers for development of the framework include policy (e.g. GP Forward View), the duty to reduce health inequalities in access to services and health outcomes and the national work programme delivered by the Arthritis and Musculoskeletal Alliance (ARMA) and its member organisations, working in partnership with NHS England, with the National Clinical Director for MSK Services and the Elective Care Transformation Programme. This national work programme includes work-streams designed to support improved communication across the healthcare sector, a more robust approach to what good looks like (and how we measure it) and ultimately improved outcomes for individuals with MSK conditions. This includes oversight by the MSK Workforce Group, building on their previous work.

In setting out the capabilities required of practitioners acting as a first point of contact for MSK conditions, the framework provides clarity both on the standards expected of first point of access MSK service delivery, and the knowledge, skills and behaviours that practitioners need to develop and demonstrate. The framework recognises that practitioners will acquire the capabilities through their pre-and post-registration education (at undergraduate and postgraduate levels) and as their learning and professional development progresses. It should inform how curricula are developed, updated and implemented (including in ways that strengthen inter-professional learning), and how learning is assessed.

The expectation is that subsequent frameworks for other specialist roles will build on the structure and capabilities presented here, so that the commonality facilitates service transformation, integrated working and enables career development.

Further information on the development of this framework is presented in **Appendix 1**.

1. Murray C et al (2010), UK health performance: findings of the Global Burden of Disease Study 2010.2. Department of Health (2006), A Joint Responsibility: doing it differently, pp 16); 3. (Department of Health (2011), Programme Budgeting Data 2009-10, June).

Scope of the framework

The capabilities within this framework are applicable to all health professionals with a role as a first point of contact for adults presenting with undiagnosed MSK conditions. They are relevant to different types of service provision and settings. This includes but is not limited to: primary care, community care and occupational health.

The expectation is that first point of contact practitioners assess, diagnose, develop and agree a management plan, offer initial treatment advice (including self-management and treatment if the pathway allows) and discharge or make an onward referral, if required.

The framework provides a focus on the workforce capability to support shared decision-making, person-centred care and fitness for work. As such, there are synergies with other frameworks, such as the Person-Centred Approaches framework (Health Education England and Skills for Health 2017) and the need to make work a health outcome.

For practitioners working in, or preparing for, a first contact practitioner role for adults presenting with MSK conditions, the framework can be used to demonstrate many of the clinical capabilities set out in the multi-professional framework for advanced clinical practice in England (Health Education England 2017).

What is outside the scope of this framework?

Given that the scope of this framework is core capabilities, it follows that many professionals will have additional knowledge and skills beyond the common core. In particular, the specialist knowledge and skills for those managing MSK conditions that require specific high-level capabilities (e.g. a biomechanical foot problem for which a podiatrist will have the required capabilities) or present high levels of complexity and high levels of uncertainty and risk (e.g. relating to individuals with multiple long term conditions and multiple healthcare needs) are outside the scope of this framework.

Similarly, specialist knowledge and skills for those managing paediatric MSK presentations are beyond the scope of this framework.

In addition, this framework is not focused on those who deliver treatment interventions for previously diagnosed conditions; i.e. those who are not first point of contact.

Structure of the framework

The framework begins with a description of professional values and behaviours that underpin all the capabilities set out under the four domains that follow.

The four domains of the framework are:

Domain A. Person-Centred Approaches

Domain B. Assessment, Investigation and Diagnosis

Domain C. Condition Management, Interventions and Prevention

Domain D. Service and Professional Development

Within the domains are a total of 14 capabilities. The capabilities are numbered for ease of reference. This does not indicate a prescribed pathway, process or hierarchy.

The capabilities set out what each first point of contact MSK practitioner should be able to do. They should be interpreted and used as a collective expression of what a practitioner is able to do, rather than taken in isolation.

The framework does not prescribe how individual practitioners' fulfilment of the capabilities should be demonstrated or assessed. This will depend upon the context or setting where the framework is used and how individuals have developed their capability as a first contact practitioner. However, principles of capability review are presented in **Appendix 2**.

The indicative knowledge underpinning all the capabilities is presented in **Appendix 3**.

A glossary of terms is presented in **Appendix 4**.

Who is this framework for?

Service commissioners

The framework enables commissioners of services to specify minimum standards of clinical care at first point of contact for people presenting with undiagnosed MSK conditions; it sets out clear expectations about what first point of contact practitioners are able to do. This should give people using services confidence in seeking early diagnosis and support. In particular, the framework highlights that people with MSK conditions must be supported to make informed choices about effective treatment, care and support alongside the MSK practitioners i.e. to participate in shared decision-making.

Service providers

The framework enables managers to demonstrate that staff meet core capabilities or have developmental plans in place and clinical supervision to meet the nationally recognised framework.
This underpins the continuing professional development of practitioners to ensure their practice remains up-to-date, safe and effective.

A further aspiration in providing this framework is to support service transformation i.e. that organisations use the framework to review their current arrangements for MSK first point of contact. The aim is to ensure staff at first point of contact are skilled in diagnosis, prevention, supported self-management advice, early treatment and onwards referral, where needed, for those presenting with an MSK condition. Each profession will have a different starting point, due to their clinical training and scope of practice — most practitioners are already likely to meet all or some of the capabilities but may need to develop additional skills — such as shared decision-making, or to orientate themselves to working in a primary care setting. The second phase of this work is to develop the assessment framework which will enable practitioners to evidence how they meet the framework requirements and any areas for professional development.

Use of this national framework also supports organisational and system wide effectiveness and efficiencies by encouraging the delivery of education and training that is focused on developing core capabilities and optimises opportunities for inter-professional learning. In so doing, it should help to increase consistency in knowledge and skills development, prevent unnecessary duplication in education and training delivery and strengthen skill mix and teamworking.

Education and training providers

The framework helps those who design and deliver training and development opportunities to focus on the key capabilities that learners need to achieve, which in turn will guide the content to be included and the use of appropriate learning and teaching strategies. The framework can also be used to support the analysis of learning needs and assessment. Work is ongoing to develop tools to support training needs analysis and assessment; the principles of capability review and assessment are presented in **Appendix 2**.

Education providers can use the framework to inform the design of their curricula and the delivery of education and training programmes, including how they couch their intended learning outcomes. This will ensure that their learning and development provision (at pre- and post-registration, and undergraduate and postgraduate levels) contributes to students and practitioners acquiring and demonstrating the full range of capabilities required for first contact MSK roles.

Practitioners — individuals and teams

The framework sets out clear expectations for individuals and teams about the requirements of roles and transferable skills. It can be used to review how capabilities are shared across teams and to conduct formal or informal training needs analysis, comparing current skills and knowledge with required skills and knowledge. The framework also provides a structure for planning career progression, continuing professional development and/or revalidation.

The framework in practice

Many health professionals (such as GPs and physiotherapists) will already be working in accordance with these capabilities, while for others the capabilities will provide a framework for continuing professional development. The framework sets out a standard for consistent, safe and effective practice across a range of practitioners working as part of a multi-professional team.

Example of the framework in practice for general practitioners (GPs)

As front-line doctors, general practitioners (GPs) play a key role in diagnosing, treating and caring for people with MSK problems in a growing range of primary care and community settings. GPs also play an essential clinical leadership role in multi-professional teams, employing a growing range of clinicians in their services and commissioning MSK services for their local populations. The capabilities expected of GPs in relation to MSK health are set out in the Royal College of General Practitioners (RCGP) Curriculum (www.rcgp.org.uk/curriculum) and tested in the Membership of the Royal College of General Practitioners (MRCGP) assessments, which together inform the standard for licensing in the UK health service.

It is therefore essential for GPs to keep their skills and expertise in MSK health up-to-date. Although it is not intended for the training or assessment of GPs, this framework will serve as a useful tool to help general practitioners review their learning needs and formulate new personal development plans (PDPs), as part of an ongoing process of continuing professional development. (Statement from the RCGP).

Example of the framework in practice for physiotherapists

Physiotherapists have a strong role to play in primary care, including as part of the broader general practice team and providing first contact services for individuals with MSK conditions. As autonomous, regulated practitioners accountable and responsible for their decisions and actions, physiotherapists manage uncertainty and risk; deploy assessment, clinical-reasoning and diagnostic skills; and undertake complex case management. Working at the front of the patient pathway, they can reduce the burden on GPs and the number of inappropriate referrals to secondary care, and enhance population and patient health (http://www.csp.org.uk/professional-union/practice/primary-care/physiotherapy-primary-care-summary-briefing).

This framework will provide a valuable resource for physiotherapists, enabling them to demonstrate and evidence how they meet the capabilities required for first contact MSK roles through their pre- and post-registration education and development. It will also help them to identify and address their specific learning needs before moving into a first contact role, and to plan and progress areas for their on going CPD once in role. It will help them to think critically about transposing their professional knowledge and skills from one care setting and role to another and responding to changing demands.

More broadly, the framework should support service re-design and workforce development (including through skill-mix review), strengthen governance arrangements, and provide assurance of physiotherapists' capacity for safe and effective practice as first contact MSK practitioners. (Statement from the Chartered Society of Physiotherapy).

Patient journey

This framework aims to ensure a person-centred approach in the first stages of managing any MSK problem with which a person may present. For this to be achieved, practitioners should meet the expectations and needs of people with an MSK problem, address the concerns they have and enable shared decision-making. The expectations and needs of people at this first stage must be understood and focus groups have been undertaken to establish the key areas that must be addressed. People recognise that this may not all be achieved in the first consultation and that there may be mixed sources of support.

The focus groups conducted with patients during development of this framework identified the following key concerns and priorities for people with a musculoskeletal problem:

The problem and its impact

- What is wrong? Why? What is the cause?
- What will happen to me? What is the possible impact on my health and function?
- Will I get better or worse?
- Is it curable?
- How long will it take to get better?

The management of the problem

- What are you (the health professional) able to do about my problem?
- What is the treatment that is most appropriate for me?
- What can I do to help myself to alleviate it?
- How can I reduce or control my pain?
- How can I maintain my function and do the things I want to and need to do?

The practical questions

- Where can I get more information?
- Where and how can I get support to help myself?
- What activities can I do and how should I adapt them (e.g. sports, driving, work)?

The future

- What's the next step?
- Do I need to come back for a review?
- Am I going to see the same health practitioner?
- Have I made an improvement?
- If little improvement
  - Will I get back to doing what I want or need to do?
  - Why am I not improving? Where have I gone wrong?
  - Am I doing the right things?
  - Am I doing myself damage?
  - Am I receiving the best treatment
  - Is there support where I can share and learn from experiences?
  - Are there any other treatments available? What else can I try?
- When am I able to do various tasks important to me (e.g. work, exercise, driving)?

It is central for the person to have confidence in the advice they are receiving. This requires confidence in the capabilities of the health practitioner and in their understanding of the person with the MSK problem and of the issues that are important to them.

People told us they wanted a holistic approach taken to their problem — both in its assessment and management. They want time to express all their issues. They want all options to be considered and to have the opportunity to make a shared decision.

People with MSK problems that are recurrent or long term tell us that they want to be in control and to have the support to achieve this. They readily blame themselves for lack of progress. They want to know that expert advice including referral will be sought for them if the problem is outside the capabilities of the health practitioner.

Professional values and behaviours

The values and behaviours set out in this section for first point of contact MSK practitioners emphasise a commitment to collaborative, person-centred and integrated services. The importance of these values and behaviours have been confirmed through focus group discussions with people with MSK conditions.

As registered health professionals, first contact practitioners:

a) Seek and engage with individuals' perspectives on their condition, their preferences for their care, and what is important to them and their carers in terms of treatment goals and outcomes.

b) Demonstrate understanding of the individual and show empathy for the impact of their MSK condition.

c) Value and acknowledge the experience and expertise of individuals, their carers and support networks.

d) Use their clinical-reasoning skills to undertake an assessment of the presenting problem, interpret findings, develop working and differential diagnoses, formulate, communicate, implement and evaluate management plans.

e) Recognise the wider impact that painful, often persistent, conditions can have on individuals, their families and those close to them.

f) Understand that their role is to support and enable individuals to lead meaningful lives, whether or not cure or resolution is possible.

g) Ensure a consistent and integrated approach throughout the episode of care, focusing on the identified needs of the individual.

h) Ensure integrated care, support and treatment through forward-planning, working in partnership with individuals, different professionals, teams, diverse communities, a range of organisations including the third sector, and through understanding, respecting and drawing on others' roles and competence.

i) Value collaborative involvement and engage people with MSK conditions to improve and co-produce person-centred, quality services.

First point of contact MSK practitioners also need to demonstrate the values and behaviours expected of all healthcare professionals and therefore to:

j) Adhere to legal, regulatory and ethical requirements, professional codes, and employer protocols.

k) Adopt a critical approach to ethical uncertainty and risk, working with others to resolve conflict.

l) Demonstrate safe, effective, autonomous, reflective practice.

m) Inform their practice and professional development and remain up-to-date with the best available evidence through the use of clinical guidelines and research findings.

n) Be accountable for their decisions and actions and the outcomes of their interventions.

o) Work effectively as part of a team, using their professional knowledge and skills, and drawing on those of their colleagues.

p) Seek to meet individuals' best interests and to optimise service delivery.

q) Enable and participate in research to advance the development of MSK knowledge and practice.

MSK underpinning knowledge and skills

The capabilities set out in this framework require practitioners to hold and use the clinical knowledge and skills to promote MSK health and to diagnose and manage the care of individuals with MSK conditions.

First point of contact practitioners must have a comprehensive understanding of the normal structure and function of the MSK system. They must understand common MSK conditions and be aware of less common and rare MSK conditions.

They need to understand the impact that MSK conditions have on individuals and on society in the context of the bio-psycho-social model and the framework of the World Health Organisation International Classification of Functioning, Disability and Health.

They must recognise and understand signals that indicate the need to refer individuals to specialist care and investigations, and when presenting symptoms or conditions require urgent or emergency intervention.

They must also have a strong understanding of health promotion and illness prevention, more specifically how to manage and prevent MSK conditions, and the skills to support individuals' self-management and behaviour change.

They must have clinical-reasoning and problem-solving capabilities and critical self-awareness skills both to apply their knowledge and skills within their professional scope of practice, and to know when to seek advice and to make referrals to others to meet the best interests of the individuals they serve.

Further details of the underpinning knowledge that are core for all practitioners, or specific to scope of practice are presented in **Appendix 2**.

Domain A.
Person-Centred Approaches

Introduction

MSK first point of contact practitioners have the interpersonal and communication skills to engage in effective, appropriate interactions with individuals, carers and colleagues in the clinical environments and roles in which they practise. They have the listening, information-processing and empathetic skills to ascertain, understand and respond to individuals' needs and concerns. They use appropriate language and media, are sensitive to individual preferences and needs, and uphold and safeguard individuals' interests.

Practitioners take account of individuals' specific needs, wants and circumstances to guide the care and treatment they offer. They respect individuals' expertise in their own life and condition and empower and support them to retain control and to make choices that fit with their goals.

MSK practitioners enable individuals to talk about their concerns and priorities relating to their MSK condition and its implications. They help individuals and carers to understand their care options, sharing information on the risks, benefits, consequences, and potential outcomes in a clear, open way to support shared decision-making.

Capability 1. Communication

The practitioner can do the following:

a) Use a critical self-awareness of their own values, beliefs, prejudices, assumptions and stereotypes to mitigate the impact of these in how they interact with others.

b) Listen to and communicate with others, recognising that both are an active, two-way process.

c) Modify conversations to optimise engagement and understanding, informed by assessing individuals' and carers levels of activation and health literacy.

d) Adapt how they engage with others (including those with cognitive and sensory impairments) through using different verbal and non-verbal communication styles, and in ways that are responsive to individuals' communication and language needs and preferences.

e) Convey information and discuss issues in ways that avoid jargon, negative descriptors and assumptions.

f) Engage with individuals and carers and respond appropriately to questions and concerns about their MSK condition and its impact on their current situation and potentially in the future.

g) Respond to individuals' communication and information needs and support the use of accessible information as needed, accessing interpreters as required.

h) Signpost individuals appropriately and effectively to sources of information and support.

i) Communicate effectively with colleagues using a variety of media (e.g. verbal, written and digital) to serve individuals' best interests.

j) Respect and draw on colleagues' knowledge and expertise within the multi-disciplinary team to serve individuals' best interests.

k) Communicate with colleagues in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate individuals' care.

For further details on core communication and relationship building skills, see Person-Centred Approaches (Skills for Health and Health Education England 2017): (http://www.skillsforhealth.org.uk/news/latest-news/item/576-new-framework-to-promote-person-centred-approaches-in-healthcare).

Capability 2. Person-centred care

The practitioner can do the following:

a) Demonstrate sensitivity to the significance of individuals' background, identity, culture, values and experiences for how an MSK condition impacts on their life, recognising the expertise that individuals bring to managing their own care.

b) Engage with the impact of persistent pain and disability on individuals' lives, including on their relationships, self-esteem and ability to participate in what they need and want to do (including paid and unpaid work).

c) Take account during care planning of the burden of treatment for individuals with long term MSK conditions and co-morbidities, including regular appointments that may also be for the management of their other healthcare needs.

d) Progress care, recognising that reducing pain, restoring and maintaining function and independence, and improving quality of life all form clinical outcomes and meaningful goals of treatment.

e) Enable individuals to make decisions about their care by:

- helping them to identify the priorities and outcomes that are important to them
- explaining in non-technical language all available options (including doing nothing)
- exploring with them the risks, benefits and consequences of each available option and discussing what these mean in the context of their life and goals
- supporting them to make a decision on their preferred way forward.

For further details on core communication and relationship building skills, see Person-Centred Approaches (Skills for Health and Health Education England 2017): (http://www.skillsforhealth.org.uk/news/latest-news/item/576-new-framework-to-promote-person-centred-approaches-in-healthcare).

Domain B.
Assessment, Investigation and Diagnosis

Introduction

MSK first point of contact practitioners conduct clinical assessments to characterise the problem and its impact and to develop differential diagnoses that will ensure most effective management and referral if needed. This includes identifying the need for and requesting appropriate investigations and tests.

MSK first point of contact practitioners demonstrate skills in problem-solving, critical thinking and evaluating the impact and outcomes of their interventions. They analyse and synthesise information, particularly in relation to unfamiliar contexts and presentations where information may be incomplete or contradictory.

They work ethically, underpinned by their professionalism. They incorporate a critical approach to uncertainty, and work actively with others to resolve conflict.

MSK first point of contact practitioners demonstrate safe, effective, autonomous and reflective practice, informed by available evidence and established best practice. They work effectively as part of a team, either as a leader or as a team member, contributing to multi-disciplinary team-working to optimise the quality of service and clinical outcomes delivered to individuals. They will support and encourage shared decision-making e.g. working together with patients and carers to agree tests and investigations based upon clinical need and individuals' informed preferences.

Capability 3. History-taking

The practitioner can do the following:

a) Listen to individuals, ask questions and obtain appropriate additional information, with due sensitivity and consideration of what information needs to be sought to optimise the effectiveness and efficiency of the subjective examination.

b) Gather and synthesise information on the nature of the individual's symptoms taking account of how these issues relate to the presenting and past history, their activities, any injuries, falls, frailty, multimorbidity or other determinants of health and the characteristics of MSK conditions.

c) Assess the impact of individuals' presenting symptoms, including the impairment of function, limitation of activities and restriction on participation, including work.

d) Gather and synthesise information on the nature of individuals' issues from various appropriate sources e.g. previous histories and investigations, considering how symptoms relating to the MSK system may manifest as pain, stiffness, weakness, fatigue, limitation of activities and restriction of participation.

e) Explore and appraise with individuals' perceptions, ideas or beliefs about their symptoms and condition and whether these may act as a driver or form a barrier to recovery or a return to usual activity or work.

f) Appraise factors affecting individuals' ability to participate in life situations, including work and social activities, and their perceptions of the relationship between their work and health.

g) Critically appraise information obtained, taking account of the potential for MSK symptoms to be features of non-MSK conditions, indicative of serious pathology, compounded by psychological and mental health factors, and affected by lifestyle factors (including smoking, alcohol and drug misuse).

h) Critically appraise complex, incomplete, ambiguous and conflicting information presented by individuals, distilling and synthesising key factors from the appraisal, and identifying those elements that may need to be pursued further.

i) Record the information gathered through taking individuals' history concisely and accurately for clinical management, and in compliance with local protocols, legal and professional requirements.

For further details on understanding frailty or dementia, see Frailty Core Capabilities Framework (Health Education England, NHS England and Skills for Health 2017): http://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework and the Dementia Core Skills Education & Training Framework (Health Education England, Skills for Health and Skills for Care 2015): http://www.skillsforhealth.org.uk/services/item/176-dementia-core-skills-education-and-training-framework

Capability 4. Physical assessment

The practitioner can do the following:

a) Appropriately obtain individuals' consent to physical examination, respect and maintain their privacy, dignity and comfort, as far as practicable, and comply with infection prevention and control procedures.

b) Adapt their practice to meet the needs of different groups and individuals (including those with particular needs such as cognitive impairment or learning disabilities), working with chaperones, where appropriate.

c) Undertake observational and functional assessments of individuals relevant to their presenting condition to identify and characterise any abnormality.

d) Select and conduct an appropriate initial MSK screening assessment.

e) Apply a range of physical assessment techniques appropriately, systematically and effectively, informed by an understanding of techniques' respective validity, reliability, specificity and sensitivity and the implications of these limitations within an assessment.

f) Identify, analyse and interpret potentially significant information from the physical assessment (including any ambiguities).

g) Record the information gathered through assessments concisely and accurately, for clinical management and in compliance with local protocols, legal and professional requirements.

Capability 5. Investigations and diagnosis

The practitioner can do the following:

a) Assess the importance and meaning of presenting features from the clinical assessment, recognising the different patterns, syndromes and conditions commonly seen in first point of contact roles.

b) Identify potential serious pathology and make appropriate onwards referral.

c) Identify risk factors for severity or impact and use tools where they exist to analyse and stratify risk of progression to long term pain and disability.

d) Diagnose common problems that can usually be managed at first point of contact.

e) Recognise and act where an early referral and diagnosis may be particularly important for optimising individuals' long term outcomes.

f) Recognise how MSK conditions and their impact can interact with mental health, and identify when this is relevant.

g) Understand how MSK problems may be a manifestation of injury not only from trauma but also abuse, recognising particular at-risk groups (such as older people with frailty and those with cognitive impairment) and take appropriate action when there are grounds for concern.

h) Instigate appropriate investigative tests to aid diagnosis and assessment.

i) Understand and interpret test results and act appropriately, demonstrating an understanding of the indications and limitations of different tests to inform decision-making and the imperative of using scarce, expensive or potentially harmful investigations judiciously.

Domain C.
Condition Management, Interventions and Prevention

Introduction

MSK first point of contact practitioners support and encourage individuals to self-manage their condition and to make behaviour changes. They focus on how they can have a positive impact on the health and wellbeing of individuals, communities and populations. They advise on interventions and therapies, and formulate and enable the development and implementation of management plans. They work in collaboration with health and social care colleagues (across services, agencies and networks) to meet individuals' best interests.

All MSK first point of contact practitioners need to be able to develop, advise on and enact an integrated management plan that considers all the options and needs and wishes of the individual, even though some of those options will be out with their scope of practice.

The MSK practitioner will support and encourage shared decision-making, i.e. working together with patients and carers to select investigations, treatments, management or support packages, based upon clinical evidence of all the options and the patients informed preferences.

The management plan needs to support self-management and consider prevention, symptom control, disease control and restoration of function dependent on the possibilities and on the needs and wishes of the individual. Options to consider are education and support, lifestyle advice, social prescribing, drug therapies for symptom or disease control (including local injections), surgery, manual techniques and rehabilitative interventions (including exercise). Capability is therefore needed by all MSK first contact practitioners as a minimum in these areas. In addition, the practitioner may have a greater level of capability related to some interventions depending on their professional scope of practice. Capabilities at higher levels are beyond the scope of this framework.

Capability 6. Prevention and lifestyle interventions

The practitioner can do the following:

a) Appraise the impact that a range of social, economic, and environmental factors can have on outcomes for individuals with MSK conditions, their carers and their circles of support.

b) Recognise and promote the importance of social networks and communities for individuals and their carers in managing an MSK condition.

c) Promote the importance of physical activity (e.g. continuing work/exercise participation) for MSK health and advise on what people with MSK conditions can and should do.

d) Promote the importance of diet and nutrition on MSK health (e.g. adequate vitamin D for good bone health).

e) Advise on the effects of injuries on MSK health and conditions.

f) Advise on the effects of smoking, obesity and inactivity on MSK health and conditions and, where appropriate promote change or refer to relevant services.

g) Advise individuals living with frailty and their carers how to adapt the physical environment to promote independence, orientation and safety (e.g. to reduce risk of falls).

h) Advise individuals and relevant agencies on how MSK related work loss can be prevented through acting on effective risk assessments and providing appropriate working conditions, including adaptation to meet the individual's needs.

i) Use interactions to encourage changes in behaviour that can have a positive impact on the health and wellbeing of individuals, communities and populations.

j) Facilitate behaviour change using evidence-based approaches that support self-management.

k) Work collaboratively across agencies and boundaries to improve MSK related health outcomes and reduce health inequalities.

For further details on approaches to public health, see Public Health Skills and Knowledge Framework (Public Health England 2016): https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf For further details on supported self-management, see Person-Centred Approaches (Skills for Health and Health Education England 2017): http://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download.

Capability 7. Self-management and behaviour change

The practitioner can do the following:

a) Support individuals to self-manage and fulfil their role in their management plan, and where appropriate use principles of behaviour change theory and patient activation, to optimise their physical activity, mobility, fulfilment of personal goals and independence relevant to their MSK condition.

b) Support individuals to explore the consequences of their actions and inactions on their health status and the fulfilment of their personal health goals (e.g. their engagement in exercise and their use of medication).

c) Support individuals to get the most from conversations about the management of their MSK condition and its impacts (e.g. loss of independence) by supporting and encouraging them to ask questions about what is a priority or concern for them.

d) Recognise in their management approach that MSK conditions are often coupled with mental health issues, frailty, multimorbidity or other determinants of health.

e) Identify risk factors for the persistence and impact of MSK conditions and help individuals manage the psycho-social implications of their condition.

f) Advise on and refer individuals to psychological therapies and counselling services, in line with their needs, taking account of local service provision.

g) Advise individuals on the effects of their MSK condition and their response to it, including the causal links between absence from work, prolonged absence, reduced return to work and subsequent loss of employment.

h) Advise individuals on how MSK related limitations of activities and restriction of participation can be reduced through adaptations to meet the individual's needs.

i) Advise and assist individuals to identify and use strategies to address work instability and to improve work retention.

j) Advise on sources of relevant local or national self-help guidance, information and support including coaching.

Capability 8. Pharmacotherapy

The practitioner can do the following:

a) Understand the role of common medications used in managing MSK conditions, including analgesics, non-steroidal anti-inflammatory drugs, corticosteroids, drugs used in treating individuals with metabolic bone diseases, gout, inflammatory arthritis, and in the management of people with persistent pain.

b) Use their understanding of the most common medications used in MSK and pain disorders to advise individuals on the medicines management of their MSK problem, the expected benefits and limitations, and inform them impartially on the advantages and disadvantages in the context of other management options.

c) Identify sources of further information (e.g. websites or leaflets) and advice (e.g. pharmacists) and be able to signpost individuals as appropriate to complement the advice given.

d) Address and seek to allay individuals' fears, beliefs and concerns.

e) Keep individuals' response to medication under review, recognising differences in the balance of risks and benefits that may occur in the context of polypharmacy, multimorbidity, frailty and cognitive impairment.

f) Refer for advice about pharmacotherapy, when considered appropriate.

Capability 9. Injection therapy

The practitioner can do the following:

a) Understand the role of joint injections, informed by the evidence base, in MSK practice.

b) Advise on the expected benefits and limitations of injection therapy for managing an individual's condition and inform them impartially on its advantages and disadvantages in the context of other management options.

c) Work in partnership with individuals to explore the suitability of injection therapy, addressing and seeking to allay individuals' fears, beliefs and concerns.

d) Refer for advice about local injections, when considered appropriate.

Capability 10. Surgical interventions

The practitioner can do the following:

a) Understand the role of common surgical interventions used in managing MSK conditions.

b) Advise on the expected benefits and limitations of most common surgical interventions used in managing specific MSK conditions where these are relevant to individuals' care and inform them impartially on the advantages and disadvantages in the context of other management options.

c) Work in partnership with individuals to explore suitability of surgical intervention, addressing and seeking to allay individuals' fears, beliefs and concerns, seeking guidance when appropriate.

d) Refer for surgical opinion when considered appropriate.

Capability 11. Rehabilitative interventions

The practitioner can do the following:

a) Understand the role of common rehabilitative interventions for MSK conditions.

b) Advise on the expected benefits and limitations of different rehabilitative interventions used in managing specific MSK conditions, providing impartial information and advice on the advantages and disadvantages of specific interventions in the context of other management options.

c) Provide advice on restoring function, including graded return to normal activity, navigation to self-management resources, and modifying activity for limited time periods.

d) Understand that some individuals such as those living with disability, mental health issues, multi-morbidity or frailty might need additional support during rehabilitation and that their trajectory of recovery or increased independence may be slower than for others.

e) Work in partnership with individuals to explore suitability of rehabilitation interventions, including social prescribing e.g. referring individuals to a range of local non-clinical services such as community-based exercise programmes where appropriate.

f) Prescribe personal rehabilitation programmes to help individuals enhance, restore and maintain their mobility, function and independence considering the use of digital technology (e.g. apps and wearables) to support adherence.

g) Refer individuals to specialist rehabilitation practitioners (e.g. occupational therapists) where this is appropriate to individuals' needs and wishes.

h) Make recommendations to employers regarding individuals' fitness to work, including through the appropriate use of fit notes and seeking of appropriate occupational health advice.

Capability 12. Interventions and care planning

The practitioner can do the following:

a) Work in partnership with the individual to develop management plans that take account of individuals' needs, goals and wishes, local service availability and relevant guidelines.

b) Ensure the management plan considers all options that are appropriate for the care pathway.

c) Advise on and instigate a management plan for common MSK conditions and their symptoms — instigating this may be through referral to others with specific relevant capabilities.

d) Advise on pharmacological and non-pharmacological aspects of acute and chronic pain management.

e) Advise on the links between prolonged MSK symptoms and reduced mental well being and refer individuals to sources of mental health support when in their best interests.

f) Identify when first-line intervention has been successful and discharge the patient with appropriate advice.

Capability 13. Referrals and collaborative working

The practitioner can do the following:

a) Practise within their professional and personal scope of practice and access specialist advice or support for the individual or for themselves when appropriate.

b) Engage in effective inter-professional communication and collaboration with clear documentation to optimise the integrated management of the individual with an MSK condition.

c) Engage in effective inter-professional communication and collaboration to optimise care for MSK conditions within the population.

d) Advise on local non-clinical services that individuals and their carers may benefit from accessing to help manage an MSK condition and its impact, including those relating to employment, voluntary activities, counselling services and leisure facilities.

e) Know and be able to draw on the expertise of all members of the multi-disciplinary team and social support to meet individuals' best interests and optimise the integration of their care.

f) Contribute effectively to multi-disciplinary team activity (including service delivery processes and learning and development).

g) Participate as an effective team member and understand the importance of effective team dynamics.

h) Make appropriate referrals using appropriate documentation to other health and care professionals and agencies when this is in individuals' best interests.

Domain D.
Service and Professional Development

Introduction

MSK first point of contact practitioners support the development of MSK services through contributing to research and evidence-based practice and evaluating the outcomes and impact of their services and interventions. They actively progress patient and public involvement in research and quality improvement activities, ensuring adherence to ethical requirements.

MSK first point of contact practitioners engage in reflective practice as part of their learning and professional development. They plan their onward personal development, taking account of self-reflection, peer review, performance feedback, and changing service needs.

Capability 14. Evidence-based practice and service development

The practitioner can do the following:

a) Critically apply relevant national guidance and other best available evidence on MSK care and service delivery, identifying where local modifications may be required.

b) Monitor and evaluate their practice and its outcomes, including through data collection and analysis to assure and improve the quality of care, service delivery and address health inequalities.

c) Engage in the distinct activities of clinical audit, service evaluation and research (leading or contributing, as appropriate) adhering to the national and local requirements, and regulatory frameworks that relate to each.

d) Engage in co-production initiatives with individuals and their carers to improve the person-centred design and quality of services.

e) Act appropriately when services deficiencies are identified (e.g. frequent long waiting times) that have the potential to affect the effective management of individuals' care and condition, including by taking corrective action, where needed.

f) Plan, engage in and record learning and development relevant to their role and in fulfilment of professional, regulatory and employment requirements.

g) Engage in reflective practice and clinical supervision as an integral part of their professional development and to inform service development and quality improvement with reference to local needs.

Appendix 1.
How the framework was developed

Development of the framework was steered by a project management group representing key stakeholder organisations — ARMA, Health Education England, NHS England, Public Health England, Skills for Health, professional bodies and higher education institutions. A wider stakeholder list was also established to include a more diverse range of organisations and individuals that wished to be up-dated on development of the framework and to provide comments or feedback as part of the consultation process.

The project built upon work undertaken by the MSK Workforce Group. It combined information obtained from the first round of a Delphi survey undertaken by the University of Leeds and a literature review conducted by the University of Leeds and Dr Chris Hiley from the British Society of Rheumatology. The Delphi survey consulted with a multi-professional group of experts, including patients and service users, nominated by national organisations to achieve a consensus on core framework content. A list of participating organisations is provided below.

Iterations of the framework were subsequently developed based on the findings of the Delphi process, literature review, and consultation with the project management group. During October and November 2017, a second round Delphi survey was conducted in parallel with a wider online consultation survey to obtain detailed feedback on a draft framework. Based on analysis of these survey outcomes, a final draft of the framework was developed and further refined through a number of focus groups for patients, leading to a final Delphi survey in December 2017.

Expert representatives of the following organisations participated in the Delphi exercise:

- British Association of Prothetists and Orthotists — BAPO
- British Health Professionals in Rheumatology — BHPR
- British Institute of Musculoskeletal Medicine — BIMM
- British Orthopaedic Association — BOA
- British Society for Rheumatology — BSR
- Chartered Society of Physiotherapy — CSP
- College of Paramedics
- College of Podiatry — COP
- Faculty of Sport and Exercise Medicine — FSEM
- Health Education England — HEE
- MSK:UK
- National Health Service England
- National Rheumatoid Arthritis Society — NRAS
- Primary Care Rheumatology Society — PCRS
- Royal College of General Practitioners — RCGP
- Royal College of Nursing — RCN
- Royal College of Occupational Therapists — RCOT
- Royal Pharmaceutical Society — RPS

Appendix 2.
Principles of capability review

A key element of individuals' preparation to practise as a first point of contact MSK practitioner in a range of settings (including primary and community care or occupational health services) is their ability to demonstrate fulfilment of the MSK capabilities, specific to the context of their practice, with appropriate processes developed for this purpose. It is critical to the implementation, acceptance and sustainability of first point of contact practice that health and care professionals working at this level demonstrate a level of capability consistent with the MSK framework (it is acknowledged that they may exceed this level within their full scope of practice).

The process of review recognises that practitioners bring a varying breadth and depth of knowledge, understanding and skill to a first point of contact role, depending on their profession and prior professional experience. Consideration needs to be focused on enabling practitioners to demonstrate and evidence how they fulfil the capabilities, rather than on issues of input or process, and to be valid and reliable. Practitioners will need to be supported by appropriate educational and clinical mentors/assessors in their roles in preparation for a capability review.

Evidence that demonstrates fulfilment of the MSK Framework may include: case-based presentations, theoretical and/or practical tests of knowledge, skills and behaviours, critical reflections on practice, and portfolios of evidence, etc.

To ensure review of capability is valid and reliable:

- Mentors/reviewers must be occupationally competent, recognised as such by employers and education providers, and be familiar with the chosen assessment tools/review process and the MSK framework capabilities.
- A range of mentors/reviewers, trained in the use of relevant processes, should be involved, including educators with appropriate academic and clinical experience and health and care professionals with the required level of clinical expertise.
- Healthcare providers must invest in and support staff to undertake assessment/mentoring and review processes in practice.

Work-based assessment must happen within the work setting undertaken by experienced clinicians aware of the capabilities required for first point of contact practitioners.

In developing and enacting appropriate, enabling and proportionate forms of mentoring/assessment, there needs to be strong collaboration and working across professional and organisational boundaries. This should provide assurance that practitioners consistently meet the capabilities across different settings and professions.

(Derived from Health Education England (2017), Multi-professional framework for advanced clinical practice in England)

Appendix 3.
Indicative knowledge underpinning the capabilities

All first point of contact practitioners regardless of their scope of practice, must have the appropriate knowledge and understanding to underpin the capabilities within this framework.

This appendix outlines the knowledge that underpins the framework capabilities. It includes what is needed to enable an assessment of any MSK problem and its impact, making a diagnosis, developing a plan of management and enacting it.

It is recognised that practitioners will also have more in-depth knowledge and understanding in their specialist area.

The indicative knowledge is presented in the following table:

Knowledge area	Indicative content
The normal structure and function of the MSK system and processes that can affect this.	• *Structure and function of bone, joints, muscle, connective tissue and disease processes relevant to supporting the diagnosis and management of MSK problems.* • *The pathological processes relating to MSK conditions, including the ageing process, injury and disease states and repair of MSK tissues (including bone, cartilage, synovium, muscle and enthesis).* • *The biological and psycho-social sciences applicable to MSK problems.*
The features of an MSK problem that are relevant to making a diagnosis, including:	• *Pain: nature, location, severity.* • *Variation of symptoms over time.* • *History of trauma.* • *Symptoms which help distinguish inflammatory from non-inflammatory conditions.* • *Decrease or loss of function or motion — weakness, restricted movement, deformity and disability, ability to perform usual tasks or occupation.* • *Altered sensation.*
How an MSK problem can impact on an individual and society including:	• *The biological and psycho-social sciences applicable to MSK problems.* • *The World Health Organisation (WHO) framework of International Classification of Functioning, Disability and Health (ICF).* • *Barriers to recovery or a return to usual activity or work including frailty, multimorbidity, dementia, learning disabilities or other determinants of health.*

Knowledge area	Indicative content
The syndromes that MSK problems present as, their differential diagnoses and the characteristics of the different MSK conditions including systemic features and their expected progression / prognosis to support making a diagnosis and management plan. (The detail of knowledge should be in relation to their prevalence and seriousness. This knowledge and understanding is relevant to all practitioners regardless of their anatomical scope of practice. However, practitioners would have a more in-depth knowledge of their specialist area).	Commonly seen patterns and syndromes may include: • *joint pain — mono, poly, peri-articular* • *regional pain or stiffness* • *generalised pain or stiffness* • *regional pain or stiffness, including foot and ankle pain* • *neck pain* • *back pain* • *bone pain* • *muscle pain, stiffness or weakness* • *systematic problems — extra-skeletal problems* • *MSK injury.* The cause of which can be related to: • *traumatic* • *vascular / ischaemic* • *neurological* • *infectious* • *degenerative* • *immune mediated* • *metabolic* • *inherited / developmental / congenital* • *neoplastic* • *psychological.* Investigations: • *Appropriate investigative tests to aid diagnosis and assessment.* • *Understand the indications and limitations of different tests to inform decision-making and interpret test results.*
How to support the development of a management plan.	• *Management strategies / models of care for common MSK problems that include supporting self-management and consider prevention, symptom control, disease control and restoration of function.* • *Conditions where an early referral and diagnosis may be particularly important for optimising individuals' long term outcomes; e.g. internal derangement of the knee, ruptured achilles tendon, massive rotator cuff tear, inflammatory arthritis and inflammatory joint and spine diseases, open fracture, fractures associated with nerve or vascular compromise, cauda equina syndrome, joint infection, soft tissue infection, bone infection, temporal arteritis.*

Knowledge area	Indicative content
Interventions used in the management of MSK problems. (This knowledge and understanding is needed by all MSK first contact practitioners in these areas. In addition, the practitioner may have a greater level of knowledge and understanding related to some interventions if they are within their scope of practice. That higher level is beyond the scope of this capability framework).	Supported self-management and behaviour change. The impact and value of supported self-management and behaviour change for optimising physical activity, mobility, fulfilment of personal goals and independence. This includes the principles of: • *shared decision-making* • *supported self-management* • *care and support planning* • *behaviour change* • *patient activation models* • *health coaching techniques* • *lifestyle advice.* Pharmacological therapies for symptom or disease control: • *Understand role of common medications, the expected benefits and limitations:* – *Medications used to treat pain, including:* • *analgesics* • *non-steroidal anti-inflammatory drugs* • *corticosteroids* • *neuropathic medication.* – *Medications used to treat metabolic bone diseases.* – *Medications used to treat gout.* – *Anti-rheumatic drugs.* – *Biological agents used for inflammatory arthritis.* Local injection: • *Understand role of common injections, the expected benefits and limitations.* *Surgical interventions:* • *Understand role of common surgical interventions used in managing MSK conditions, the expected benefits and limitations:* – *arthroscopy* – *arthroplasty* – *spinal surgery (discectomy, spinal fusion),* – *amputation* – *synovectomy* – *osteotomy* – *arthrodesis* – *nerve / carpal tunnel decompression.*

Knowledge area	Indicative content
Interventions used in the management of MSK problems. *(continued)*	Rehabilitative interventions including manual techniques exercise: • *Understand the role of common rehabilitative interventions for MSK conditions, the expected benefits and limitations.* • *Basic advice on restoring function, including graded return to normal activity, navigation to self-management resources, and modifying activity for limited time periods.* • *Exercise programmes to help individuals enhance, restore and maintain their mobility, function and independence.*

Appendix 4.
Glossary of terms

Term	Definition
Accessible information	Information presented in a format that is easily used and understood by its intended audience. In the context of healthcare, the Accessible Information Standard aims to make sure that individuals who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services. From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard[4].
Capability review	A formal method by which an individual's progression is monitored and recorded[5].
Co-production	At the level of individuals, services and systems, co-production means professionals and citizens sharing power to plan, design and deliver support together, recognising that everyone has an important contribution to make to improve quality of life for people and communities[6].
Frailty	A distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years[7].
Health coaching	Enabling an individual to maximise their own health through raising awareness and responsibility for their own health. Key characteristics include a focus on an individual's goals rather than what professionals think they should do; empowering individuals to take ownership and responsibility for their health; and helping individuals plan and break down their goals into manageable steps[8].
Health literacy	The personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.
Informed consent	An individual must give permission before they receive any care, support or treatment. For consent to be valid, it should be given voluntarily, be based on accurate information including risks and benefits, and the individual giving consent must have the capacity to do so. Where a person does not have capacity to consent to the care, support or treatment a decision should be made in accordance with the Mental Capacity Act.

4. https://www.england.nhs.uk/ourwork/accessibleinfo/ 5. Joint Royal Colleges of Physicians Training Board (2016), Speciality Training Curriculum for Core Medical Training
6. http://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/ 7. http://www.bgs.org.uk/frailty-explained/resources/campaigns/fit-for-frailty/frailty-what-is-it 8. Realising the Value (2016), Realising the Value: Ten key actions to put people and communities at the heart of health and wellbeing

Term	Definition
Making Every Contact Count (MECC)	An approach to behaviour change that utilises the many day to day interactions that organisations and individuals have with others to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations[9].
Motivational interviewing	A method based on facilitating and engaging an individual's intrinsic motivation in order to change behaviour. It is a goal-oriented, person-centred counselling style for eliciting behaviour change by helping individuals to explore and resolve ambivalence.
Musculoskeletal (MSK) conditions	Musculoskeletal (MSK) conditions are a diverse group of conditions that affect the joints, bones musculoskeletal system and muscles, are associated with pain and also impaired physical function. They range from those that arise suddenly and are short lived to lifelong disorders. They include rarer autoimmune: • Joint conditions—for example, rheumatoid arthritis (RA), osteoarthritis (OA), psoriatic arthritis (PsA), gout, ankylosing spondylitis (AS). • Bone conditions—for example, osteoporosis and associated fragility fractures, osteomalacia and rickets. • Spinal disorders—for example, low back pain and disc disorders. • Regional and widespread pain disorders. • Musculoskeletal injuries—for example, strains and sprains often related to occupation or sports, high-energy limb and spinal fractures. • Genetic, congenital and developmental disorders. • Multisystem inflammatory diseases and back pain which commonly have musculoskeletal manifestations such as connective tissue diseases and vasculitis — for example systemic lupus erythematosus.
Musculoskeletal disorder (MSD)	"Musculoskeletal disorder (MSD)" is often used when the problem is associated with occupation.
Musculoskeletal disease	"Musculoskeletal disease" implies that there is pathogenic cause.
Musculoskeletal problems	Musculoskeletal problems is a useful term to describe symptoms affecting the musculoskeletal system, whereas "musculoskeletal conditions" or "musculoskeletal disorders" can be used when a cause is known.
Rheumatic and musculoskeletal disorders (RMDs)	Musculoskeletal problems and conditions not related to injuries or traumas are sometimes called rheumatic diseases and those predominantly affecting joints are collectively called arthritis. "Rheumatic and musculoskeletal disorders" (RMDs) is also used to collectively describe these conditions.
Patient activation	An individual's knowledge, skill and confidence for managing their own health and health care.

9. http://www.makingeverycontactcount.co.uk/

Term	Definition
Prevention	Providing or arranging services that reduce needs for support among individuals and their carers, and contributes towards preventing or delaying the development of such needs. The Care Act (2014) describes prevention at three levels: • primary prevention — to stop care and support needs from developing among those who do not have them • secondary prevention — for individuals at increased risk of developing needs, which could involve adaptations or short term provision of services that prevent deterioration • tertiary prevention — for individuals with established needs to help improve independence[10].
Registered healthcare professional	A person who is registered as a member of any profession to which section 60(2) of the Health Act 1999 applies.
Self-management support	When health professionals, teams and services (both within and beyond the NHS) work in ways that ensure that individuals with long term conditions have the knowledge, skills, confidence and support they need to manage their condition(s) effectively in the context of their everyday life[11].
Shared decision-making	Shared decision-making starts with the conversation between the individual receiving care and the person delivering care. It puts individuals at the centre of decisions about their own treatment and care by: • exploring care or treatment options and their risks and benefits • discussing choices available • reaching a decision about care or treatment, together with their health or social care professional or support worker. Shared decision-making occupies the middle ground between traditional practitioner-centred practice, where patients rely on the practitioner to make decisions about their care, and consumerism where patients have access to information and make their own choices. In shared decision-making there are two sources of equal expertise that come together to enable better decisions — practitioner and patient. In shared decision-making the patient's knowledge and preferences are taken into account, alongside the practitioner's expertise and the decisions they reach in agreement with each other are informed by research evidence on effective treatment, care or support.
Social prescribing	The practice of health and care professionals referring individuals to a range of local non-clinical services. Services linked with social prescribing schemes might include volunteer groups, befriending, gardening, arts-based activities, healthy eating and cooking schemes, or sports and physical activity.
Supporting behaviour change	Encouraging individuals to adopt a healthier lifestyle by, for example, stopping smoking, adopting a healthy diet, being more physically active, better blood sugar control or adherence to medicines[12].

10. Care Act (2014) 11. http://www.health.org.uk/publication/practical-guide-self-management-support#sthash.2gsLQThX.dpuf
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Musculoskeletal core capabilities framework for first point of contact practitioners

Skills for Health

Public Health England

ARMA Arthritis and Musculoskeletal Alliance

NHS England

NHS Health Education England