

# National Evaluation of First Contact Practitioner (FCP) model of primary care

Patient characteristics, outcomes and qualitative evaluation

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# Executive Summary

## Background

In the UK, musculoskeletal (MSK) problems are predominantly managed in primary care where they account for approximately 14% of General Practitioner (GP) consultations. Managing these presentations occurs within the wider context of rising workload (in English practices) and difficulties maintaining the GP workforce. To streamline care for patients with MSK problems and to increase capacity within, and to improve access to primary care, the First Contact Practitioner role has been introduced.

## What is a MSK First Contact Practitioner?

MSK First Contact Practitioners (FCPs) are Physiotherapists with advanced clinical practice skills who are able to assess, diagnose, treat and discharge without medical input. They are competent at managing the full spectrum of MSK patients. Within the UK, FCPs advanced skills include communication and the ability to deliver personalised. Advanced clinical skills in some cases may also include prescribing medication, ordering scans, performing joint injections and directly listing patients on waiting lists for surgery. Patients with MSK pain, can contact the FCP directly, rather than wait to see a GP or getting a referral to other community or hospital services. The ambition is that the whole NHS England patient population has direct access to MSK First Contact Practitioners by 2023/24, across all primary care networks.

## National FCP Evaluation

This is the report outlining the findings of the third phase of the FCP National Evaluation.

A national FCP evaluation group, which included all the key stakeholders (at national and regional level), oversaw all aspects of the three phases of evaluation. The group, organised by NHSE met on a monthly basis to review data and progress and put in place strategies to enhance FCP engagement in all three phases of the evaluation.

Phase 1 was an information-gathering survey about FCP services. Phase 2 collected FCP activity data over 10 months using a tool embedded in the electronic health record system of FCP pilot sites. (These two phases were led by NHSE).

Phase 3 of the National Evaluation, undertaken by Keele University and University of Nottingham, was funded and supported by the Chartered Society of Physiotherapy Charitable Trust (CSP-CT) and the Joint Work and Health Unit. This phase consisted of a mixed-methods evaluation of the FCP model of care. Data on patient reported experience and outcomes were collected using an on-line platform. Qualitative data on FCP, GP, general practice non-clinical staff and patient experience was gathered through interviews and focus groups.

This report presents and discusses the findings of this Phase 3 of the FCP national evaluation.

## Purpose

The overall aim of the phase 3 FCP national evaluation was to evaluate the FCP model of care against predefined service aims and success criteria.

## Process

Five service aims and 12 success criteria were predefined with help from stakeholders and patients before data collection commenced. A mixed methods approach collected data over 24 months using an online platform for patient reported experience and outcomes and interviews and focus groups of professionals and patients.

## Agreed service aims and success criteria

Five service aims were agreed which focused on the themes of (a) GP workload, (b) patient assessment and self-management advice, (c) high quality care and a good patient experience, (d) support to remain in, or return to, work and (e) staff experience. There were 12 success criteria in total, described in detail in the results section.

## FCP services

- 240 FCPs from 40 services in England participated in the evaluation.
- 34 of the 40 services were taking part in the NHSE FCP pilot

## Patient registrations

FCPs registered patients to receive information about the evaluation from December 2018 to January 2019.

- 2825 patients were registered by FCPs
- All registered patients were invited to participate in the evaluation by email
- 24% (n=680) completed the initial questionnaire

## Patient characteristics after initial consultation with FCP

Of the 680 patients who completed the initial questionnaire:

- Mean age was 56.2 (SD 14.9), 61% were female, 97% reported their ethnicity to be white
- Average pain intensity (on a scale of 0 to 10) was 6.1 (SD 2.13) and average MSK-HQ score (range 0 to 56, higher scores reflect less impact of MSK symptoms on health) was 33.8 (SD 9.5)
- 47% had an acute/subacute MSK problem ( $\leq 3$  months)
- 25% had pain in  $>1$  body region
- 49% reported  $\geq 1$  co-morbidity
- The Keele STarT MSK tool to determine the risk of persistent disabling pain classified patients as: 29% low-risk, 58% medium-risk, 13% high-risk.

## Follow up outcomes over 3 months

Follow-up rates at 1, 2 and 3 months were 63% (n=430), 62% (n=419) and 54% (n=370).

Of the 370 patients who completed the 3-month follow-up questionnaire:

- Mean reduction in pain intensity from baseline was 2.8 (95% CI 2.5,3.1)
- Mean score improvement in MSK-HQ was 7.1 (6.0, 8.2)
- 64% reported overall improvement (much better/better) since seeing the FCP.

The proportion of patients in employment (n=388) who took time off work in the previous month due to pain remained consistent over 3 months (9%):

- 6% (22 patients) received a Fit note from the GP
- 3% (12 patients) received an Allied Health Professions (AHP) Health and Work Report from the FCP.

### Patient experience

Patient acceptability of FCP was very high;

- 98% of responding patients reported having confidence in the FCP's competency to assess their problem
- 95% reported receiving sufficient information about self-care
- 93% reported receiving sufficient information about their MSK condition

Patients reported feeling valued as individuals with respect to 'care and respect' from general practice staff and 'understanding and engagement' of their problem by the FCP.

### Qualitative findings: interviews and focus groups

Participants for the qualitative interviews, focus groups and observational diaries were recruited from six FCP sites in England. Of the 39 participants, there were 14 patients, 11 FCPs, 8 GPs and 6 general practice non-clinical staff. Data were transcribed verbatim and analysed using thematic analysis by two researchers.

### Interview key themes

Four key themes emerged from the in-depth interviews with patients, GPs and FCPs.

#### 1. Communication

Three communication strategies were identified (i) advertising (ii) signposting (iii) systems and processes. Traditional advertising was ineffective and General Practice reception staff signposting was essential to direct patients to the FCP. Alignment of both IT and non-IT systems of communication facilitated FCP services.

#### Patient understanding of FCP

Some patients lacked complete understanding of modern-day physiotherapy practice and FCP roles.

#### 2. Embeddedness

It took time for FCP services to embed within general practices. Once established, obstacles, such as unfamiliarity with systems and processes diminished. Integration of FCP services was enhanced by consistency in FCP staffing and session scheduling and most importantly, having the FCP co-located in the general practice.

### 3. Contribution of FCP

FCP was described as contributing significantly and in a number of ways.

- i. It was important to participants to collect data about effectiveness of FCP services.
- ii. Current FCP provision was insufficient to reduce GP workload but did positively influence their work experience.
- iii. All participant groups were satisfied with FCP services.
- iv. FCP was described as introducing MSK expertise to general practice and this was valued by participants

### 4. Reconceptualising physiotherapy work

The physiotherapists welcomed the first contact role. There was inconsistency in the scope and models of FCP services. Co-located models appeared most impactful. Additional Advanced practice (e.g. injection, prescribing) skills were seen as desirable rather than essential. Providing advice about work was seen as integral to the FCP role. It was felt that the FCP role provided the physiotherapy profession the opportunity to develop alongside other professional disciplines within a multidisciplinary general practice team.

### Achievement of Success criteria

Eleven of the twelve success criteria were met. Criterion 8 was not met.

Success Criteria 1: 20% of patients saw the GP for the same MSK problem in the 3-months following their baseline visit (target  $\leq 25\%$ ).

Success Criteria 2: GPs discourse reflected confidence in the FCP service and competence of the FCPs.

Success Criteria 3: 95% of patients received sufficient information on self-care (target  $\geq 70\%$ ).

Success Criteria 4: Patient discourse reflected self-efficacy and confidence in self-management techniques.

Success Criteria 5: 54% of patients achieved a 6-point minimal important change on the MSK-HQ at 3-months follow-up (target  $\geq 51\%$ ).

Success Criteria 6: 94% of patients reported being 'likely' or 'very likely' to recommend the FCP service to family and friends (target  $\geq 80\%$ ).

Success Criteria 7: Patient discourse reflected a positive experience of FCP.

Success Criteria 8: 29% of those in employment (n=388) reported receiving specific work advice from the FCP (target  $\geq 75\%$ ).

Success Criteria 9: 54% of patients reported less impact of their MSK condition on work performance (as measured by the Stanford Presenteeism Scale) at 3 months (target  $\geq 51\%$ ).

Success Criteria 10: Physiotherapist's discourse reflects confidence in their competence to offer advice with regards to work related issues.

Success Criteria 11: Patient's discourse reflected perceived benefit from the advice offered by the FCP with regards to work related issues.

Success Criteria 12: Staff discourse reflected a positive experience of working with and in the FCP services.

### Recommendations for the scalability and successful implementation of the FCP model of care.

- To improve access to FCPs, general practice-staff should be supported to signpost appropriate patients to the FCP; this may require investment for training or to develop agreed resources.
- Co-locating FCPs in general practices facilitates optimal efficiency and efficacy of the FCP role.
- FCP service capacity and presence appear positively related to the impact of the service and inversely associated with the effort required to maintain its profile.
- Aligning FCP and general practice IT systems is essential for optimum working.
- Non-IT methods of communication such as an 'open door' policy between clinical staff helps build trust and confidence in the FCP service and should be proactively fostered.
- The demand: capacity conundrum remains unresolved. Current models of FCP do not provide sufficient capacity to significantly reduce GP workload. FCP services, as they are currently implemented do positively influence GP work experience. Greater investment is required if FCP services are to reduce GP burden.
- Public awareness and understanding of FCP remains poor. Initiatives to raise public understanding and awareness of the different roles within the physiotherapy profession would help break down some of the barriers identified.
- Collecting data to demonstrate effectiveness of FCP remains a priority for services. This should include patient reported clinical outcome measures.
- Advanced practice skills in FCPs are desirable rather than essential
- FCPs introduce a MSK specialism into the general practice. This is advantageous to patient care and is valued by the wider general practice workforce. FCPs can positively impact and shape services.

### Conclusion

Ahead of the planned scale-up of the FCP model of primary care across the UK, this evaluation provides useful data on the patients who are accessing these services, their short-term clinical outcomes and whether key success criteria are being met.



To optimise FCP service design and delivery, further work is needed to:

- Explore barriers to FCPs providing work advice
- Reach agreement on the most appropriate FCP access model to optimise patient experiences and outcomes
- Determine whether the FCP model is effective at reducing the workload of GPs.

# Background

Meeting the growing demand for musculoskeletal (MSK) healthcare in the face of a growing and ageing population is a significant challenge for health service delivery. MSK conditions are characterised by pain, loss of movement and function. In turn, this impacts on an individual's quality of life, family and social relationships, and capacity to work. Worldwide, MSK conditions are the leading cause of disability adjusted life years (1).

In the UK, MSK problems are predominantly managed in primary care where they account for approximately 14% of General Practitioner (GP) consultations (2). These presentations occur within the wider context of rising workload (in English practices) (3) and difficulties maintaining the GP workforce. Policy-driven diversification of the workforce has been addressing these issues over the last five years. Part of this solution are MSK First Contact Practitioners (FCPs); autonomous practitioners who have been introduced to make MSK care pathways more efficient, provide faster access to specialist MSK healthcare, and release GPs' MSK capacity to manage other patients.

MSK First Contact Practitioners (FCPs) are Physiotherapists with advanced clinical practice skills who are able to assess, diagnose, provide self-management advice, sign post to other services and discharge without medical input. They are competent at managing the full spectrum of MSK patients, including the most complex cases. Within the UK, FCPs scope may include prescribing medication, ordering scans, performing joint injections and directly listing patients on waiting lists for surgery (4). Patients with MSK pain, can contact the FCP directly, rather than wait to see a GP or getting a referral to other community or hospital services. Alternatively, they may be signposted to see the FCP by a GP practice receptionist, or referred by the GP. The *NHS Long Term Plan* in 2019 committed to ensure the whole NHS England patient population has direct access to FCPs by 2022/23, across all primary care networks (5).

Since 2018, a rapid rollout of FCP services across England has been the focus of the Elective Care Transformation Programme (ECTP). This roll out was part of NHS England's supported pilot of FCP services within 42 Sustainability and Transformation Partnership areas (STPs). For this High Impact Intervention (HII), all the FCPs were Advanced Practice MSK physiotherapists. A pilot site constituted a nominated Clinical Commissioning Group (CCG) and/or group of general practices (circa 50,000 population) and required participation in the FCP National Evaluation led by NHS England.

The FCP National Evaluation comprises three phases. All phases of the evaluation were overseen by the NHSE FCP evaluation steering group. Phases 1 and 2 were led by NHS England ECTP with support from the Chartered Society of Physiotherapy in the development and mobilisation of the two phases. Results were published in January 2020 (6). Phase 1 was an information-gathering survey about FCP services. Phase 2 collected FCP consultation data over 10 months using a tool embedded in the electronic health record system of FCP pilot sites.

Phase 3 of the National Evaluation was a collaboration between Keele University (lead) and University of Nottingham and funded and supported by the Chartered Society of Physiotherapy Charitable Trust and the Joint Work and Health Unit.

Phase 3 consisted of a national evaluation of the FCP model of care. Data on patient reported experience and outcomes were collected using an on-line platform. Qualitative data on FCP, GP, general practice non-clinical staff and patient experience was gathered through interviews and focus groups.

This report presents the findings of this Phase 3 of the FCP national evaluation.

**Overall aim:** To evaluate the FCP model of care against predefined service aims and success criteria.

### Objectives

- i. Achieve agreement of the FCP's service aims and success criteria, against which the new FCP model of care could be evaluated.
- ii. Describe the patients who access the FCP
- iii. Describe patient experiences and outcomes.
- iv. Describe the experiences of FCPs, GPs and general practice staff
- v. Describe the role of the FCPs in providing advice about work in the context of the patient's presenting MSK condition.
- vi. Identify barriers to and facilitators for the successful implementation of the FCP model of care.
- vii. Provide recommendations for the scalability and successful implementation of the FCP model of care.
- viii. Establish a standardised data collection tool for PROMS and PREMS compatible for this setting and ideally for use within the Community Services Dataset.

# Methods overview

## Agreement of Service aims and Success criteria

The evaluation team, with stakeholder input, drafted five service aims and 12 success criteria based on published literature (2,7) and the NHSE Elective Care High Impact Interventions Implementation Framework (8). The draft service aims and success criteria were made available to CSP's interactive (iCSP) FCP network, the FCP steering group and presented to a Patient and Public Involvement and Engagement (PPIE) Group for discussion and finalisation.

## Evaluation study design and setting

The evaluation was a mixed-methods service evaluation of 24-months duration, from August 2018 to August 2020. An online platform collected patient reported experience and outcomes from patients immediately following their attendance at the FCP and at 1, 2 and 3-months follow-up. The qualitative component of the evaluation involved a series of interviews, observations and focus groups at FCP pilot sites to explore the views and experiences of patients, FCPs, GPs and general practice non-clinical staff. As this was an evaluation of an existing clinical service no ethical approval was necessary. The online platform data meets regulatory requirements for General Data Protection Regulation (GDPR), NHS Information Governance and Good Clinical Practice.

## FCP sites

A pilot site had to meet the criteria within NHSE's FCP for MSK Services specification; this included employing FCPs working at Agenda for Change Band 7 or 8a and who meet the criteria of the Health Education England and NHSE MSK Core Capabilities Framework (9). To ensure sufficient patient responses, FCP sites, from across the UK, who were not participating in the NHS England National Evaluation were also invited. Services were eligible to take part if their service met the pilot site criteria. The invite for additional FCP services was advertised via social media (Twitter and interactive CSP (iCSP) network) and at a national conference.

## Online data collection methods

### FCP site participation

The CSP FCP coordinating team contacted pilot FCP sites to request that they participate in the phase 3 national evaluation. FCPs who contacted the evaluation team were given an individual login to access the online patient registration platform. A short training video and instructions were provided to explain to FCPs how to invite their patients to receive further information about participating in the evaluation.

### Patient recruitment and consent

Patients accessing the FCP service, between late December 2018 and early January 2020, were asked by the FCP for verbal consent to be contacted via email by the evaluation team. When a patient consented to be contacted, the FCP entered the

patient's date of birth and email address into the online registration system so the patient could automatically be sent a link and unique ID code for further information about the evaluation and the initial online questionnaire. Patients consented to share their data with the evaluation team by ticking a 'consent to share data' box at the end of the questionnaire and submitting their completed questionnaire through the online system.

#### Data collection - system

An online evaluation platform collected clinical outcome and evaluation data. The platform used an adapted version of the patient survey from a previous study (MSK-Tracker (10)). Emailed invitations to complete online follow-up questionnaires at 1, 2 and 3 months were sent automatically to patients who completed the initial questionnaire.

#### Data collection

The self-reported measures from the initial and monthly follow-up questionnaires are detailed in Table 1.

Measures collected in the initial questionnaire included patient characteristics, PROMS (Patient reported outcome measures) and PREMs (Patient reported experience measures). Monthly follow-up questionnaires collected global change of MSK symptoms since the patient first consulted with the FCP, whether patients consulted the GP for the same problem in the last month, MSK pain intensity and time off work due to pain. MSK health status (MSK-HQ) and impact on work were collected at 3-month follow-up only.

**Table 1 Summary of FCP participant self-reported measures**

Patient descriptors	Definition	Time point of data collection
Age	Age at initial consultation	I
Gender	Gender	I
Pain location	Site of pain complaint on body mannikin	I
Pain intensity	Average pain intensity during the last 2 weeks NRS (0-10)	I, M1, M2, M3
Episode duration	Length of time of current pain ≤ 3 months, 4-12 months 12-36 months, >36 months	I
Ethnicity	What is your ethnicity? Mixed, Asian, Black, White, other, prefer not to say	
Comorbidities	Self-reported diagnosed comorbidities from a provided list: heart disease, high blood pressure, poor circulation, lung disease, diabetes, kidney disease, neurological disorder, liver disease, cancer, depression, arthritis	I
Widespread pain	More than one pain site marked on manikin	I
Health literacy screen (20)	Need help with instructions on written material from doctor/pharmacy	I
Risk status Keele STarT MSK tool (21)	Risk of persistent disabling pain High, medium or low risk	I
Musculoskeletal health MSK-HQ (13)	Impact from MSK symptoms	I, M3
Global change	Change in MSK symptoms since index pain consultation	M1, M2, M3
Work status and work pattern	In paid employment Typical working week (full time or part time)	I, M3
Baseline employment	Receive benefits In those employed: Receive fit note from GP Received Advisory Fitness for work report from FCP	I I I
Work absence	Time off work last 12 M because of pain	I, M1, M2, M3
Work Presenteeism Stanford Presenteeism work scale (11)	Impact of MSK pain on work experiences in the past month	I, M 3
Work advice	Received specific advice from FCP about work	I
Patient enablement (25)	Patient enablement instrument As a result of your visit to FCP, do you feel you are able to... Cope with life Understand your condition Cope with your condition Keep yourself healthy Be confident about your health Able to help yourself	I
Valuing people (24)	Valuing people as individuals scale: Problems were regarded as important by the FCP Clinic staff listened attentively FCP answered all my questions Clinic staff were approachable and east to talk to FCP treated me as an intelligent human being The clinic staff treated me kindly	I
Friends and family test (22)	Recommend to friends & family:	I

Shared decision making (22)	Support available to help make decision about treatment How well you know your treatment options Pros and cons for each option	I
Acceptability	Sufficient information on condition Sufficient information on self-care Confidence in FCP's competency to assess problem	I

I – initial participant questionnaire; M1, M2, M3 – month 1, month 2, month 3 questionnaire; NRS – numerical rating scale.

### Sample size for online data collection

A sample size calculation was not required for this service evaluation. However, to make reasonable estimates of key patient reported outcome measures (within a margin of error of +/-5%), 350-400 patient responses at three-months follow-up were required for the most conservative estimate of 50% prevalence on the key outcome of global change (binary outcome at cut-point of 'much better' to 'better' compared with 'no-change' to 'much worse').

### Data analysis

Data analysis was primarily descriptive. Patient characteristics, PROMs and PREMS were summarised using frequencies and percentages or as mean and median (standard deviation and interquartile range) as appropriate. Impact on work (work absence and work presenteeism (11) was determined for those in paid employment. The percentages reporting their MSK symptoms (global change item) as better or much better (12) and reporting consulting their GP for their MSK symptoms in the last month were determined for each month of follow-up. Mean difference (95% confidence interval) in scores from baseline to the three-month follow-up were determined for pain intensity, the impact on health (MSK-HQ) (13), and on work presenteeism (11). The percentage of participants who had a change score in the MSK-HQ of 6 points or more, which is considered the minimal important change (MIC) in score, was determined to reflect an improvement in MSK health (14).

### Qualitative methods

#### Design

Data were collected via semi-structured interviews and focus groups. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (15) was used throughout to ensure necessary components of study design were reported. The published literature regarding FCP and the service aims and success criteria (Box 1) helped to provide a framework to develop the topic guides for the interviews and focus groups.

#### Participant recruitment and data collection process

An invitation to FCP services to participate in the qualitative component was disseminated via the interactive CSP (iCSP) network. A link FCP was identified for each participating site.

Participants were recruited in two phases (December 2018 and January to February 2020). Participant groups included patients who had attended the FCP service, FCPs,

GPs, administration staff, and commissioners. A purposeful sampling method was used to recruit participant (16). FCPs and patient participants were recruited by the link FCP based on availability and convenience. Recruitment of administrative staff, GP and commissioner participants was influenced by convenience, practicality, availability and relationships established by the link FCP within the respective GP practices.

During the patient recruitment process the link FCP contacted patients, providing them with an information sheet. A nominated code was given to each participant in order to preserve confidentiality and anonymity. Patient participants were interviewed individually to ensure each participant was allowed the opportunity to contribute fully. The majority of the FCPs, GPs and administration staff were interviewed in focus groups.

The interviews and focus groups were recorded using digital voice recorders, transcribed verbatim and coded by the evaluation team. The transcriptions were uploaded into QSR International's qualitative data analysis NVivo 11 Software.

### Data analysis

This evaluation used a hybrid deductive and inductive thematic analysis (17,18). The service aims and success criteria and published literature regarding FCP provided a priori theories that informed the deductive analysis and concurrent inductive analysis allowed the emergence of novel themes. In accordance with COREQ guidelines (15) transparency in data coding is described. All transcripts were coded by two researchers with co-investigators resolving any disagreements. A total of 30% of the transcripts were joint coded. Previous research has shown this method is adequate to demonstrate consistency in coding, interpretations and inferences made by the lead researcher (19). Using this method demonstrated excellent agreement in coding and analysis of the data and no further joint coding was deemed necessary.



# Results

The results are presented in six parts.

Part 1: Service aims and success criteria (objective i).

Part 2: Characteristics and clinical outcomes of patients based on the online data collection (objectives ii, iii and iv).

Part 3: Sites and participants in the qualitative data collection (objective iv).

Part 4: Themes identified in the qualitative interviews and focus groups (objectives iv,v,vi and vii).

Part 5: Combined patient outcomes and qualitative data relevant to the service aims and success criteria (objective ii,iii,iv and v).

Part 6: Standardised data collection tool (objective viii).

## Part 1: Service aims and success criteria

The agreed service aims and success criteria included five aims (A to E), and within each aim specific success criteria, 12 in total (Box 1). Six of the 12 success criteria pertain to the quantitative online data collection (success criterion 1, 3, 5, 6, 8 and 9). The remaining six are addressed by the qualitative component of the evaluation (2, 4,7,10,11,12).

### Box 1 Service aims and Success criteria of FCP model

#### **Aim A: FCP services should reduce the workload of GPs**

Success criterion 1: The percentage of patients consulting the FCP who report (within 3 months) visiting their GP for the same problem will be: 25% or less (fully met), 26-50% (partially met), 51% or more (not met).

Success criterion 2: GPs discourse reflects confidence in the FCP service and competence of the FCPs.

#### **Aim B: FCP services should provide assessment and self-management advice.**

Success criterion 3: Patients will report receiving self-management information/exercises from their FCP relating to their joint or muscle symptoms. 70% or more (fully met), 50-69% (partially met), 49% or less (not met).

Success criterion 4: Patient discourse reflects self-efficacy and confidence in self-management techniques.

#### **Aim C: FCP services should provide high quality care and a good patient experience to patients with MSK problems**

Success criterion 5: Patients should report improved MSK health at 3 months (as measured by achieving a minimal important change of 6 points on the MSK-HQ): 51% or more (fully met), 40-50% (partially met), 39% or less (not met).

Success criterion 6: Patients report being 'Likely' or 'Very likely' to recommend the FCP service to friends and family. 80% or more (fully met), 60-79% (partially met), 59% or less (not met).

Success criterion 7: Patient discourse reflects a positive experience of FCP.

**Aim D: FCP services should support patients to remain in/return to work**

Success criterion 8: Patients in employment report receiving specific advice about work. 75% or over (fully met), 50-74% (partially met), 49% or less (not met).

Success criterion 9: Patients will report less impact of their MSK condition on work performance at 3 months (as measured by the Stanford Presenteeism Scale): 51% or more report reduced impact (fully met), 40-50% (partially met), 39% or less (not met).

Success criterion 10: Physiotherapist's discourse reflects confidence in their competence to offer advice with regards to work related issues.

Success criterion 11: Patient's discourse reflects perceived benefit from the advice offered by the FCP with regards to work related issues.

**Aim E: FCP services should provide staff with a positive experience**

Success criterion 12: Staff discourse reflects a positive experience of working with and in the FCP services.

## Part 2: Characteristics and clinical outcomes of patients based on the online data collection

### Service participation

In total, 240 FCPs (204 from NHSE National Evaluation pilot FCP services) from 40 services in England participated in the evaluation. Thirty-four of these services were from the 46 NHSE pilot services (74% participation rate) and six were additional sites. All six additional sites were located in England. The numbers of FCPs per service ranged from 1 to 19 (median 4).

### Patient registrations and data

Over 13 months, FCPs invited 2825 patients to participate in the evaluation and 24% (n=680) consented and completed their initial questionnaire. Across the 40 services, the number of patients invited ranged from 1 to 613 and response rates to the baseline questionnaire ranged from 0% to 46%.

## Characteristics of patients accessing the FCP

The characteristics and PROMs of the 680 patients who completed the initial questionnaire are presented in Tables 2 and 3. Mean age was 56.2 (SD 14.9), 61% were female, 97% reported their ethnicity to be white. On the Health literacy screen (20) 93% never needed help with instructions on written material.

Findings related to the success criteria are presented separately in part 5.

### Initial PROMS

Mean pain intensity was 6.1 (SD 2.13) out of 10. 47% reported an acute/subacute MSK problem ( $\leq 3$  months), with 25% having pain in more than one body region and 49% reporting at least one co-morbidity. The Keele STarT MSK tool (21) (classified 29% at low-risk of persistent disabling pain, 58% at medium-risk, and 13% at high-risk. Of the 388 patients (57%) in paid employment, 89 (23%) had taken time off work in the previous 12 months due to their pain.

**Table 2 Patient characteristics and initial questionnaire PROMS**

<i>Total response</i>		680
Age <sup>a</sup> : Mean (SD)		56.2 (14.92)
Median (IQR)		58 (47, 68)
Range		18-87
Female <sup>b</sup> : <i>n</i> (%)		411 (61)
Ethnicity <sup>c</sup> : <i>n</i> (%)	White	647 (97)
	Asian	10 (1)
	Other	13 (2)
MSK Problem body site: <i>n</i> (%)		
Head		7 (1)
Neck		63 (9)
Shoulder/upper arm		179 (26)
Lower arm/wrist		45 (7)
Hand		55 (8)
Upper back/chest/abdomen		38 (6)
Lower back/pelvis		136 (20)
Hip/groin/thigh		129 (19)
Knee/lower leg		177 (26)
Ankle/foot		79 (12)
>1 area of pain		167 (25)
Duration current MSK problem <sup>a</sup> : <i>n</i> (%)		
$\leq 3$ months		321 (47)
4-12 months		187 (28)
12-36 months		86 (13)
>36 months		85 (13)
Pain intensity <sup>d</sup> :	Mean (SD)	6.1 (2.13)
	Median (IQR)	6 (5, 8)
Keele STarT MSK tool <sup>e</sup> : <i>n</i> (%)	Low Risk	194 (29)
	Medium risk	396 (58)
	High risk	88 (13)

MSK-HQ <sup>f</sup> :	Mean (SD)	33.8 (9.53)
	Median (IQR)	35 (27, 41)
Comorbidity <sup>g</sup> : yes, <i>n</i> (%)		334 (49)
Health literacy screen (Need help with instructions on written material from doctor/pharmacy) <sup>a</sup> :		
Never <i>n</i> (%)		630 (93)

<sup>a</sup> total *n* = 679; <sup>b</sup> total *n* = 677; <sup>c</sup> total *n* = 670; <sup>d</sup> pain intensity on average over past 2 weeks, score range 0-10, high scores indicate worse pain; <sup>e</sup> total *n* = 678; <sup>f</sup> total *n* = 679, score range 0-56, high scores better; <sup>g</sup> reported diagnosis of at least one of: heart disease, high blood pressure, poor circulation, lung disease, diabetes, kidney disease, neurological disorder, liver disease, cancer, depression, arthritis

**Table 3 –Employment characteristics**

Total response	680
Claiming benefits <sup>a</sup> : <i>n</i> (%)	40 (6)
Universal Credit	10
Personal Independence Payment	8
Working Tax Credit	8
Disability Living Allowance	7
All others	<5
Paid employment: <i>n</i> (%)	388 (57)
Full-time <sup>b</sup> : <i>n</i> (%)	265 (68)
Time off work last 12m due to pain <sup>b</sup> : <i>n</i> (%)	89 (23)
Amount of time off work last 12m <sup>c</sup> : <i>n</i> (%)	
≤2 weeks	70 (80)
>2 weeks to 3 months	12 (14)
3 months or longer	5 (6)
Fit note from GP <sup>b</sup> : <i>n</i> (%)	22 (6)
AHP Health and Work Report from FCP <sup>b</sup> : <i>n</i> (%)	12 (3)
Received advice from FCP about work <sup>b</sup> : <i>n</i> (%)	114 (29)
Received advice from FCP about work in those off work in last 12m <sup>d</sup> : <i>n</i> (%)	40 (45)
Not in paid employment	292
Due to long-term sick/disabled <sup>e</sup>	21 (7)
Most recent job ended <sup>e</sup>	
Within last 6m	23 (8)
7-12m ago	12 (4)
>12m ago	252 (86)
Never had a job	5 (2)

<sup>a</sup> total *n* = 633; <sup>b</sup> denominator is those in paid employment; <sup>c</sup> total *n*=87;

<sup>d</sup> total *n* = 89; <sup>e</sup> total *n*=292; AHP Allied Health Professional.

### PREMS after accessing the FCP

Patient acceptability of FCPs was very high; 93% and 95% reported receiving sufficient information about their MSK condition and about self-care, respectively and 98% of responding patients reported having confidence in the FCP's competency to assess their problem. On the Friends and Family test (22), 94% would recommend the FCP. Shared decision making (23) domains scored highly. Patients reported feeling

valued as individuals (24) with the domains of ‘care and respect’ and ‘understanding and engagement’ scoring 13.8 and 13.3 respectively out of a maximum score of 15. All PREMs are reported in Table 4.

**Table 4 – PREMS after visit to FCP**

<i>Total response</i>	680
Friends and Family test: n (%)	
Recommend to friends & family:	
<i>Extremely likely</i>	490 (72)
<i>Likely</i>	148 (22)
FCP acceptability: n (%)	
Received sufficient information on condition	632 (93)
Received sufficient information on self-care	645 (95)
Confidence in FCP’s competency to assess problem	665 (98)
Shared Decision Making: n (%)	
Amount of support to help you make decisions about treatment:	
<i>Excellent or good support</i>	562 (83)
How well now know treatment options:	
<i>Very well or well</i>	580 (85)
Now know pros and cons for each treatment option:	
<i>Very well or well</i>	519 (76)
Valuing People as Individuals <sup>a</sup>	
Care and Respect: Mean (SD)	13.8 (1.55)
1) Clinic staff listened attentively	
2) Clinic staff very approachable & easy to talk to	
3) Clinic staff treated me kindly	
Understanding and Engagement: Mean (SD)	13.3 (1.64)
1) Problem regarded as important by therapist	
2) Therapist answered all my questions	
3) Therapist treated me as intelligent human being	
Patient Enablement Instrument <sup>b</sup> : Mean (SD)	5.8 (3.77)

<sup>a</sup> Range 3-15; high scores better. Each scale made up of the 3 items listed <sup>b</sup> total n = 634, range 0-12, high scores better

### Follow-Up results

Follow-up response rates at 1, 2 and 3 months were 63% (n=430), 62% (n=419) and 54% (n=370) respectively. Global change in MSK symptoms (defined as better/much better) since patients first saw the FCP increased slightly from 58% at month 1 (n=249) to 64% (n=237) at month 3. There was a 2.8 (95% CI 2.5, 3.1) mean reduction in pain intensity from baseline (published MIC is 2 (26)) and a mean 7.1 (95% CI 6.0, 8.2) score improvement on the MSK-HQ (published MIC is 6). Over 3 months, the proportion of patients in employment who took time off work in the previous month due to pain remained consistent. All follow-up data are reported in Tables 5 and 6.

**Table 5 – Follow-up: all respondents PROMS**

	Month 1	Month 2	Month 3
<i>Total response</i>	430	419	370
Age: Mean (SD)	58.2 (14.12)	57.9 (14.04)	59.0 (13.58)
Median (IQR)	61 (49, 69)	60 (49, 69)	62 (51, 70)
Range	18-87	18-87	21-87
Female <sup>a</sup> : <i>n</i> (%)	251 (59)	260 (62)	223 (61)
Global change since first saw FCP: <i>n</i> (%)			
Much better/Better	249 (58)	261 (62)	237 (64)
Same	140 (33)	110 (26)	93 (25)
Much worse/Worse	41 (10)	48 (11)	40 (11)
Saw GP for same problem in last month: <i>n</i> (%)	43 (10)	60 (14)	37 (10)
Saw GP for same problem in last 3 months <sup>b</sup> : <i>n</i> (%)	N/A	N/A	56 (20)
Pain intensity score <sup>c</sup> : Mean (SD)			
Baseline	6.03 (2.15)	6.10 (2.19)	6.11 (2.16)
Follow-up	4.04 (2.55)	5.76 (2.44)	3.31 (2.74)
Mean difference from baseline <sup>d</sup> (95% CI)	1.98(1.73, 2.23)	0.33 (0.10, 0.56)	2.80 (2.51, 3.09)
MSK-HQ score <sup>e</sup> : Mean (SD)			
Baseline	N/A	N/A	34.4 (9.22)
Follow-up			41.5 (11.31)
Mean difference from baseline <sup>d</sup> (95% CI)			7.1 (6.0, 8.2)
MSK-HQ score improved by $\geq 6$ <sup>f</sup> points: <i>n</i> (%)	N/A	N/A	199 (54)

<sup>a</sup> total *n* month 1=427, month 2=419, month 3=368; <sup>b</sup> those responding at all 3 follow-up points only, total *n* = 275; <sup>c</sup> pain intensity on average over past 2 weeks, score range 0-10, high scores indicate worse pain; <sup>d</sup> Mean difference > 0 indicates improvement; <sup>e</sup> score range 0-56, high scores better; <sup>f</sup> 6 points is minimal important change

**Table 6 – Follow-up: employed only**

	Month 1	Month 2	Month 3
<i>Total response to date</i>	430	419	370
In paid employment at baseline: <i>n</i> (%)	225 (52)	222 (53)	186 (50)
Time off work last 1m due to pain <sup>a</sup> : <i>n</i> (%)	21 (9)	16 (7)	17 (9)
Stanford Presenteeism Scale score <sup>a,b</sup> : Mean (SD)			
Baseline	N/A	N/A	21.4 (5.66)
Follow-up			22.8 (5.98)
Mean difference from baseline <sup>c</sup> (95% CI)			1.46 (0.70, 2.22)
Improved score Stanford Presenteeism Scale <sup>a,d</sup> : <i>n</i> (%)	N/A	N/A	98 (54)

<sup>a</sup> In those in paid employment at baseline; <sup>b</sup> score range 6-30, high scores better; <sup>c</sup> Mean difference > 0 indicates improvement; <sup>d</sup> Improvement defined as an increase in score from baseline to 3 months

## Part 3: Sites and participants in the qualitative data collection

### Sites

In phase 1 two sites were visited. In phase 2, four new sites were visited and one site from phase 1 was revisited. The second site from phase 1 no longer delivered a FCP service. Site visits to Scotland and Northern Ireland were cancelled due to the COVID-19 pandemic. Sites varied in the number of GP practices and population serviced and the service model. This ranged from a single GP practice (site 2) with a population of 10,000 to 68 GP practices with a population of 800,000 (site 6). In one site, the FCP was employed directly by the general practice (site 3). In the remainder sites, there were a number of employment models ranging from primary care FCPs employed by a GP Federation (site 5) to a secondary care outreach model where FCPs based in secondary care were doing sessions in primary care community settings and general practice (sites 2,4 and 6). In most sites, the funding was from commissioning organisations and was frequently FCP pilot initiative funding. As a consequence of this variability in funding, the FCP sessions per site varied. On average, most GP practices had an FCP located in their practice between 0.5 to one day per week. Table 7 gives details of the visited FCP sites.

**Table 7 FCP site details for Qualitative evaluation**

Site	Site 1*	Site 2**	Site 3	Site 4	Site 5	Site 6
Length of time FCP site established	6 months (in phase 1 visit)	3 months	4 years	17 months	2 years	5 years
Service model	Community care provider	Secondary care provider	Employed by GP practice	Secondary care provider	GP Federation	Secondary care provider
Population served by FCP service	50000	10000	19000	160000	290000	800000
Number of GP practices	5	1	1	20	37	68
FCP capacity/ GP practice/week	1 day	1 day	5 days	1 day	0.5 to 1 day	0.5 to 2 days
Number of FCPs/ FTE	3/ 1	2/ 0.2	1/ 0.75	1/ 0.2	8/ 7.45	14/ 14
FCP Banding/s	2 x B8a, 1 x B7	8a	8a	8a	3 x B8a, 5 x B7	7 & 8a
Advanced skills of FCPs	B8a: NMP, injection therapy. B7&B8a: radiology & pathology requesting	1 x NMP	Pending NMP & injection therapy	NMP, injection therapy, radiology requesting	NMP, injection therapy, radiology requesting	NMP, injection therapy, radiology & pathology requesting
Appointment length	20 minutes	30 minutes	20 minutes	20 minutes	30 minutes	20 minutes
*Site 1 was visited in both phase 1 and phase 2; ** Site 2 was visited in phase 1 only; FCP, first contact physiotherapist, GP, general practitioner; B Band;, FTE, full time equivalent; NMP, Non-medical prescriber						



## Interview and focus group participants

Over the two phases there were a total of 39 participants, this included 14 patients, 8 GPs, 11 FCPs and 6 general practice administration staff. The duration of each interview and focus group ranged between 25 and 75 minutes. In total approximately 20 hours of audio data was recorded. Participant details are provided in Table 8.

**Table 8 Participant details for Qualitative evaluation**

<b>Site 1</b>	GP (I)	FCP (I)	Patient 1 (M, White British, Age 62) (I)	Patient 2 (M, White British, Age 53) (I)	Patient 3 (F, White British, Age 47) (I)	
<b>Site 2</b>	GP (I)	FCP (I)	Practice Manager (I)	Patient 1 (F, British Asian, Age 62) (I)	Patient 2 (F, White British, Age 67) (I)	Patient 3 (M, British Asian, Age 32) (I)
<b>Site 3</b>	FCP + GP (FG)	Practice Manager (I)	Patient 2 (F, White British, Age 67) (I)	Patient 2 (F, White British, Age 29) (I)		
<b>Site 4</b>	FCP (I)	GP (I)	Practice Manager (I)	Patient 1 (M, White British, Age 69) (I)	Patient 1 (M, White American, Age 57) (I)	
<b>Site 5</b>	FCP x 2 (FG)	GP + Practice manager (FG)	GP (I)	Practice Manager (I)	Patient 2 (F, White British, Age 49) (I)	Patient 2 (F, White British, Age 75) (I)
<b>Site 6</b>	FCP (I)	GP + Practice Manager (FG)				
<b>Site 1 (revisited in phase 2)</b>	FCP x 3 + GP (FG)	Patient 1 (M, White British, Age 73) Patient 2 (M, White British Age 77) (FG)	Practice Manager (I)			

I, interview; FG, focus group; M, male; F, female.

## Part 4: Themes identified in the qualitative interviews and focus groups

Six over-arching themes were developed with sub-themes. These will be briefly described



## Theme 1 Communication strategies

There were four important communicative strategies and considerations considered important in the implementation of FCP

### Advertising

Advertising was described as essentially invisible and consequently ineffective. There appeared to be a conscious decision by the healthcare professionals to de-prioritise advertising. There was a clear impression in all sites that FCP capacity could not match anticipated demand for MSK patients. Services did not want to risk becoming overwhelmed.

### Signposting

Signposting, or care navigation, is a process increasingly seen in general practice to help patients identify and access available services. Often this is undertaken by frontline general practice administration staff. Signposting was consistently and repeatedly described as essential in facilitating access to FCP and was enhanced by training.

Signposting was considered an evolutionary process, both '*within*' a particular practice and more widely. It was apparent that a national agenda of signposting, or care navigation, existed.

Despite this overwhelming consensus that the success of the first contact principle "*boils down to the sign-posting*" (FCP) there remained a considerable degree of inconsistency and variability in approach.

### Systems and Processes

The importance of aligned IT systems was highlighted in both phase 1 and 2 of data collection. Sharing the same electronic patient record system as GPs was considered essential and seen as a clinical governance issue with easy access to 'live' changes in patient care. These aligned systems were also described as facilitating FCP autonomy.

Even more weight was attributed to personal methods of communication with repeated reference made to use of an 'open door' policy between FCPs and GPs. Being co-located in the same building as administration staff and clinical staff allowed face-to-face communication and FCPs attendance at multidisciplinary meetings.

## Theme 2 Awareness and understanding of FCP was poor

Important themes synthesised in both phases of data collection was that awareness of FCP services and patient understanding of what to expect from FCP services was poor.

### Awareness of FCP services.

There was evidence of widespread lack of awareness of the existence of FCP services among the patient population. The evidence suggested that awareness of FCP services increases over time. There was no evidence that this was anything other than a passive process, reliant on awareness spreading through the patient population.

### Understanding of FCP

The broad understanding of FCP was poor in all participant groups, barring the FCPs themselves. Poor patient understanding of FCP was felt to be against a background of poor understanding of physiotherapy more generally. This lack of understanding appears to increase the propensity of patients defaulting to their GP as a first point of contact.

### Theme 3 Role of the GP in the FCP agenda

The role that the GP plays in the FCP agenda was complex. The original round of data collection in phase 1 found no evidence of GP resistance to the FCP model in primary care. In the phase 2 data, there were some descriptions of GP resistance attributed to a reluctance to loosen control of the traditional GP-led gatekeeping model. Despite this evidence of GP resistance, there were data from all GP participants that evidenced their support for the FCP role.

There was a strong acknowledgement that GPs could also be FCPs' greatest advocates. Positive GP influence was described in the day-to-day support in clinical case management. This was frequently reported by FCPs who worked in a co-located model. This was facilitated by the 'open door' policy described above and extended to GPs providing support to FCPs with a more restricted scope of practice such as prescribing or diagnostic referrals. The support of GPs also extended to mentorship for the training of FCPs in their advanced practice education.

### Theme 4 FCP contribution to general practice

FCP was seen to contribute in several ways to general practice and four sub-themes were developed.

#### Evidence

Collecting data to evidence FCP effectiveness was regarded by the FCPs as an important activity that all engaged with to varying degrees. Most data collection concerned activity the FCPs undertook and this was felt to be influential in the implementation and utilisation of FCP services. It was felt important to collect data about the number of 'true first contacts' as a key performance indicator and where necessary methods to improve the number of these first contacts.

#### Efficacy

Most discussion around efficacy of FCP services related to the routine metrics collected as described above. There was a generalised consensus that FCPs were generally more specialised in the management of MSK pain but no sites presented robust data using patient reported clinical outcomes.

## Impact on the GP work experience

The over-riding consensus was that there was a clear proportionality in the potential for FCP services to reduce the MSK caseload of GPs. On the whole the current models of FCP had not demonstrated a freeing-up of GP time to see other patients. The vision of increasing capacity to closer match demand in the future was seen as achievable and could potentially result in increased duration appointments for GPs and shorter general practice waiting times more generally.

A concern previously raised in the literature was that of GP de-skilling in MSK health management. It was immediately evident that with FCP capacity so limited, GP deskilling was unlikely. The general sense was that the often complex nature of primary care work where patients can present with several comorbidities requires GPs to maintain a MSK competence. Two consequences of this were articulated. GPs acknowledged that MSK conditions brought some '*light-relief*' into an increasingly complex caseload and stripping away of these elements of their caseload would leave them to become '*geriatricians*' and risk burnout.

However, for others there could be, and for some had been, a worthwhile trade off. Some GPs were already able to describe an extension to their consultation times as a response to the additional primary care roles with a relatively small lengthening of consultation time described as significant.

The final impact of FCP on GP work experience was an acknowledgement of the introduction of a MSK specialism into the practice. This specialism was celebrated as a resource to be utilised within the practice. There were multiple examples of this, ranging from the informal conversations to more formal training delivered by FCPs.

## Theme 5 FCP reconceptualises physiotherapy work

It was clear that the FCP role was still somewhat immature in conception but provided the opportunity to change the face of traditional physiotherapy work. The nature of the first contact role means FCPs see some patients with undiagnosed pain and with this comes competency to assess and diagnose this patient safely and appropriately. All FCPs, with the support of GPs, were able to describe cases where they had identified non-MSK conditions masquerading as a MSK problem within their role.

The novelty of this model of working, the perceived risk of the first contact principle and the personal development of advanced practice physiotherapy roles gave a sense that FCP was a change to traditional physiotherapy practice.

## Theme 6 The variation in the FCP scope and model

FCP sites were selected to reflect different service model typology. There was significant diversity between sites (Table 7) and subsequent learning.

An important finding from the data was the advantages of having the FCP co-located in a general practice. The advantages included improved communication, improved support, consistency of messaging to the patient population, enhanced confidence among the clinical and support staff within the practice and decreased clinical risk. FCP impact would also appear to be proportional to time spent in a practice.

Agenda for change banding was consistent and aligned with the current guidelines with all FCPs employed at band 7 or band 8a. For some clinical staff (FCPs and GPs), the prospect of lesser qualified staff undertaking the role was intolerable, whereas for others it was not so clear cut with a lower banded physiotherapist being able to work in a FCP role with greater supervision. Some participants (a GP and practice manager and a FCP) took a longer-term vision of succession planning suggesting broader grades and banding should be considered with junior staff trained in the post.

The distribution of advanced practice roles was variable (Table 7). Clinical experience was seen by FCPs as the most important prerequisite with experience needing to be clinically broad, rather than just MSK specific, and ideally gained in a variety of settings across care sectors.

Advanced practice roles such as injection therapy and non-medical prescribing were seen, across all participant groups as desirable rather than essential. Utilisation of these skills was suggested by the interviewed FCPs to be as infrequent as 5-10% of FCP contacts.

Most services had appointments of twenty-minutes and most FCPs, and other staff, felt this was sufficient and aligned with GP working practice- that of running over in diary time management. For one service, twenty-minutes was 'hugely unrealistic' and was felt to increase risk, compromise the advanced practice aspects of the role and undermine the whole FCP initiative.

#### Part 5: Combined patient outcomes and qualitative data relevant to the service aims and success criteria

Eleven of the twelve success criteria were met (Table 9). Success criteria 8 (patients in employment receiving specific advice about work) was not met.

**Table 9 Results relevant to success criteria**

Agreed Service Success Criteria		Target	Outcome	Target met
1	The percentage of patients consulting the FCP who report (within 3 months) visiting their GP for the same problem	25% or less	20% of patients who responded at all 3 follow-up points (n=275) saw the GP for the same MSK problem in the 3 months following their initial visit	YES
2	GPs discourse reflected confidence in the FCP service and competence of the FCPs.			YES
3	Patients report receiving self-management information/exercises from their FCP relating to their joint or muscle symptoms	70% or more	95% of patients received sufficient information from their FCP on self-care relating to their MSK problem	YES
4	Patient discourse reflected self-efficacy and confidence in self-management techniques.			YES
5	Patients report improved MSK health at 3 months (as measured by achieving a minimal important change of 6 points on the MSK-HQ)	51% or more	54% of patients achieved a minimal important change of 6 points on the MSK-HQ at 3 months follow up	YES
6	Patients report being 'Likely' or 'Very likely' to recommend the FCP service to friends and family	80% or more	94% would recommend the FCP service to family and friends	YES
7	Patient discourse reflected a positive experience of FCP.			YES
8	Patients in employment report receiving specific advice about work	75% or over	29% of those in employment reported receiving work advice from the FCP	NO
9	Patients report less impact of their MSK condition on work performance at 3 months (measured by the Stanford Presenteeism Scale)	51% or more	54% of patients reported less impact of their MSK condition on work performance at 3 months	YES
10	Physiotherapist's discourse reflected confidence in their competence to offer advice with regards to work related issues.			YES
11	Patient's discourse reflected perceived benefit from the advice offered by the FCP with regards to work related issues.			YES
12	Staff discourse reflected a positive experience of working with and in the FCP services.			YES

## **Aim 1: FCP services should reduce the workload of GPs**

**Success criterion 1:** In patients who responded at all 3 follow-up points (n=275), 20% (n=56) saw the GP for the same MSK problem in the 3 months following their baseline visit (target 25% or less).

**Success criterion 2:** GP's discourse reflects confidence in the FCP service and competence of the FCPs.

The aim of decreasing the workload of GPs was not described in the qualitative data but the findings shed light on the wider impact of FCP implementation on GP work experience. Participants felt that with adequate capacity the FCP service could have an impact on GP workload. For example, in site 4, the FCP said.

*"I don't think I've reduced the burden on GPs in terms of, I don't think I've increased their capacity, purely because I'm doing two sessions for 22 GP practices, so I don't think they'll notice a difference"*

FCP

The potential to impact GP workload positively by addressing the mismatch between FCP capacity and MSK demand was explored in later interviews. Matching MSK demand with FCP capacity was, envisaged as a realisable objective with caveats. The first caveat was the nature of patient complexity and comorbidity:

*"Also sometimes, it's sometimes it's appropriate to you know, when I'm seeing you know, Mr Smith about his diabetes, and he wants to talk about his knee pain you know, his osteoarthritis, then fine you know, that will always carry on. It's the new presentations of you know, I've got new elbow pain, I've got new knee pain, new back pain, that is massively reduced. And you know, that's been a real benefit"*

GP

The second caveat related to patient beliefs and understanding with some patients (commonly, although not uniquely, the older population) likely to default to their GP as a first point of contact, there was an acknowledgement of the funding gap in existing service models that needed to be addressed to release capacity to realise this objective. A practice manager (and CCG commissioner) and a GP both spoke of the bravery required in this vision:

*"I think as you said it's sort of bravery. I think if you look at pure appointment numbers, and if every MSK issue went to the physiotherapist, then you could probably justify dropping a GP clinician. But it's a... you've got to have the balls to do it"*

GP

GP participant discourse consistently reflected high levels of confidence in the competence of FCPs and GPs welcomed the addition of FCPs to the general practice workforce:

*"It has been a fantastic addition actually. And I think I've seen patients who have seen [FCP] subsequently, and they've been delighted with the treatment that they've got. I*

*think we've very lucky for [FCP]'s experience, I mean it's Advanced, so I don't know how you know, how realistic that is to replicate across the whole population. Because you know, there's always going to be variability in the experience and expertise. But so far it's been almost all positive"*

GP

**Aim B: FCP services should provide assessment and self-management advice.**

**Success criterion 3:** 95% of patients received sufficient information from their FCP on self-care relating to their MSK problem (target 70% or more).

**Success criterion 4:** Patient discourse reflects self-efficacy and confidence in self-management techniques.

Patients spoke confidently about the self-management advice they had been given and also described an associated sense of self-efficacy as the following patient quote demonstrates:

*"So it was years of, oh no, my back's gone again, and then regretting, oh why haven't I done my exercises? And that's why I do the exercises [FCP] has given me. Yeah, and there's a switch, a change in how you take control of your own healthcare really"*

Patient

Patients also appeared to be cognisant of the changing face of primary care and general practice and how FCP sat within this contextual reconfiguration.

*"I hope it will be. I think it's great to involve other... what do you call yourselves... practitioners, other care givers, other people who know what they're talking about. So that the GP can see the people who are really sick and need to see the GP. You could have a cold specialist as well, and all the people could go in with their coughs and colds to see one poor person who'd have to have a really good immune system"*

Patient

**Aim C: FCP services should provide high quality care and a good patient experience to patients with MSK problems**

**Success criterion 5:** 54% of patients achieved a minimal important change of 6 points on the MSK-HQ at 3 months follow up (target 51% or more).

**Success criterion 6:** 94% would recommend the FCP service to family and friends (target 80% or more).

**Success criterion 7:** Patient discourse reflected a positive experience of FCP.

Patient satisfaction was reflected in discourse related to success criteria 4 (Patient discourse reflects self-efficacy and confidence in self-management techniques.) In addition, FCP was welcomed as an introduction of a specialism within general practices.

*"My first impression, it's been excellent, it's had me in and out of here way quicker than it would have done if I'd have had to wait for the GP. And actually [FCP]'s*

*knowledge and expertise is much more specific to the problem that I came with. Than possibly a GP who again, I'm just stereotyping, who possibly would have focussed on the pain, and the pain relief, rather than the rehabilitation and fixing the problem. Or potentially referring me to a physio, so it's cut that stage of it out"*

Patient

Satisfaction with FCP services was reported by all patient participants.

*"the positiveness that we've had back has been quite overwhelming. 100% satisfaction, positive, excellent reviews from patient groups and patient participation"*

Practice Manager

#### **Aim D: FCP services should support patients to remain in/return to work**

**Success criterion 8:** 29% of those in employment reported receiving work advice from the FCP (target 75%).

**Success criterion 9:** 54% of patients reported less impact of their MSK condition on work performance (as measured by the Stanford Presenteeism Scale) at 3 months (*target 51% or more*).

**Success criterion 10:** Physiotherapists' discourse reflects confidence in their competence to offer advice with regards to work related issues.

All FCPs stated that they would consider work-related issues with every patient of working age.

Two FCPs spoke specifically about using the Allied Health Professions (AHP) Health and Work Report and finding this useful. However, availability of training to use the report was patchy and inconsistent and the practical application of the form itself was described as cumbersome.

All participants saw the value in FCPs being able to sign patients off work with legislative authority. The fact that they currently could not do so was seen as strange and counterintuitive. GPs saw FCPs as far better equipped to make that assessment and often described themselves as following FCP advice. The only concern expressed with regards to this was a FCP who paralleled signing patients off work with other advanced practice skills:

*"In terms of prescribing, I'm scared of the, maybe the addictive nature of it, you don't know really what they're on, or what they've taking, and you're being held accountable for that. But then in terms of work, if you sign someone off who, you then could get them into this cascade of being off work. So I don't know which one scares me more"*

FCP

The overwhelming consensus was that employment advice was integral to the FCP role and greater legislative accountability should be attributed to the role.



**Success criterion 11:** Patients' discourse reflects perceived benefit from the advice offered by the FCP with regards to work related issues.

The majority of working patient participants reported discussing work and receiving advice from the FCP. The age of some patient participants meant that they were retired, however the patients who had received employment related advice found this helpful.

*"So I had taken sick leave the first week when I was back, and then... So the next week she said, yes I could go but only two days a week...I must wear the sling except when I'm at my desk. So I could take it off when I'm sitting at my desk, but at all other times I have to wear the sling, so that's really helpful. And then last week it was, certain exercises I had to do when I'm at my desk...and that's really helpful"*

Patient

### **Aim E: FCP services should provide staff with a positive experience**

- **Success criterion 12:** Staff discourse reflects a positive experience of working with and in the FCP services.

All FCPs found it a rewarding and enhancing career opportunity. For this physiotherapist it was extremely positive being at the front end of the patient journey.

*"As a clinician it's fantastic to be at the front of a pathway, to be seeing people when it's first happening, when they're all, even, I mean I used to work in chronic pain as well and there you're seeing people at the very end of the pathway"*

FCP

The first contact nature of FCP work was reported as both rewarding for the physiotherapist and beneficial for patient care.

*"Yeah, I love doing it. I really love working in the clinics. I feel you're just getting to people so much quicker and giving them the right information to make changes"*

FCP.

Nevertheless, the acute nature of the work was acknowledged as introducing some challenges and associated risk

*"You don't know what's coming through the door. You can't look at your list two weeks in advance and say, oh I've got X, Y and Z coming in then, let's read up on it, it's on the day you know, you have no prior warning"*

FCP

Consequently, the FCPs spoke about the need to manage risk and associated competency requirements.

In both phases of data collection FCPs discussed the novelty of working in a way that emulated the GP model of care. As one FCP reported:

*“I can say try these for a month and if it doesn’t work, they know that I’m in primary care... they can come back at any time. They could book an appointment with me tomorrow if they wanted to. So that reassurance for them is also quite helpful”*

FCP

#### Part 6: Standardised data collection tool

FCPs regarded collecting data to evidence their effectiveness as important but no sites involved in the qualitative data collection presented robust data of patient clinical outcomes. One of the objectives of our evaluation was to establish a standardised data collection tool for PROMS and PREMS compatible for this setting and ideally for use within the Community Services Dataset.

This dataset is now available on our Keele website

(<https://www.keele.ac.uk/pcsc/research/researchthemes/musculoskeletalpainandstratifiedcare/msktracker/>) and available as an Appendix with this report.

# Discussion

## Summary

This is the first national, mixed methods evaluation of the FCP model of care. The aim of the national evaluation (phase 3) was to evaluate the FCP model against pre-agreed service aims and success criteria. Data included self-report patient data following initial consultation with FCPs and 3 monthly follow-up questionnaires, alongside views and experiences of patients, FCPs, GPs and general practice non-clinical staff explored through interviews and focus groups.

## Success criteria

Eleven of the twelve pre-determined success criteria for FCP services were met. The majority of MSK patients do not see the GP again once they consult with an FCP, FCPs provide patients with self-management advice, high quality care and a good experience. The service is acceptable to GPs, practice staff and patients and the evaluation highlighted important learning points for those involved in the FCP initiative.

## Work and Employment

One of the twelve criteria was not met, given that less than one third of patients in employment reported receiving specific work advice from the FCP. On reflection, the target (75%) may have been too ambitious in the context of the first consultation and may have been better focused on those reporting days-off-work due to MSK symptoms. In the 89 patients that reported MSK-related days-off-work, 45% reported receiving advice about work. Given that individualising care and advice to patients is a marker of high-quality care, we should expect more than 45% of those who had experienced work-related absence to have had a memorable conversation with the FCP about this. For LBP patients a recent study also showed that physiotherapists are not in line with recommendations for giving specific work advice (27). Supporting FCPs to deliver work advice appears to be an unmet need and specific support for the delivery of work advice by FCPs may be needed. Interviews with FCPs suggested training to use the AHP Health and Work Report was inconsistent. GPs saw FCPs as better suited to make assessments on fitness for work and often described themselves as following FCP advice.

We know that about 35% of MSK consultations with GPs will result in a Fit note (28) which is considerably higher than the numbers in our evaluation reporting receiving a fit note from the GP (6%) or an AHP Health and Work Report from the FCP (3%). What is not known is how many MSK consulters bypassed the FCP because they were actively care-navigated to GPs due to needing a fit note or if patients self-selected to see a GP instead of a FCP, if they thought they needed time off work. The other potential bias is that the patients who took part in the evaluation may have been less likely to be off work.

## Comparison to existing literature

Findings from a systematic review suggested that MSK triage and direct access services can have comparable clinical outcomes when compared to GP-led care (29). Those who access self-referral services are often younger, slightly more educated, with better socio-economic status and shorter duration of symptoms (30). These differences in patient profile may be due to the way services are advertised, organised and implemented. It may also be because the GP is historically viewed as the default first point of contact (31, 32). From the qualitative results, signposting was consistently and repeatedly described as essential in facilitating access to FCP as there was evidence of widespread lack of awareness of the existence of FCP services among the patient population.

Of most influence from the qualitative findings was the effectiveness of the co-located model of FCP, where the FCP is based in the GP practice. This facilitated a number of important features that increased FCP impact. Benefits included improved communication, improved support, consistency of messaging to the patient population, enhanced confidence among the clinical and support staff within the practice, and a perception of decreased clinical risk.

Our evaluation data can be compared to our recent study undertaken among patients (n=524) consulting their GP in England about MSK pain (33), in an area without an FCP pathway. The aim was to examine the feasibility of a future cluster randomised controlled trial of stratified care for MSK pain. Comparing the evaluation results with this study, demonstrates similar baseline characteristics between FCP and GP consulters for gender and pain site. Patients consulting FCPs and responding to our emailed invitation and online data collection system, were younger than those consulting GPs and responding to a paper-based questionnaire through postal mail (mean age 56.2 versus 61.1). The proportion of patients with comorbidities was higher in GP consulters (65%) than the FCP consulters (49%). The proportion of patients classified at high risk of persistent disabling pain was identical for FCP and GP consulters (13%) and was similar for those at low risk (29% v 33%). FCP consulters had better health status as measured by the MSK HQ (33.8) compared to a score of 29.6 in patients consulting the GP. Clinical outcomes at 3 months for FCP consulters compared to 6-month follow-up data for GP consulters were similar for pain (mean change in pain score of 2.8 for FCP consulters versus 2.1 for GP consulters) and mean difference in MSK-HQ score (7.1 in FCP consulters versus 7.5 in GP consulters). However, the proportion of patients reporting global change of worse/much worse was lower in FCP consulters (11%) than GP consulters (22%).

This suggests the cohort of patients seeking GP care is more complex than those seeing FCPs, findings also mirrored in a Swedish study where MSK patients consulting the GP reported worse general health (measured by EQ-5D) than physiotherapy consulters (34). These differences in characteristics and outcomes may be due to methodological differences between the studies, such as patients' willingness to participate in online data collection versus paper-based data collection. It may be that FCPs were less likely to invite complex patients to register in the evaluation. It may also reflect findings from our interviews and focus groups where

local implementation policies mean receptionists or care navigators may direct more complex patients to GPs and some descriptions of GPs' reluctance to loosen control of the traditional patient gatekeeping model.

The STEMS-2 study which assessed the impact of self-referral to physiotherapy services, again where there was no FCP pathway, showed an inconsistent impact on GP workload with a significant increase in GP consultations for MSK conditions observed in some practices (35). In STEMS-2 the physiotherapists were situated separately to the general practices. The presence of a FCP within a GP practice is likely to have a combined impact of diverting some GP MSK workload to FCPs, providing access to some patients who may not have consulted a GP with their MSK condition and reducing the burden within a GP consultation by removing the MSK element within multi-problem consultations.

Discourse with FCPs, GPs and practice staff in our evaluation acknowledged a funding gap in existing service models to realise the capacity increase needed to genuinely impact GP burden to a measurable level. This is a pertinent finding with the current nationwide commitment to FCP whereby a population of 50,000 receives funding for 1 full time equivalent FCP. Potentially, any meaningful impact on GP burden, at this proposed level, is unrealistic.

### Limitations

For the online data collection, patients consulting the FCPs were not registered consecutively by the FCP and there was a myriad of reasons for this based on informal feedback with FCP clinicians. The CSP and NHSE used a number of different strategies to encourage more FCP engagement with phase three evaluation; webinars for both FCPs and NHSE regional leads; targeted support with patient resources; FCP peer network. The reasons included time constraints of the consultation (likely to be more of an issue among complex patients), language barriers and FCPs in a new role. There was wide variation in patient registration across the FCP sites. Various local strategies may have influenced this, e.g. inputting data at the end of the week to the database, instead of registering patients as recommended at the start of each clinic. The ethnicity of responding patients was overwhelmingly white, despite FCP services located in diverse areas including both rural and urban areas. A limitation of the on-line tool was that it was only available in the English language.

There are no data on patients who did not participate in the online evaluation despite being asked by the FCPs, and no data on the patients who agreed to be registered but did not complete the on-line questionnaires. Therefore, we cannot judge if the sample is representative of the general population consulting FCPs. In terms of non-response bias over the three-month follow-up, those with follow-up data were slightly older but there was little difference in gender and baseline severity.

For the online data collection, we did not gather information about the variation in the services and cannot assess whether certain models performed more effectively than others; for example, the FCP co-located within the GP practice versus a community hub model. The roll-out phase of the evaluation was open to FCP services anywhere in the UK but there was no uptake from services outside England. A longer roll-out

phase may have facilitated wider engagement. Site visits to Northern Ireland and Scotland were planned for interviews and focus groups but were cancelled due to the Covid19 pandemic.

## Conclusion

This evaluation provides useful data on the characteristics of patients who are accessing the FCP service, their short-term clinical outcomes and experiences of FCPs, GPs, general practice non-clinical staff and patients. The results confirm that key success criteria are being met.

## Recommendations for the scalability and successful implementation of the FCP model of care.

The learning points from the evaluation are:

- To improve access to FCPs, general practice-staff should be supported to signpost appropriate patients to the FCP; this may require investment for training or to develop agreed resources.
- Co-locating FCPs in general practices facilitates optimal efficiency and efficacy of the FCP role.
- FCP service capacity and presence appear positively related to the impact of the service and inversely associated with the effort required to maintain its profile.
- Aligning FCP and general practice IT systems is essential for optimum working.
- Non-IT methods of communication such as an 'open door' policy between clinical staff helps build trust and confidence in the FCP service and should be proactively fostered.
- The demand:capacity conundrum remains unresolved. Current models of FCP do not provide sufficient capacity to significantly reduce GP workload. FCP services, as they are currently implemented do positively influence GP work experience. Greater investment is required if FCP services are to reduce GP burden.
- Public awareness and understanding of FCP remains poor. Initiatives to raise public understanding and awareness of the different roles within the physiotherapy profession would help break down some of the barriers identified.
- Collecting data to demonstrate effectiveness of FCP remains a priority for services. This should include patient reported clinical outcome measures.
- Advanced practice skills in FCPs are desirable rather than essential
- FCPs introduce a MSK specialism into the general practice. This is advantageous to patient care and is valued by the wider general practice workforce. FCPs can positively impact and shape services.

## Future work

Further work is needed to explore barriers to FCPs providing work advice, to reach agreement on the most appropriate FCP access model to optimise patient experiences and outcomes and to determine whether the FCP model is effective at reducing the workload of GPs.



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