**Patient Satisfaction with the First Contact Physiotherapy Service: Results from the National Evaluation Survey**

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**Key words:**

First contact physiotherapy, patient satisfaction, free-text analysis

**Abstract:**

Background:

Musculoskeletal (MSK) First Contact Physiotherapists (FCPs) are diagnostic clinicians able to assess and manage undifferentiated and undiagnosed MSK presentations. The FCP role in primary care has been introduced to allow patients with MSK pain to see a FCP directly rather than wait to see a GP first, which improves capacity within primary care. A national evaluation was undertaken of the FCP model. This paper reports the thematic analysis of the free-text responses of patients who participated in the national evaluation.

Methods:

An online platform collected patient-reported experience and outcomes following the FCP consultation and at 1, 2 and 3-months follow-up. Free-text responses to the Friends and Family test, reasons for consulting another health care professional and general comments were thematically analysed and grouped according to their responses.

Results:

Over 13 months, 680 of 2825 registered patients (24%) completed the initial questionnaire and 54% (n=370) completed the 3-month follow-up. During the course of the evaluation, 785 participants provided free-text responses. Themes identified from free-text responses were: communication and knowledge, clinicians’ characteristics, efficiency, treatment provided, assessment skills and service provided in comparison to GP care. Complaints represented 4% (n=26 comments) of total feedback. The main reasons for consulting other health care professionals after seeing a FCP were persistent pain, delays in referrals or already attending NHS physiotherapy.

Conclusion:

Thematic analysis of free-text responses in the national FCP evaluation provides context and detail to the positive outcomes reported by patients after consulting a FCP in primary care.

**Background**

In the United Kingdom (UK), musculoskeletal (MSK) conditions are predominantly managed in primary care where they account for approximately 14% of General Practitioner (GP) consultations (Jordan et al., 2010) This is important in the wider context of rising workload (in English practices) (Hobbs et al., 2016) 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 first contact physiotherapists (FCPs): autonomous practitioners who have been introduced to streamline MSK care pathways, provide faster access to specialist MSK healthcare and release GPs’ MSK capacity to manage other patients (Goodwin et al., 2021). Currently the majority of FCPs are physiotherapists, so they are able to bring physiotherapy expertise to the front of the musculoskeletal pathway (NHS England, 2019). This will help to ensure patients are seen by the right person at the right time.

FCPs, included in this Evaluation, were musculoskeletal physiotherapists. As an FCP, they are able to assess and manage undifferentiated and undiagnosed MSK presentations independently (Health & England, n.d.), reducing the need for patients with MSK pain to see the GP (Downie, McRitchie, Monteith, & Turner, 2019). FCPs often have advanced skillsets, and it may be within their scope of practice to order investigations, refer to other services, perform joint steroid injections and/or independently prescribe medication, such as pain-relief for musculoskeletal conditions (Downie et al., 2019).

Since 2018, a rapid roll-out of FCP services across England was stimulated by the Elective Care Transformation Programme within NHS England’s supported pilot of FCP services within 42 sustainability and transformation partnership areas (STPs). A pilot site required participation in the National FCP Evaluation. Phase 1 used a local context questionnaire to collect data on services funding, governance, staffing and care providers. Phase 2 collected FCP consultation data over a 10-month period using an embedded tool in the electronic health system of pilot FCP sites. Phase 3 of the National Evaluation was a national mixed-methods evaluation of the FCP model of care against pre-defined service aims and success criteria. The phase 3 mixed-methods approach collected patient reported experience and outcomes data using an online platform, from 240 FCPs in 40 services in England. Qualitative data on FCP, general practice non-clinical staff and patient experience was gathered through interviews and focus groups.

The findings of the phase 3 Evaluation are reported elsewhere (Goodwin et al., 2021; Stynes et al., 2021) and confirm that key success criteria are being met. This paper presents a thematic analysis from the phase 3 Evaluation, of previously unreported free-text responses provided on the online questionnaires, from patients on their experiences and satisfaction following consultation with a FCP.

**Methods**

*Patient recruitment, consent and data collection*

Between late December 2018 and early January 2020, 240 FCPs across 40 FCPS sites in England asked patients accessing their service for verbal consent for email contact 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. Emailed invitations to complete online follow-up questionnaires at 1, 2 and 3-months were sent automatically to patients who completed the initial questionnaire. As this was an evaluation of an existing clinical service, no ethical approval was necessary. The online platform data met regulatory requirements for General Data Protection Regulation, NHS Information Governance and Good Clinical Practice.

*Data collection*

The self-reported measures from the initial and monthly follow-up questionnaires are reported in full elsewhere (Stynes et al., 2021). Patient reported experience measures included the Friends and Family Test (FFT)(NHS, 2015) which is a two-part question. The first part asks patients to rate on a 5-point likert scale, (ranging from extremely likely to extremely unlikely) “How likely are you to recommend this service to friends and family if they need similar care or treatment?” The second part of the question gives an opportunity to explain the scoring and asks “Thinking about your response to this question, what is the main reason why you feel this way?” This free-text response was analysed thematically for the purpose of this report. One of the questions in the monthly follow-up questionnaires asked participants whether they had consulted any other health care professional (HCP) for the same problem in the previous month, specifically GPs, Nurses, Private Physiotherapists, Chiropractors, Emergency Departments or none other. Comments were analysed regarding which HCP they had seen and why. At 3-months follow-up, the responses to a free-text question of “any other comments?” at the end of the questionnaire were also analysed.

*Data analysis*

Data analysis was primarily descriptive. Free-text data responses from the initial questionnaire and 1, 2 and 3 months’ follow-up were reviewed. The individual comments were categorised thematically by the lead author (LW), and results were reviewed and discussed with co-authors for consistency with the overall responses. Agreement with coding of the baseline data was gained prior to further evaluation of all responses. All responses were coded according to response theme for each time-point. Response data for other HCPs utilisation was summed and calculated as a percentage of total responses for each category. Free-text responses were grouped and categorised thematically.

 **Results**

2825 eligible patients over 13 months were invited by email to participate in the Evaluation and 24% (n=680) participated. Follow-up rates at 1, 2 and 3 months were 63% (n=430), 62% (n=419) and 54% (n=370) respectively. Baseline characteristics and follow-up outcomes of participants are reported in more detail elsewhere (Stynes et al., 2021).

***Free-Text Responses***

In response to the FFT, 73% of participants (n= 498) reported “extremely likely” to recommend the FCP service to friends and family and 22% (n=151) reported “likely” to recommend the service. 4% (n=26) were neither likely nor unlikely to recommend the service. Only 1% (n=6) would not recommend the FCP service, and a further 1% (n=9) of respondents were unsure whether they would recommend the service or not. The free-text responses to the FFT in the initial questionnaire (n = 592 comments, 87% of responses), and the general comments about experience of the FCP service in the 3-month questionnaire (n=172, 46% of responses) were analysed together.

Thematically these were classified into six broad categories, with overlap existing between each category: communication, treatment and assessment, clinician characteristics, efficiency, service considerations, and complaints.

Communication:

Most respondents commented on the communication skills of the FCP. Respondents valued good listening skills, and commented that helpful information provided in a clear and understandable way was important. They felt their concerns or problems were understood by the treating FCP when they were provided with the opportunity to ask questions or, diagnoses, management options and prognoses were explained to them.

*“He listened, was very thorough, and provided answers to all my questions. I understood his diagnosis, and he gave me an immediate treatment plan and follow-up advice”. (Initial questionnaire after visit to FCP)*

*“They were sympathetic to my problem and were keen to ensure that my questions were answered and that I had a good understanding of my problem”. (Initial questionnaire after visit to FCP)*

At three-month follow-up respondents still reported value in the helpful advice and information received by the FCP, and the importance of having their problems and concerns understood.

*“I have been followed up by the practice physio, who built on the strong foundation put in place by –FCP. Together they have provided a helpful programme to manage my issue.” (3-month follow-up after visit to FCP)*

Treatment and Assessment

Respondents valued a diagnosis and treatment plan, and the opportunity to consult with a knowledgeable specialist or expert in the field of their condition. They valued a thorough assessment, and were mostly confident in the knowledge provided or treatment given. Self-management skills were appreciated and shared-decision making was reflected as a valuable component of the FCP session.

 *“It was a highly effective short assessment that gave me the tools to solve the problem. Very little drain on my time. An efficient use of NHS resources.” (Initial questionnaire after visit to FCP)*

*“Brilliant concept to have someone who really understands the problem. Many years ago I was a GP. We wouldn't have the time/ full understanding to play this role. Full Marks!” (Initial questionnaire after visit to FCP)*

*“Wonderful service in that I was able to see a specialist quickly without having to wait to see a Consultant, and I also received treatment very quickly. The only downside of the service was that if I wanted a further consultation/assessment after the treatment then this would not have been possible as the practitioner was only attached to my surgery on a temporary basis, as it was part of a pilot”. (Initial questionnaire after visit to FCP)*

At three-month follow-up, many had reported improvement or resolution of their problem, with many reporting the right treatment had been provided, pain had resolved or that they had received the right care at the right time. However, a smaller proportion (n=19 comments, 11% of free-text responses) at three-month follow-up reported their condition had not resolved or the diagnosis and or treatment had not been helpful.

*“Still have got a constant ache in the left lower back muscles/hip area. Will be making an appointment with GP…” (3-month follow-up after visit to FCP)*

Potentially related to this were the frustrations described by some participants with respect to delays in onward referrals. This appeared to leave some participants waiting for diagnoses or recommended treatments. This association left some participants (n=10 comments, 6% of responses) making a direct correlation between the delays they experienced and the lack of resolution of their complaint, as described below.

*“The FCP was very helpful and it was easy to get an appointment, but I was meant to be referred on to a specialist by them and several months later have heard nothing, so in the end it didn't really help as I'll now need to go via my GP again to try and get referred.” (3-month follow-up after visit to FCP)*

Clinician Characteristics

Participants frequently made reference to the personal characteristics of the FCP. As described above, participant’s placed importance on feeling the FCP had effective communication skills including empathetic listening, reflection and effective information giving. Further ‘softer’ FCP characteristics were also described and appeared important to respondents, who described features such as “kind”, “caring”, “nice”, “friendly” or “pleasant”. In combination, these FCP characteristics were appreciated by respondents as support or efforts to make them feel comfortable and put their “minds at rest”. They also led to participants feeling like they were being treated as a person, with respect, and sympathy or empathy valued.

*“I was given an appointment very quickly and treated with care, consideration and kindness and professionalism”.* *(Initial questionnaire after visit to FCP)*

*“I was treated with dignity and respect”. (Initial questionnaire after visit to FCP)*

Efficiency

Many respondents interpreted the FCP service as efficient and as providing quick access to specialised care. They highlighted the short waiting-time to see the FCP. Despite this efficiency, they did not feel rushed in their FCP appointment and found it convenient to not have to access the hospital or leave their local area. Participants also described it as negating the previous long waits to see a physiotherapist.

 *“It was just as quick as seeing the GP, but I had far more specialised advice. Usually I would have to see a GP to get a referral to a physio, but this service allowed me to see one within a week…” (Initial questionnaire after visit to FCP)*

“Apart from having been an overall good experience, it was much more convenient to be seen at my doctor’s surgery & was less waiting time than a hospital appointment.” *(Initial questionnaire after visit to FCP)*

Comparison to GP Care

Some respondents compared their care from an FCP to that of the GP. Of those that did, many reported the consultation was better than with their GP, or that the FCP was easier to access than their GP. The FCP service was felt to be a positive addition to the primary care health service and respondents prioritised the accessibility of the FCP within their local community.

*“For injuries such as mine the FCP was more relevant than a GP. My visit was to gain an understanding of the injury and ascertain if it was safe to carry on training/playing rugby. A GP was not necessary.” (Initial questionnaire after visit to FCP)*

*“Being able to bypass the GP made the process speedier. Felt like I was seeing an expert about my condition who had time for me.” (Initial questionnaire after visit to FCP)*

*“I felt that my FCP not only took time to explain my problems but also suggested extra courses of action besides the injections and he gave me confidence that he would guide me in right direction if necessary I feel that the FCP system is excellent and a valuable addition to my surgery and if not already definitely should be introduced across country in other surgeries” (Initial questionnaire after visit to FCP)*

***Other Health Care Professional Use***

In those that indicated they had visited another HCP since their FCP consultation, the number of free-text responses at each time point was low, 27% (n=68/442) at 1-month, 19% (n= 82/435) at 2-months, and 26% (n=67/375) at 3-months.

At two of the three follow-up points, the majority of respondents had not used any other HCP (73% at 1-month, 74% at 3-months), in contrast to the two-month follow-up where 63% of participants had not consulted with another HCP. In the 275 participants who responded at all 3 follow-up points, 20% (n=56) had consulted the GP for the same problem. The breakdown of which HCPs were used across the 3-month follow-up period, from a total of 1191 responses was: 11% (n=142) for GPs, 7% (n=82) for private physiotherapists (n=82), 6% (n=72) for chiropractors, 2% (n=19) for nurses and <1% (n=5) for ED attendance. Other referrals were not always specified in the free-text, but frequently referred to NHS physiotherapy or regular osteopathic appointments.

**Figure 1: Bar chart to demonstrate frequency of consulting any other health care professional**

The range of reasons for seeking other HCP input at one-month follow-up included having persistent pain or symptoms (n=76, 35% of responses), seeing an NHS physiotherapist (n=37, 17% of responses), having an injection or requiring medication (n=15, 6% of responses), and further investigations (n=10, 4%). Comments such as:

“*My physio wasn't able to help me diagnose the source of the pain. The exercise had not helped and nor has adjusting my desk position. I asked the physio if my hip aching might be linked to my knee pain, he said it wouldn't be but it felt to me like it could be. I didn't feel like he was able to offer me anything more and I felt my pain level was too low for him to take it very seriously. The osteopath has diagnosed the issue and helping me resolve.” (1-month follow-up)*

By 3-month follow-up, some responses suggested a sense of desperation led people to seek other HCPs’ care.

*“I was in unbearable pain and requested to see the GP” (3-month follow-up)*

**Table 1: Reasons for seeking other HCP input**

**Discussion**

This was a thematic analysis of free-text questions asked in online questionnaires of patients with MSK pain who consulted a FCP, followed up over three months. The overall themes of free-text responses highlighted the value placed on the FCP’s communication skills, the demeanour of the FCP, the treatment and diagnosis provided, the efficiency of the FCP service, and improved experience compared to the traditional GP model. Respondents valued seeing a specialist in their local community and ease of access was frequently reported. Although most respondents (70%) did not access other HCPs after seeing the FCP, the most common reason to seek other care was persistent pain, followed by attending NHS physiotherapy appointments or seeking other treatments.

The results of this thematic analysis are in line with the qualitative findings of the National Evaluation (Goodwin et al., 2021). In particular, respondents valued the FCP service, the efficiency of the service and how it brought a MSK specialism to general practice. Respondents saw FCPs as specialists providing advice beyond the scope of GPs. Although the speed and ease of access was also acknowledged in the qualitative findings of the National Evaluation (Goodwin et al., 2021), some confusion was also described. It appears that FCP services and the pathways pertaining to them are less than optimal. Within this thematic analysis, some respondents felt one session with the FCP was not enough, but they were not ‘allowed’ further appointments. This resulted in them seeking a further GP review. Additionally, there were the frustrations described by some respondents with respect to delays in onward referrals: however, onward referrals outside of the GP and FCP practice would be subject to the same delays, irrespective of referrer. This appeared to leave some respondents waiting for diagnoses or recommended treatments. One of the recommendations from the qualitative findings of the National Evaluation was improving access to FCPs. Patients were often unaware of FCP services and patient understanding of FCP services specifically, and physiotherapy more generally, was poor (Goodwin et al., 2021). As a result, access to FCP services is, on the whole, reliant on effective signposting, a feature repeatedly identified as essential (Goodwin et al., 2021; Moffatt, Goodwin, & Hendrick, 2018). It is, therefore, important to invest in increasing public awareness, understanding and investing in training of staff to signpost effectively.

Whereas respondents in this thematic analysis appreciated the convenience of having FCP services in their own GP practices, the benefits of this co-located nature of FCP services have been seen to extend beyond geographical convenience. The qualitative National Evaluation also found that co-locating FCP services in GP practices enhanced adoption of systems and processes, improved and enhanced day-to-day communication between FCPs and GP practice staff (Goodwin et al., 2021). The co-location model also resulted in more consistency of messaging to the patient population, enhanced confidence among the clinical and support staff within the practice, and decreased clinical risk (Goodwin et al., 2021).

This thematic analysis aligns with previous work identifying FCP services as introducing MSK specialism in to general practice. This impression has been articulated by general practice staff (Moffatt et al., 2018), both staff and patients (Goodwin et al., 2021) and, by patients in this current thematic analysis. Many respondents in this thematic analysis highlighted the added benefit they felt by seeing an ‘expert’ in musculoskeletal conditions. The FCP model is designed to bring physiotherapy expertise to the front end of the musculoskeletal pathway (NHS England, 2019). It is perhaps not surprising therefore that the current national roll-out of FCP services is stipulated at Band 7 Agenda for Change or above(Health Education England NHS England and Skills for Health, 2018). Indeed, GPs have expressed concerns that if less experienced physiotherapists were placed in FCP roles, then more work may be ‘bounced back’ to them (Moffatt et al., 2018). Interestingly, there is no empirical evidence of this, and previous work demonstrated similar outcomes when FCPs worked at band 6 level (Martini & Kelly, 2017).

It is reassuring in terms of FCP efficacy that most respondents did not seek support from another HCP following their FCP appointment/s. On the one hand this lends weight to the advanced clinical skill set of the FCPs (Health & England, n.d.). However, those skills most frequently attributed ‘advanced practice’ (injections, non-medical prescribing, and referral for diagnostic investigation) have been described as being utilised infrequently (Goodwin et al., 2021; Langridge, 2019; Morris, Moule, Pearson, Foster, & Walsh, 2020). It is interesting to note that of those respondents who did seek additional HCP input, the majority attributed this to persistent pain. Furthermore, of the patients that participated in the National Evaluation (Stynes et al., 2021), almost half had comorbidities, and 25% had more than one site of pain. This aligns with the ‘reconceptualisation of role’ that the FCPs described in previous work (Goodwin et al., 2021, 2020; Moffatt et al., 2018). This reconceptualisation emphasised the shorter consultation time and the undifferentiated nature of the first contact patient. This reinforces support for the specialist role of the FCP to ensure safe, clinically effective decisions can be made in a model that differs to a traditional physiotherapy appointment (Health & England, n.d.; Langridge, 2019; Morris et al., 2020).

Respondents in this Evaluation appeared to value the time the FCP gave them. This included time to answer all their questions, time to have adequate explanations and thorough assessments. This is reflected in the patient reported experience measures collected, where 98% of responding patients reported having confidence in the FCP’s competency to assess their problem, 95% reported receiving sufficient information about self-care and 93% reported receiving sufficient information about their MSK condition (Stynes et al., 2021). An important consideration appears to be the length of time FCPs have to spend with patients. Halls et al. (2020) found that most FCP consultations lasted 20 minutes, almost double a conventional GP appointment. Similarly, previous research has highlighted the importance of patients having their needs met in one appointment (where possible)(Morris et al., 2020).

**Strengths and Limitations**

This is a novel thematic analysis of the free-text responses provided in a National Evaluation of FCP services in England, providing further context and interpretation of the data collected. A strength of this analysis is the method of data collection, and the subsequent large number of respondents. Free-text responses are often included in outcome data collection, but rarely reported. With 785 responses, the strength in numbers provides more explanation to the positive quantitative results (Stynes et al., 2021) and complements the qualitative data (Goodwin et al., 2021) already gathered in the National Evaluation. The comments were analysed and thematically grouped to provide themes which are in keeping with previous analyses reported (Downie et al., 2019).

However, this thematic analysis of free-text comments was not correlated to individual patient outcomes, or the individual's specific reason for consulting with a FCP e.g. the body site of their musculoskeletal problem. The free-text responses were not always complete, and text was occasionally limited or missing. The results of this free-text analysis need to be interpreted in light of the context of FCP delivery in the NHS. For the online data collection, information about the variation in the services was not collected 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. The data analysed in this evaluation were collected before the Covid-19 pandemic began, and some FCP models have now evolved to include hybrid consultation options, including remote and face-to-face. This evaluation included only face-to-face consultations.

**Implications for Practice and Research**

This thematic analysis demonstrates the importance that patients place on the FCPs’ communication skills such as being listened to, having a sense that their problem has been understood, and involved in a shared decision making strategy. Respondents valued being provided with all the treatment options available, and given self-management strategies to begin with. A clear diagnosis and treatment plan was important. This highlights the importance of physiotherapists undertaking shared-decision making within their consultations, and providing the patient opportunity to share their story (Phillips & Ospina, 2017).

For the impact of FCP services to be realised, patient pathways need clear articulation to patients. This will be facilitated by practice-level training to staff to ensure clear signposting of MSK patients to FCPs. Alongside this, public health education around FCPs, their role and possible benefit to society should be widely advertised to allow for uptake and request by the public, who may not have a clear understanding about who an FCP is, or why they should consult with them.

**Conclusion**

This thematic analysis of free-text provided in the national Evaluation of FCP services in England demonstrates the value placed on a FCP consultation by patients with MSK pain. Patient access and pathways should be clarified to optimise the impact that FCP services can have in the future. A minority of respondents sought care from other health care professionals therefore future investigation of reasons for care-seeking will help to inform further development of the FCP services and MSK pathways in primary care in the UK. Nevertheless, this thematic analysis provides further support for the use of FCPs in primary care for the management of musculoskeletal conditions.

**Figure and Table Legends:**Figure 1: Bar chart to demonstrate frequency of consulting any other health care professional

Table 1: Reasons for seeking other HCP input

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 **Table 1: Reasons for seeking other HCP input**

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| --- | --- | --- | --- | --- |
| Theme | All Months (n=217) | One-month Follow-up (n=68) | Two-month Follow-up (n=82) | Three-month Follow-up (n=66) |
| Persistent Pain | 38% (n=82)  | 32% (n=22)  | 43% (n=35)  | 38% (n=25) |
| Seeking Other treatments | 26% (n=57)  | 13% (n=9)  | 30% (n=25)  | 35% (n=23) |
| Attending NHS Physiotherapy | 19% (n=41)  | 25% (n=17)  | 22% (n=18) | 11% (n=7)  |
| Other investigations (e.g. bloods, imaging) | 11% (n=23) | 9% (n=6) | 10% (n=8)  | 14% (n=9)  |
| Medication Queries/ Prescriptions | 7% (n=15)  | 4% (n=3)  | 6% (n=5) | 11% (n=7) |
| Delay in referrals | 5% (n=11)  | 4% (n=3) | 5% (n=4) | 6% (n=4) |
| Private insurance | 2% (n=5) | 1% (n=1) | 2% (n=2) | 3% (n=2) |
| Injections | 2% (n=4) | 3% (n=2) | 0% (n=0) | 3% (n=2) |
| Adverse Events | 1% (n=2) | 3% (n=2) | 0% (n=0) | 0% (n=0) |
| GP Check-up | 0% (n=1) | 0% (n=0) | 1% (n=1) | 0% (n=0) |
| Insurance claim | 0% (n=1) | 1% (n=1) | 0% (n=0) | 0% (n=0) |