Service Evaluation of First Contact Practitioner (FCP) Physiotherapy model in Scotland and Northern Ireland

Phase 3

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

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 the final element of this Phase 3 national evaluation undertaken by the University of Nottingham. This served the purpose of collecting qualitative data from a small number of services in the devolved nations of Northern Ireland and Scotland while additionally providing a snapshot of FCP services at a unique and challenging time, during the Covid-19 pandemic.

Methods

Design

Data were collected via semi-structured interviews. The published literature regarding FCP and the service aims and success criteria helped to provide a framework to develop the topic guides for the interviews and focus groups.

Participant recruitment and data collection process

This final element of the evaluation was deferred from March 2020 due to the Covid-19 pandemic. Data collection took place during the months of March and April 2021.

Participants were recruited via service leads in Northern Ireland and Scotland. These service leads invited individuals, from each of the participant groups (First contact physiotherapists, GPs, and GP practice administration staff), who subsequently volunteered to be interviewed.

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 (2, 3). 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. All transcripts were coded by two researchers with co-investigators resolving any disagreements. A total of 30% of the transcripts were jointly coded. Previous research has shown this method is adequate to demonstrate consistency in coding, interpretations and inferences made by the lead researcher (4). Using this method demonstrated excellent agreement in coding and analysis of the data and no further joint coding was deemed necessary.

Sites and participants in the qualitative data collection

A total of 22 participants were recruited from a small number of services in Scotland and Northern Ireland. A total of 15 interviews and 1 focus group were undertaken. The participants are detailed below.

Northern Ireland	GP- Interview Administrator- Interview FCP Focus Group (7)- focus group FCPs (5)- Interviews
Scotland	GPs (2)- Interviews Administrator- Interview FCPs (5)- Interviews

The variety of general practices where each of the participants worked varied considerably; with a significant number being rural locations. Practice sizes ranged from those in more urban settings with patient populations circa 12/13 thousand with an 11 GP workforce to more rural setting with single handed GP practices with approximately 2 to 3 thousand registered patients and as a consequence the models of implementation varied considerably. From a practical perspective this meant some FCPs could be covering up to six GP practices with as little contact time as 2 hours every fortnight, through to a single GP practice who provided 47 hours of FCP access per week. FCP services in Scotland and Northern Ireland were implemented in response to national health policy commitments for the development of multi-professional teams in general practice. In Northern Ireland, in the GP Federations where FCP has been implemented, there is approximately one whole time equivalent FCP for a population size of 10,000. In Scotland, population coverage is more variable across the Health Boards. In both countries, FCPs remain employed within the NHS organisations which provide the service to primary care. All FCPs in Northern Ireland are

currently recruited at NHS Agenda for Change Band 8a. In Scotland, FCPs are most commonly recruited at Band 7, with some lead posts being at band 8a.

Findings

The themes identified in the previous Phase 3 report (CSP, 2020) are updated and adjusted with reference to the new data, and new themes are described.

Theme 1 Communication strategies

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

Advertising

There was little new data to revise the findings from the earlier evaluation. Traditional advertising approaches continued to be applied. These approaches ranged from posters to more technological approaches including electronic displays in GP practices to notices on Websites and Facebook pages. There was no evidence provided that these approaches were effective in increasing awareness.

Participants did speak of a number of issues pertaining to advertising. One of the issues was a concern that advertising would create a new market of people seeking advice related to MSK related health complaints who would not have otherwise sought an appointment. In addition, there was an acknowledgement that, as a consequence of the Covid-19 pandemic, people would be even less likely to see the traditional adverts- such as posters- that were placed in general practice waiting areas. Equally, concerns were expressed about the inability to advertise due to regional inequity to FCP services. However, this concern was not expressed in Northern Ireland where a nationally orientated strategy was described with provision of advertising and marketing material. In addition to traditional advertising strategies more local, bespoke strategies were also described. Nevertheless, even when these coordinated approaches were applied it was acknowledged that “more needed to be done”.

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.

As in the earlier evaluation, signposting was spoken about frequently as being fundamental to FCP services. This was both in respect to facilitating access to FCP services but also in the process of ‘embedding’ FCP within the general practice and the local community.

Appropriate signposting was considered an evolutionary process and a new finding in this theme was that participants spoke about viewing signposting pragmatically, with an

acceptance that it would never be either 100% accurate or capture 100% of people with MSK problems.

Systems and Processes

As reported in the earlier evaluation, aligned IT systems and informal methods of communication were described as facilitative to FCP working, FCP embedding, team working and patient care.

> *"Whenever I type in my notes, they can see what I have written, and equally I can see what they've written. So, for me, that kind of closes a big, big gap that was previously there whenever we had separate paper notes, and they couldn't see you know, what was happening with that patient. So that has made a massive difference. And I think that has opened up the line of communication much more".* FCP2

Theme 2 Specific contextual considerations

As a consequence of the nature of the geography of the sites recruited in Scotland and Northern Ireland a new theme was synthesised that articulated the specific contextual considerations of rurality and estates capacity. It was felt that the originality of this information warranted a theme within its own right.

Rurality

New data emerged with respect to the specific context of the rurality of some FCP services. The rural setting of some FCP services, within GP practices, provided both opportunities and challenges.

For some, working in small, rural, sometimes single-handed GP practices provided opportunities for flexibility, enhanced team working and enhanced embeddedness within the 'community of practice'. However, where a FCP provided limited capacity within a GP practice the rural nature meant that capacity and communication could be more challenging. With respect to the GP practice itself this was described as somewhat mitigated by using email to communicate with the practice. For teams of FCPs, working across rural settings similar IT solutions were described including Microsoft Teams meetings and WhattsApp group. The operationalisation of rural services was described as challenging.

> *"Yes, really challenging… You know that's been probably the biggest issue, because you're trying to mix individuals, their home life, their working hours with practices, the allocation, and the rooms they have available. So, you know, lovely as remote and rural practice is, they're you know, two room buildings. Which you know, where they've got a practice nurse and a GP, and they've got part time hours, and you're trying to fix it, you know matching an FCP to that. The logistics of trying to get a computer you know, all that was part of the logistics of setting it up. It was really challenging".* FCP4

Space

Of significant note was the frequent reference to space within GP practices as a barrier to FCP services. This was an issue in both Northern Ireland and Scotland and was described as a problem by all participants groups. For practice staff this problem extended to both before FCP- whereby some buildings were described as not fit for their purpose- and beyond FCP- whereby other additional roles would only add to the problems of insufficient capacity. For the FCPs this was problematic when they acknowledged the benefits to communication, and subsequent patient care, when co-located.

> *"it would come to the space issue, I mean even their pharmacists are working upstairs in the conference room, so there's not enough space for all the extra staff that they've promised us".* GP1

Theme 3 Awareness and understanding of FCP was poor

The earlier evaluation had highlighted that both patient awareness and patient understanding of FCP was poor. These findings were reinforced in this later evaluation.

Awareness of FCP services.

There was evidence of a widespread lack of awareness of FCP services among the patient population. There was no empirical evidence that any of the advertising techniques impacted patient awareness. There appeared to be an acceptance that in the early stages of implementation the patient population would have little awareness of the new service. As such, it was acknowledged by staff that some patience needed to be exercised and most people would need signposting to services in the early stages. If, during this stage, the signposting came via a GP consultation this might need to be accepted, pragmatically.

As previously, the evidence suggested that awareness of FCP services increases over time with word of mouth again being highlighted as an important mechanism, especially in rural areas. Clinicians provided anecdotal evidence that suggested this process took some time; in one practice they described their FCP service, of two-years, as well established. This was also set alongside the concomitant changing face of general practice more broadly and the significant culture change therein.

Understanding of FCP

The earlier evaluation had shown that patient understanding of FCP was poor. This evaluation did not include patient participants but the evidence from the participants' narratives suggested patient understanding of FCP services remained poor.

The consequence of this misunderstanding of FCP services was potential patient disappointment when expectations were not met. Alternatively, participants described experiences where people had anticipated physiotherapy making their symptoms worse and consequently not attending.

The data suggested that lack of understanding of FCP extended beyond the patients/public to include other staff such as GPs. Consequently, some physiotherapists suggested the importance of the Physiotherapy professional exercising autonomy to drive and develop FCP services beyond the conceptions of others.

Patient understanding

"FCP would have said to me that patients are just terrified that we're going to increase their pain you know. So, they're never going to turn up for an appointment. So, it's about that education piece". FCP6

GP Understanding and professional autonomy

"I think GPs recognise what a physio can do…But we want to bring the additional things that we're able to do. And sometimes getting that bit across to them... it's not that they're... resistant to it, but it's the other side of really trying to stress what the role is, as opposed to them sort of assuming they know what we're going to do". FCP6

Theme 4; The evolving role of the GP within an evolving general practice.

The theme of the 'Role of the GP in the FCP agenda' was interpreted as having evolved since the earlier evaluation. This evolution was reflected in the re-naming of the theme.

The earlier evaluation had shown the role that the GP played in the FCP agenda was complex. Once again, the overall evidence generally described GP support for, and appreciation of, FCP services with little evidence of GP resistance or dissatisfaction. However, there were some anecdotal recounts of GP resistance to FCP implementation. Where this had occurred it had constituted a challenge for the FCP and had taken some time to ameliorate. There continued to be a strong acknowledgement that GPs could also be FCPs' greatest advocates with several examples describing positive relationships. GPs saw it within their role to provide support to FCPs and other professional groups within the additional roles agenda. It was also suggested that the relationship developed with GP confidence in the FCPs competence increasing with time.

Several systems could facilitate this relationship such as being co-located, use of the same electronic record system and the FCP member of staff being consistent. Where the FCP attendance was infrequent, such as in rural settings, communication, and relationships, could be maintained by the use of electronic communication systems such as email.

As in the earlier evaluation the use of an 'open door' policy facilitated communication and the working relationship.

Communication and Open door
"And I think it goes back to the, being able to knock on a door and ask a question, which is obviously easier. And again, what I've always said as well, you know, if you don't know or you're not sure come and ask, because you might feel a bit stupid but if you don't come and ask it will prove that you're stupid, you know" GP1

GP work experience

There was a clear sense that the GP role had evolved and was continuing to evolve. The current FCP agenda was, in some way, contributing to this evolution within broader changes that included the wider additional roles provided by the reimbursement scheme. There was a dominant perspective from GP and practice manager participants that the traditional general practice was moving towards a multidisciplinary model of general practice.

"I think general practice is, no matter what they say, it's on its last legs. I think we'll have large centres for looking after large populations with everybody in place and so you can refer, or the patient can make their own way (through the system)" GP3

A key performance indicator often cited for FCP has been a reduction in GP MSK workload burden. The earlier evaluation had suggested that most FCP services provided insufficient capacity to bring about a meaningful reduction in GP MSK burden. On the whole this was repeated in this later evaluation. However, there were occasions when GPs described noticing a reduction in their MSK workload burden and this impact could be enhanced when the FCPs had greater autonomy, such as non-medical prescribing. This negated the need for a subsequent GP consultation or liaison. Despite there still being inconsistency and, at times, low levels of 'true' first contact FCP appointments it was recognised that even if the first contact had been with a GP, the subsequent GP appointments that may have occurred were saved. It may be as a consequence of this that GPs reported a decrease in their MSK-related consultations. The consequences of the perceived evolution of general practice were multifaceted. Those who reported a change in their case-mix, as a consequence of the FCP (and perhaps other additional roles) also reported an increased complexity of that case-mix. Associated with this change was the perception of increasing levels of pressure/ stress of GPs.

GP stress

"I suppose it could be a criticism of all these extra bits if you like, is that your day actually becomes more intense because you don't have a…sore throat…you don't see someone for a pill check. All the people you're seeing have got bigger problems and maybe comorbidities and yeah kind of ramps it up a bit as well. It comes back to time, you know, you've got to deal with that in ten minutes and it's difficult. And again, previously you might have had a pill check for five minutes and then you had another for 15 minutes, and then you had a sore throat for five minutes your hour would be kind of managed and on time. But if you've got five people that need 20 minutes, you're not going to fit them in in an hour". GP1

However, there were also a number of further inter-professional issues that arose from the data. Firstly, despite the apparent evolution of general practice it was clear that the GPs still saw themselves as the focal point of general practice and also as the person/ professional where the responsibility sat. As such, they saw themselves as having a degree of responsibility for the FCPs. Consequently, some GPs described their own vision for FCP implementation and delivery. This did not always match with physiotherapists' vision of FCP, whether this be the first contact principle, the clinical boundaries of the role, GPs still 'gatekeeping' patients or other issues around FCP flexibility. The physiotherapy profession's response to this was that they needed to ensure that their voice was heard in terms of the model, and implementation, of FCP.

The GP profession itself was noted to be evolving in response to the changes in general practice. Indeed, for some GPs the wider question pertained to the future of the profession given the encroachment into their jurisdiction from other professions. Potential responses to this encroachment were described as the development of the 'GP Specialist' who oversaw the multidisciplinary team (MDT) and the development of special interests beyond the routine GP role. In the latter instance, GPs with a special interest were discussed as being able to provide specialist opinion to other practices, or organisations. There was an impression of some challenge to the GP profession with one GP suggesting; *"GP burnout, what will people be asking, what do [they] do? That's what I would be concerned about"* (GP3).

Despite concerns for their own profession, GPs appeared to be, on the whole, supportive of the evolution that they observed within general practice. They described the benefits of having FCP in terms on the impact on onward referrals, the introduction of an MSK specialism into general practice and the benefits of team working and a widening of the community of care. This was echoed by the physiotherapists who described support from GPs and the overwhelming impression that GPs just wanted more physiotherapy capacity in general practice.

With regards to their own unique contribution to, and specialism in, primary care, GPs saw themselves as dealing with the diagnostic uncertainty inherent in general practice and the 'first contact' clinical encounter. As such they described an awareness and acceptance of this and contrasted this with their perception of the apparent unsettlement of physiotherapists with uncertainty and red flags. They interpreted these concerns as resulting in overly lengthy documentation and creating challenges to time management.

GP specialism of uncertainty

"And we are generalists, but we are specialists in managing uncertainty. And that risk. And…that's quite difficult when you're not used to it…how do you manage that, and how do you keep yourself sane, and how do you sleep at night. So, we had a lot of talking about that at the beginning…talking about, you know, who's responsibility is it, is it his responsibility, is it my responsibility, the patient's responsibility… [I]n general practice it's very different, isn't it, that you might see somebody, it might take you three or four consultations to come to a definite diagnosis…So it was explaining those kind of things to X, you know, you're not going to be able to diagnose everybody the first time you see them. Because there's a lot of uncertainty in general practice. And what we have to do sometimes is do other investigations and then narrow it down. And rule things out and rule things out, eventually come to what was wrong". GP2

Theme 5 FCP services are evolving flexibly and continue to have an impact on general practice.

Themes 4, 5 and 6 from the previous evaluation work (FCP contribution to general practice, FCP reconceptualises physiotherapy work and variation in the FCP scope and model) are now articulated in this single new theme.

Impact

FCP continued to be described as having a number of impacts on both general practice and the wider patient pathway. FCP provides an MSK specialism in general practice and this can be broadened with the addition of advanced practice skills. FCPs described GPs as administering fewer injections, and fewer injections early in the patient journey, as a consequence of relevant advanced skills. The ability to offer advice around medication and prescribing was also spoken about frequently as a useful adjunct. Moreover, it appeared that medication optimisation and de-escalating patients' medication was seen as more useful than prescribing per se.

MSK Specialism

"So sometimes I get people who I think oh, dear me, I don't know what's wrong with them. And I say to the patient look, here's the plan, we're going to try and find out what's wrong with you, we're going to use some bloods, and we might just make sure it's... but I want you to see the physio. And then I send, I write him a note saying…once you've seen that person please feedback to me what you think is going on here, because I'm not sure". GP2

As well as appearing to decrease GP MSK burden, FCP services also had the potential to impact the work experience of others within general practice. Some participants described nurse practitioners typically seeing patients with sprains and strains and, as such, FCP had subsequently impacted their work experience. It was, once again, acknowledged that there was no empirical evidence of changes to GP case-mix and also that this was a potentially complex construct to capture.

Another impact described was that of reductions in onward referrals, more appropriate referrals to secondary care and subsequently fewer non-attendances within secondary care. This was described as applying to secondary care orthopaedic services and other mainstream physiotherapy services. Although most of this evidence was anecdotal there was one description of secondary care physiotherapy waits being reduced from 7-months to 1- month. It remained somewhat frustrating to senior FCP leads that IT challenges made robust data collection problematic.

Flexibility

What was very clear from this stage of the evaluation was the FCP role itself was evolving and in particular becoming more flexible.

Although the impact of the Covid-19 pandemic was not explored specifically it was mentioned frequently and had influenced the flexibility in FCP services described. It was often referenced as a caveat to the experiences described by participants as it had very clearly impacted the delivery of all health services, including FCP. Where services had continued to provide care during the Covid-19 pandemic it was most often remotely. The adoption of remote working was, on the whole, welcomed. Remote working allowed services to continue when face-to-face consultation was not possible. It was also discussed as potentially facilitating the process of increasing the awareness of services. A common adaptation to the Covid-19 pandemic was GP telephone triage for all patients. The subsequent signposting by GPs to FCP services was seen as a mechanism for increasing awareness.

However, there were also some disadvantages of remote consultations. Participants spoke of the increased relative risk of not being able to assess someone face-to-face. The consequence of this was that, where possible, an additional appointment was made to see the patient in clinic. This quite clearly had the potential to impact FCP capacity.

> *"So, we're almost double booking because we're speaking to them on the phone, that takes up one appointment slot, and then we're like, oh actually, we need to see you. Not always, but you know"* FCP5

Alongside the enforced flexibility resultant from the Covid-19 pandemic it was clear that the conceptual model of FCP (20-minute appointment time, limited to assessment and advice, very limited follow up capacity) was evolving into a much more bespoke model. The impression was that the flexibilities spoken about by all participant groups were positive. Indeed, GPs spoke of FCPs working in their Covid vaccination clinics and saw this flexibility as further embedding the physiotherapists into the general practice and the wider community of care.

This welcoming of a varying degree of flexibility extended beyond GPs to the physiotherapists themselves. It was clear that the Covid-19 pandemic had brought about some enforced changes, but the impression was that these changes may benefit the service beyond the pandemic. This was particularly the case for physiotherapists working in rural locations with infrequent attendance at GP practices, and those with issues of accessibility.

There was flexibility described around the concept of 'true first contact' and the notional limit of FCP services to an assessment and one follow up. Although, the benefits of the concept of 'true first contact' were clearly acknowledged it appeared that there was an acceptance that this was not always possible. Even where signposting from administration staff was embedded and effective it was not possible to signpost all patients to the FCP services. This might be due to the multi-morbidity of the patients or limited availability within the FCP services. GP behaviours and the lack of adherence to the first contact principle also represented a challenge to the intended model of FCP delivery. On the one hand this was not interpreted as overly problematic- with a degree of pragmatic acceptance from GPs and physiotherapists. However, it was acknowledged that in services that had insufficient capacity to match the demand of patients with MSK conditions this practise further exaggerated the capacity: demand mismatch.

There was evidence of flexibility in terms of the number of consultations a patient might have within an FCP service. Particularly, but not exclusively, FCPs working in rural services spoke about continuing to treat patients for several sessions to the point of discharge/ self-management. They spoke about this being welcomed by patients as it avoided further delays/ waits for subsequent physiotherapy elsewhere, provided care closer to home (when the journey to alternative services could be several hours) and, once again, embedded the

FCP service in the wider community of care. Furthermore, flexibility was described around appointment length with participants often describing appointments of thirty minutes.

Flexibility in models of FCP delivery

"And so, when I cover 'X' the nearest physio services is 'Y'…so that's a 45-minute drive each way. And it's a very hilly, very… it's a long drive. So it kind of almost… if I can see them a couple of times in that sense and then have them independent [in] self-management and do what they can do it makes more sense, particularly if I've got that flexibility in my diary". FCP1

"If I see a patient, and I think maybe within three appointments, I can manage this patient, and that would be it, then I will do that. I'm quite happy for you know, the GP to contact me if they want me to see a particular patient you know, even if I had on a quick telephone call at the end of the day. You do have to work flexibly, and especially [when] you're not at the practice all day every day…I'm quite happy to you know, adapt my day in the way that benefits the patients, and benefits the primary care team". FCP2

This flexibility in delivery was welcomed by all stakeholders. Physiotherapists spoke of this flexibility- in appointment number and appointment length- providing greater patient satisfaction, greater job satisfaction, the necessary parameters to perform the role safely and satisfactorily, and an opportunity to 'keep their hand in' clinically.

Flexibility in models of FCP delivery II

"I think we were quite clear on at the beginning was, keeping that primary aim of the FCP service at the most. So, if we can say we're saving the practice time, and we're saving GP time…whether that's first contact, or through these return appointments. But as far as kick back goes (for repeated follow up appointments), nothing direct. So we come under that kind of caveat as well, if we're meeting the aim of what we're trying to do, and we are making life easier for the patient, and the physio's are getting a little bit of continuing to use their treatment skills, as much as their assessment skills, which is some of the [unclear at 00:25:13] as well, then all good" FCP5

It was clear that the FCP role was still somewhat nascent but offered the potential 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 associated with 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. There was frequent acknowledgement of the 'GP model' of working. On the one hand the 'non-discharge'

nature of general practice was described as “liberating” whilst the undifferentiated nature of the patients presented some uncertainty and risk. The responses to this were articulated at a professional and personal level. Professionally, the ‘Roadmap’ was seen as providing a level of credentialing at an advanced practice level, necessary for the role. At a personal level physiotherapists described the additional stress, and GPs noted FCPs’ concern with screening, red flags, and safety netting. From a practical sense GPs spoke about how the physiotherapists had had to adapt in terms of making their record keeping and time management more succinct. It was clear that this was a general observation, but some physiotherapists found this transition easier than others

Physiotherapist evolution to GP model of working

GP observations

“There’s a lot of focus on red flags, but that goes right through the system…I sat on all the interviews for the posts and that really was the one thing that…they were all focused on. Now in my career I have had a few red flag problems that have arisen, but they’re few and far between. I mean it’s not a regular occurrence…But there’s a focus on it and almost a terror or missing something. And I suppose if you’re out of your comfort zone and you’re on your own, you don’t have a whole team of people behind you, it must be challenging, but once again it will take time for people to build up the skills”. GP3

“she would be in her office at six o'clock at night, even after the manager, and we were trying to work out why. And a lot of it was just due to the workload or the timing, so you know, writing sheets and sheets and sheets in the notes where it doesn't really need to be like that in general practice, you know…But we… again this was at the start and she was able to go in with one of the other physios and she had an afternoon with X as well and she actually had an afternoon with me just doing general practice stuff. And I was doing patient appointments, and so I think boom-boom-boom we were going through these things”. GP1

Physiotherapist evolution

“You know, there was one particular... it was very early on, and she was trying to deliver her mainstream service into her FCP work. And I was saying to her, listen you're going to have to let that go a bit, you're going to have to you know, you’re going to have to relax a wee bit. Because you know, you're going to burn out in terms of trying to deliver that. You know, let the patients come to you”. FCP4

Theme 6 The FCP role is evolving and requires adaptability

It was clear that FCP services continued to evolve but the initiative was greeted positively, at both a service provision level and a career opportunity level, and ‘here to stay’.

There appeared to be some contradiction in the evidence synthesised. On the one hand, senior physiotherapists described the importance of an agreed model for FCP service, to strengthen the collective voice of physiotherapy, while on the other hand there was the

evidence for flexibility, as described above. It appeared clear that the senior-level voice had been extremely influential both in the Scottish board/service and Northern Ireland to ensure both senior level recruitment and an FCP-per-population ratio that exceed that of England. Certainly, some surprise and bemusement was expressed by participants at the prospect of delivering FCP services at the capacity commissioned in English primary care networks (PCNs).

However, it was also clear that the 'high bar' set, in terms of recruitment, had somewhat drained the workforce of the 'top level of MSK physiotherapists' and in both Scotland and Northern Ireland and that they were experiencing problems with recruitment. Consequently, in Northern Ireland they were looking at development FCP roles at Band 7 level. More specifically, due to the workforce challenges, Band 7 link grade posts have been developed. The funding for the posts remained at a level of Band 8a. However, the physiotherapist worked initially at the level of Band 7, working through identified continuing professional development under supervision. Once they met the required capabilities/ competencies they are moved up to Band 8a post.

In amongst the flexibility and adaptability to FCP services, there was some consistency. One dominant narrative was the acknowledgement that the physiotherapists perceived themselves to be working at an advanced level. The earlier evaluation had also identified this belief with diverse clinical experience seen by FCPs as the most important prerequisite for the role. However, senior physiotherapist leaders, in this final stage evaluation, expressed a yet more nuanced description of the requisite characteristics with adaptability, flexibility and confidence emphasised.

"I think it's hard to pinpoint the nature of clinician that can do that. I suppose there's…the assumption can be that it's an experienced clinician. And I would…challenge that assumption that it's not necessarily just experience. Because sometimes it comes along [that] an experienced, or and MSK clinicians working a long time, is that they're very set in their ways. So, they're very, they're almost institutionalised into a department type work. So, I think it's a blend of MSK experience and confidence. But rather than it being just experience, I think there's an element of you know, autonomous confidence and their ability to communicate and understand where the practice are coming from. I think that's quite a key thing really. A characteristic where they can quite quickly grasp, oh right, so there's a... this practice has got a certain element of priority…So I think the characteristics are you know, how open that clinician is to it, how flexible they are to be able to work with the practice, and be able to mould to the situation that they were stepping into. So, there are certain clinicians who…are a bit fixed, and they're very much you know, MSK's my job, I come in and do my MSK and I walk out the door. There are other practitioners who are much more flexible and are much more open to a flexible service delivery. And to me, that's the kind of ideal person you're looking for, rather than experienced". FCP4

The physiotherapists also spoke about supporting people beyond the boundaries of MSK health, such as mental health, pelvic health, long term pain management and preventative

healthcare. This on-the-job experience, in terms of the scope of the FCP, was seen to further justify the advanced nature of the role. Despite this, as in the earlier evaluation, traditional advanced practice skills were seen as desirable, rather than essential, with non-medical prescribing as being frequently cited as useful- but more to support medication optimisation rather than prescription.

Because of these adaptations, FCP participants discussed their individual evolution within the new role and highlighted the importance of time spent 'learning the ropes'. In particular, a number referred to becoming familiar with the art of primary care consultation and the time necessary for this adaptation. Dual consultations with the GP and clinical supervision were suggested as being critical to this tacit knowledge development and new approach to patient care. For some participants, this form of 'in situ' learning was valued more than formalised education. It was also seen as essential to succession planning.

In situ learning

"I think having the day-to-day contact and the willingness to, you know, keen to educate obviously, have [FCP] in for an afternoon with me or just be willing to ask hopefully builds the confidence and takes away the uncertainty" GP1

"...the supervision, the mentoring, the coaching, we are you know, aware of and able to help and facilitate that to bring the workforce through" FCP6

The 'art' of the general practice consultation

"But it was very rewarding, and it was you know, it was an important learning thing for me. From a point of view of you know, that sort of style of consulting, and letting the patient come to you with the information that they find important rather than fixing them with what you think" FCP4

"Yes, and I think like, I talked about this before, from a point of view of the art of consulting. I talk to my clinicians a lot of the time about the... not the science of consulting...and you'll find this in General Practice quite a lot. There's a sort of art to it I think…And I'm reflective enough to know that my consulting style has evolved over time". FCP4

Another dominant narrative focused on the importance of leadership. This senior leadership was described as being critical nationally to influencing the strategic development of FCP, and at a more operational level to provide structure to the support the physiotherapists received.

Stress was spoken about frequently as a feature of the FCP role and a potential limiting factor in the capacity and longevity of the FCP role as a career choice.

FCP role and stress

"I think it's the most satisfaction I've had out of work for a long time, but it's definitely I feel far more sort of low level stress in this job than I did when I..worked in an MSK department…I look at my day and..you don't know what's coming into your diary so you've no idea what's ahead of you, and you know, 80% of the time it's all quite straightforward and you go home at the end of the day and think, oh that was fine. But I always wake in the morning thinking, oh I wonder if today is going to be one of those days when you just get that really difficult thing or you get that thing that you just can't, you don't know how to manage or there's something, you know, that you need to act on because, you know, it's a certain more urgent situation, the ones that get your pulse racing a bit. And although they don't happen every day and they may be few and far between, I always feel like I approach every day as if it might be a stressful day". FCP3

"Yeah, I mean certainly, I mean just speaking from my own experience, I wouldn't do this job full time. I think it would be pretty hard going to do it full time. [working] part time, and all my part time hours being FCP, that's absolutely fine…there are some of my colleagues that do full time FCP – not many, but some do – and I really think, I don't know how they would do that when they're working 37 to 40 hours a week just battling through patients, I think that would be quite draining…equally there aren't that many GPs who work, you know, you don't see that many GPs who work a full clinical week. And I think you can see the sort of pressure that they work under; there's probably good reason why they don't". FCP4

There were some concerns expressed by the physiotherapists that the stress of the role could lead to professional burnout. Appropriate levels of supervision for those new to the FCP role were considered critical.

FCP and supervision

"There's definitely no way that new recruits are getting the level of support that I got initially, and that's just a numbers thing. I mean there's no way in the size that the team is now that, you know, our line managers could provide that level of sort of hand holding essentially that I got. And I mean I think our line management is excellent and incredibly approachable and supportive, you know…that one-to-one support and opportunity to go and sit in on other people's clinics, and you know, watch how other people consult, or maybe go and spend some time in orthopaedic clinics or, you know, some training, you know, just from GPs locally in your practice that's all stuff, you know, I had access to and had time built into my week. But that's certainly not the case now, you know, if you're contracted to 22 hours a week, that's 22 hours of clinical work, whereas I was, you know, maybe contracted to 22 hours a week and, you know, whatever, you know, an hour of that was set aside for going in and sitting in with other people, and that part of the job description, which it isn't anymore". FCP3

Associated with supervision was the evidence around the First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal); A Roadmap to Practice (NHS, 2020). It was clear that this was seen as an initiative developed and intended for England with access unavailable for physiotherapists in Northern Ireland and Scotland. On the one hand this was interpreted as inequitable while on the other hand it provided a template against which physiotherapists could measure their own competency and frameworks against. Indeed, in Northern Ireland the FCP leadership expressed confidence in their own competency frameworks.

There was a strong voice for continued development of services to provide a smoother patient journey from the first contact and beyond. FCP services were viewed as an important component in this vision with efforts to further break down professional and organisational boundaries, including preventative roles.

Discussion

Summary

This, final stage, of the first national evaluation of FCP services provided some corroborating and new findings. The reinforced and evolving themes are represented below (Fig. 1).

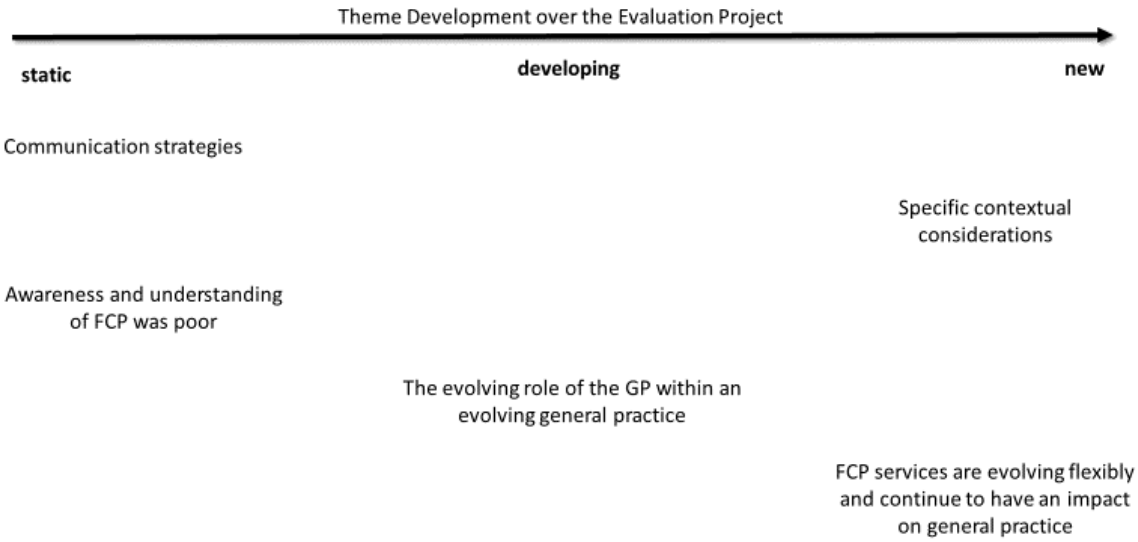

Figure 1. Theme development over the evaluation project

Consistency was seen in terms of the benefits of having FCP services collocated and the importance of signposting in access to FCP services. Collocation facilitated FCP embedding, communication and familiarisation with FCP services. Within this latest stage of the evaluation this extended beyond the GP practice to the wider community of care. This was particularly relevant in rural locations.

The stages of the evaluation highlighted the general lack of awareness, and understanding, of FCP services. It also highlighted a more generalised lack of understanding of physiotherapy.

The previous theme of The Role of the GP in the FCP agenda was synthesised as developing into the theme 'The evolving role of the GP within an evolving general practice'. It was apparent that the FCP agenda sat within a wider agenda that was bringing about an evolution of general practice and the GP role itself. The previous themes of Theme 4 FCP contribution to general practice, Theme 5 FCP reconceptualises physiotherapy work, Theme 6 The variation in the FCP scope and model have evolved into the new theme of 'The FCP role is evolving and requires adaptability' and 'FCP services are evolving flexibly and continue to have an impact on general practice'.

This is the final stage of the first nationwide, mixed methods evaluation of the FCP model of care. The aim of this final stage of the national evaluation (phase 3) was to evaluate the experiences of FCPs, GPs and general practice non-clinical staff explored through interviews and focus groups.

In summary FCP appears very well received by all participant groups. All participants felt that FCP roles were becoming a permanent feature of primary care and general practice. However, this latest stage of the national evaluation described an increasing degree of flexibility in the design and execution of FCP services.

This final stage of the evaluation offered the perspective from participants in areas of the devolved nations of Scotland and Northern Ireland. Furthermore, it provides evidence from FCP services that have had a longer time to establish and also services that have experienced the extra-ordinary impact of the Covid-19 pandemic. As such, this final stage of the evaluation provides novel data.

Comparison to existing literature

There was consistency in these most recent findings with the early stage of this national evaluation and previous research in that the importance of having the physiotherapist collocated (5) was once again emphasised. 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.

Despite their enhanced funding model of 1 FCP per 10,000 patient population the consensus was the FCP capacity still did not match the demand of people experiences MSK related health complaints. The perceived funding gap in existing service models was reported in the early stage which evaluated services in England predominantly where the current nationwide commitment to FCP whereby a population of 50,000 receives funding for 1 full time equivalent FCP. This complexity on the basis of the impact of FCP on GP workload has been reported elsewhere (5).

Despite this, FCP services were described as having significant impact in general practice, and more widely. This aligns with previous evidence describing the benefits of FCP as reduction in referrals for diagnostics, reductions in referrals to secondary care services and overall satisfaction (6). Greater nuance was added to this evidence with suggestion that waiting times to mainstream MSK physiotherapy services were shortened and those patients who were referred were more appropriate and more likely to attend. Once again, FCP was seen as introducing a MSK specialism into general practice.

Physiotherapists described working as an FCP as a positive experience as it provided them with a rewarding career opportunity. However, there was also concern expressed about the role in terms of the unpredictable nature, associated sense of risk and busyness of the

diary/ caseload. This was seen as introducing some challenges staff burnout, a concern reported elsewhere [7] with anxieties around FCPs' wellbeing expressed both in terms of workload, diagnostic uncertainty and the subsequent risk associated with the FCP role.

New evidence was synthesised around the adaptation to the FCP role, with the 'GP model' of working spoken about and the time required to adapt to this model and the specific 'art of the consultation' required in general practice. This was also reflected in the need for physiotherapists to adapt to the risk of the undifferentiated patient. GPs certainly described their role as specialising in uncertainty and some physiotherapists adapted to this more easily, and quickly, than others.

There was also new evidence around the evolving flexibility of the FCP role. The tight parameters of the conceptual model of FCP (20-minute appointment time, limited to assessment and advice, very limited follow up capacity) were described as becoming more fluid. Patients were sometimes seen for greater follow up appointments and appointment time were sometimes extended. While some of this flexibility was context specific- for example in rural locations where mainstream services were a considerable distance way- the flexibility was described as extending beyond this, more generally. There was no evidence of any resistance to this from any participant group and some physiotherapists described this flexibility as enhancing the role and their satisfaction.

As in the earlier stage of the evaluation the importance of signposting was emphasised, particularly in view of the evidence of a lack of awareness among patients about FCP services. Signposting by reception staff has been previously described as presenting a potential challenge to receptionists in terms of explaining new consultation methods to patients [1, 8, 9] and this potential unintended consequence of FCP, needs considering within the wider agenda.

Limitations

This final stage of the first national evaluation explored the views of participants in FCP services in particular areas of Scotland and Northern Ireland. It was clear from the evidence that some differences existed to the earlier stage, which was essentially an evaluation of English FCP services. As such, this evidence may not be applicable to England. Furthermore, the evidence may not be applicable to all FCP services across the whole of Scotland and Northern Ireland. This stage of the evaluation took place during the unprecedented Covid-19 pandemic. Participants were eager to caveat their conversations with this contextuality.

Conclusion

Despite the limitations described above this evaluation provides an informative snapshot of FCP services in Scotland and Northern Ireland. This evaluation adds to previous evidence in providing the impression of long-term commitment to FCP services in Scotland and Northern Ireland. New evidence is provided around how the traditional physiotherapy role

needs to adapt to working in general practice. Furthermore, it appears that the tighter boundaries of the conceptual model of FCP are flexing over time, whether this be for specific contexts- such as rurality- or more generally. There was a sense that this, to some extent, was necessary to allow physiotherapists to manage and cope with the demands of the role and prevent burnout and attrition. This is clearly important as it appears FCP physiotherapy is here to stay.

Future work

Further work is needed to explore the efficacy of FCP services- particularly with reference to previous care models. Further work would also be useful to explore physiotherapists experiences of the role and the consequences thereof.

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