

# Patient acceptability of the physiotherapy first contact practitioner role in primary care: A realist informed qualitative study

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## Abstract

**Background:** Approximately 30% of general practitioner (GP) consultations are due to musculoskeletal disorders (MSKDs). Physiotherapists are trained to assess, diagnose and treat MSKDs and provide an alternative to GP consultation for primary care patients as first contact physiotherapists (FCPs).

**Aim:** To explore patient perceived acceptability of the FCP role using realist methods to understand what works for whom, how, why and in what circumstances.

**Methods:** A realist evaluation was undertaken, which involved three stages: forming the theory area framework; testing the theory framework and refining the programme theory. The theory framework was formed through realist synthesis. Realist interviews tested this framework. Data were collected from two GP practice case study sites and interviews were undertaken at each site.  $N = 20$  participants were interviewed in total. In each practice, this constituted patients ( $n = 5$ ), GPs ( $n = 1$ ), FCPs ( $n = 2$ ), receptionists ( $n = 1$ ) and practice managers ( $n = 1$ ). Interview data were analysed against preliminary hypotheses and, where appropriate, new theory areas were created.

**Results:** The evaluation highlighted that acceptability of the FCP role was influenced by 'expectations', 'accessibility' and 'promoting the role'. Whilst some findings were shared by both practices, different contexts resulted in unique practice findings.

**Conclusion:** Patients were predominantly accepting of FCPs, nevertheless, there was a scope to increase acceptability through an implementation strategy that considered the contexts of the individual patient, as well as wider practice contexts.

## KEYWORDS

acceptability, first contact practitioner, FCP, musculoskeletal, physiotherapy, primary care, realist evaluation

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## 1 | INTRODUCTION

Primary care consultations grew by more than 15% between 2010/11 and 2014/15 (The King's Fund, 2016). An estimated 30% of general practitioner (GP) consultations are related to musculoskeletal disorders (MSKDs; Goodwin & Hendrick, 2016), impacted by the ageing population and the rise in obesity (Collino et al., 2013; Health and Social Information Centre 2019; Roberts et al., 2016). However, the number of full-time equivalent GPs has decreased (National Health Service [NHS] Digital, 2018).

### 1.1 | The first contact practitioner role—The 'intervention'

A solution to these problems included increasing the number of advanced practitioners (AP) in primary care. APs are working at 'a level of practice [that is] characterised by a high degree of autonomy and complex decision making' (NHS, 2017). Some GP practices employ first contact practitioners (FCPs)—physiotherapists with expertise in MSKDs that patients can access directly without an initial GP assessment (NHS, 2018). Traditionally, patients with MSKDs required either a GP referral to physiotherapy or, in some cases, could directly self-refer to Secondary Care physiotherapy (Foster, Williams, Grove, Gamlin, & Salisbury, 2011; National Health Service England (NHSE), (2018). The FCP role aims to provide access to a MSKD expert, located within primary care within two weeks of them requesting an appointment, which may reduce the risk of chronic problems and they may provide management advice or refer/signpost to services (Campbell, Leighton, Martin, & Friedly, 2012; Chartered Society of Physiotherapy [CSP], 2018). The FCP model is being implemented across the United Kingdom but with variations, including: the mode of access; virtual/telephone assessments and/or face-to-face appointments; number of appointments; length of the consultation and the interventions the FCP can action (CSP, 2017; 2018a; 2018b; 2019a; Halls et al., 2020; Health Education England (HEE), 2020).

NHSE's (2019) preliminary evaluation demonstrated that 97% of patients would be likely/highly likely to recommend the FCP service. The available FCP research is predominantly audit based and focused on satisfaction rates (CSP, 2019b). Some qualitative work has explored Practice staff's acceptability of the FCP role. Goodwin et al. (2020) explored factors that affected patient awareness and understanding of the role, however, not patient acceptability specifically. If an intervention is acceptable, patient adherence to treatment and improved clinical outcomes are more likely (Hommel, Hente, Herzer, Ingerski, & Denson, 2013).

### 1.2 | The evaluation

The study aimed to explore patient acceptability of the FCP role in primary care, and gain an understanding of the model and the

practice factors that are essential for FCP's effective implementation. These insights demonstrate how the FCP role could be developed to meet patient needs.

### 1.3 | Theoretical approach

The methodological approach was realist evaluation, which seeks to explain 'what works for whom, how and under what circumstances' (Pawson, Greenhalgh, Harvey, & Walshe, 2005, p. 32). A realist approach is suited to interventions where implementation is not consistent, such as the FCP (Rycroft-Malone et al., 2012).

Realist evaluations typically include three phases (Cheyne, Abhyankar, & McCourt, 2013):

1. Forming of the theory area framework
2. Testing of the theory area framework
3. Refining the programme theory

*Phase 1* seeks to identify how the programme is expected to work. Data are utilised to create hypotheses about causal relationships between contexts (C), mechanisms (M) and outcomes (O) to form CMO configurations (see Table 1; Pawson & Tilley, 2004). Any relevant source can be utilised, including grey literature, and a realist synthesis of the literature may be undertaken (Wong et al., 2013).

*Phase 2* involves collecting data that will go on to test the previously formed ideas on what may affect patient acceptability of the FCP role (hypotheses; Pawson & Tilley, 2004).

*Phase 3* is the analysis and interpretation that results in a refined programme theory (Pawson & Tilley, 2004). The hypotheses are interrogated through subgroup comparisons; where did it work/not work, who did it work/not work for (Pawson & Tilley, 2004).

## 2 | METHODS

The theoretical framework underpinning the study consisted of three main phases (see Figure 1).

### 2.1 | Phase 1—Forming the theory area framework

The framework was established through a realist synthesis which extracted and connected data, with regular stakeholder consultation, to form CMOs (Olsen, 2010). Similar CMOs can be expressed as a hypothesis, which are synthesised statements of findings (Rycroft-Malone et al., 2012). The synthesis explored the patient views of the AP, an umbrella term that includes the FCP and the more well-established nurse practitioner (NP) role (see Appendix S1 for an overview of the synthesis).

TABLE 1 CMO definitions

Concept	Definition
Context	The context is fundamental to a mechanism operating to achieve the outcome (Wong et al. 2016). Micro-level contexts may include: Characteristics of the population; staffing and beliefs. Macro-level examples include the geographic setting and the organisational setting.
Mechanism	The underlying processes or social structures that—when operating in particular contexts—lead to outcomes (Astbury & Leeuw, 2010). A resource mechanism is implemented into a context and results in a response mechanism, which is the reasoning that results in behaviour change (Dalkin, Greenhalgh, Jones, Cunningham, & Lhussier, 2015). Latent mechanisms are those that are not active, but could be revealed if the context was altered (Jagosh, 2019).
Outcome	Outcomes are the intended or unintended consequences of a programme (Pawson & Tilley, 2004). Unintended outcomes are unwanted effects that result from unintended mechanisms (Wong et al., 2016; Astbury & Leeuw, 2010).
CMO configuration	A realist evaluation attempts to trace back a programme's outcomes to its associated contexts and mechanisms in order to pinpoint the configuration of features needed to sustain a programme (Pawson & Tilley, 2004). This study's formula is inspired by Dalkin et al.'s (2015): Mechanism (resources) + context → mechanism (response) = outcome

Abbreviation: CMO, contexts, mechanisms and outcomes.

## 2.2 | Phase 2—Testing the theory area framework

### 2.2.1 | Design

Realist interviews tested the theory framework; this interview technique uses theory to inform the topic guides and the interviewer is responsive to emerging theory (Pawson & Manzano-Santaella, 2012).

### 2.2.2 | Recruitment

Via email correspondences, practices were identified through established network links of a member of the research team and via the Core Clinical Commissioning Group's (CCG). Practices were invited to participate via email correspondences with the lead researcher (LM).

### 2.2.3 | Sampling

Within each case study site, purposeful sampling was adopted to sample staff and patients. The purpose of purposeful sampling is to select participants that best answer the research question (Emmel, 2013). In a realist approach, the sample is selected based upon theory, which is considered before data collection (Pawson and Tilley, 1997). Staff participants were recruited via the practice manager circulating a staff information booklet. Patient recruitment methods included: information booklets distributed by FCPs, GPs and the researcher during observation of FCP consultations; poster advertisements and leaflets in the surgery.

Only those who had experienced the role and did not match any of the study's exclusion criteria were selected. Inclusion criteria:

experienced a MSKD; over 18 years old; consulted with a FCP. Exclusion criteria: did not meet the inclusion criteria; considered to be 'vulnerable adults'; non-English speaking.

## 2.3 | Data collection

Ethical approval was granted by Westminster NHS Research Ethics Committee (ID: 18/LO/0037) and participants provided both written and verbal informed consent.

The study's topic guides were informed by the realist synthesis' hypotheses ( $n = 19$ ) and had questions to identify specific contexts, mechanisms and outcomes, alongside prompts (see Appendix S2 for theory areas and hypotheses; Manzano, 2016). A topic guide was produced for patients and each professional group (see Figure 2). The research team and patient research partner met to refine the topic guides and a pilot interview of the patient topic guide was carried out with the patient research partner.

Interviews were conducted by LM, a physiotherapy graduate undertaking a PhD.

Interviews were predominantly over the telephone ( $n = 9$ ), with only one face-to-face interview ( $n = 1$ , for Practice Manager 2's convenience) (Drabble, Trocki, Salcedo, Walker, & Korcha, 2017). Interviews were audio-recorded and transcribed (Given, 2008).

## 2.4 | Phase 3—Refining the programme theory

A realist evaluation aims to test data against the initial programme theory in real Practice (Pawson & Tilley, 2004). Transcripts were coded in a process similar to thematic analysis in NVivo 12 (Braun &

Clarke, 2006). Coding was inductive (formed from the data) and deductive (coded to a pre-existing framework; Olsen, 2010). Data were coded as context, mechanism or outcome and the concepts were connected in a CMO 'notes' document. Practices were coded as separate cases, with new coding frameworks created. Participants were asked to comment on the researcher's descriptive interpretation of the interview. None of the respondent validations changed the presentations of findings.

## 2.5 | Findings

### 2.5.1 | Phase one—Forming the theory area framework

There were eight theory areas formed on what may influence the patient acceptability of the FCP role, with 19 hypotheses formed under the theory areas.

### 2.5.2 | Phase two—Testing the theory area framework

Two GP sites were evaluated and there were five patient participants and five members of staff per practice.

In Practice A, staff interviews were on average 25 min long and ranged from 11 to 47 min in length. Patient interviews lasted between 36 and 54 min and were on average 43 min long.

Staff interviews in Practice B ranged from 11 to 40 min and had an average length of interview of 24 min. The average length of patient interviews for Practice B was 46 min and lengths ranged from 32 to 61 min.

### 2.5.3 | Contexts

Table 2 describes an overview of the practices' contexts. See Appendix S3 for an overview of the participants.

All theory areas identified in the realist synthesis were tested ( $n = 8$ ). A researcher (JP) on the team reviewed the coding of the LM which highlighted one omission and previous interviews were revisited (Rothbauer, 2012).

### 2.5.4 | Phase three—Forming a narrative

Wong (2016) stated the importance of clearly articulated inferences supported by data. Due to extensive findings, CMOs are not reported if they were: formed through inferences with limited supporting data; supported by only one source or limited in their implementation value. Three theory areas and their relevant CMOs ( $n = 13$ ) are presented. CMOs are presented under their theory area or under 'overlap', when several theory areas overlapped.

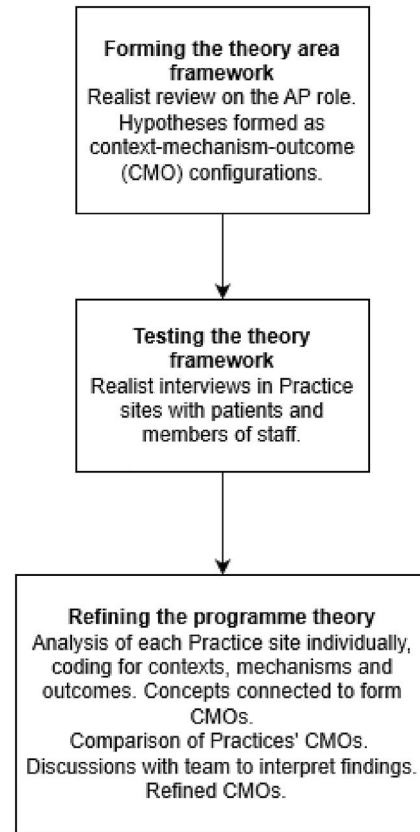


FIGURE 1 Overview of realist methods

When the CMO was applicable to both Practices, it is presented as 'shared CMO', otherwise it is presented as a Practice-specific CMO.

## 2.6 | Theory area 1—Expectations

This theory area's CMOs are presented in Figure 3.

### 2.6.1 | Shared CMO 1: The effect of a patient's perception of a serious condition

If patients perceived their condition to be 'serious', they wanted the choice of whether to access the FCP or GP. Patients defined 'serious' as anything trauma related; conditions that were not improving; back pain; new conditions; systemic conditions; effect on other conditions and general pain. The perception of a serious condition resulted in patients wanting to access a GP for a diagnostic scan, unless the FCP could action this:

'I'd prefer physio but also, I prefer to make [sic] a scan. And if physio can refer me to scan same as GP, yes, I'd prefer physio'. (Patient 10, Male, Practice B)

1. Check tape recorder works.
2. Introduce self.
3. Explain the purpose of the interview.
4. Confirm the patient has read and understood the patient information booklet
5. Invite participant to ask any questions they may have.
6. Reconfirm they are in control of the interview and can stop at any time.
7. Obtain recorded verbal/written consent.

**Opening:**

- In lay terms, what do you think a musculoskeletal disorder is?
- Confirm that they have had any experience of FCPs for their MSKD
- Confirm that the patient has, or has had in the past, a MSKD
- The type of MSKD
- Length of time had the MSKD
- Explore what the patient thinks a First Contact Practitioner physiotherapist is
- Identify how long ago this experience was
- Who have you seen in the past?
- How have you come to see a FCP?

**Theory 1 – Experience of Roles Associated with the FCP Role**

- (1) Other than seeing your GP, do you have experiences of consulting other healthcare professionals at your GP practice?

**Prompts:** *tell me about this experience, for conditions other than MSKDs also, what were the outcomes, differing/similar experience with different professionals*

- (2) How did the experience differ to your experience with your GP?

**Prompts:** *treatments/outcomes, equivalent outcomes as GP*

- (3) Has your GP discussed the First Contact Practitioner roles in the Practice with you?

**Prompts:** *positive/negative views, influence on your views, discussed other healthcare roles in Primary Care*

**Theory 8 – Hierarchy**

- (4) Have health care professionals in the Practice, or in hospitals ever expressed their views on physiotherapists which you feel have impacted on yours?

- (5) Have the Practice Receptionists ever expressed their views on physiotherapists that you feel have impacted on yours?

**Prompts:** *negative/positive views, health care professional of choice, best health care professional to be seen by*

**Theory 2 – Expectations**

- (6) Which professional would you rather see and why?

**Prompts:** *for your MSKD, any particular MSKDs you wouldn't see your FCP for, health conditions that you consider to be more serious than others, multiple conditions, who would you access for the conditions you consider to be more serious, do you feel different Health care professions have different diagnosis skills, views on FCPs prescribing*

FIGURE 2 Patient topic guide

- (7) How do you feel about having a choice on seeing a range of different professionals in your GP practice?

**Prompts:** *lack of patient choice, FCP leading to indirect access to GP*

### Theory 3 – Communication

- (8) Can you tell me what about your GP's consultation [or other professionals they have experienced] that you liked/disliked?

**Prompts:** *communication skills, explaining information, personable, demonstrate knowledge*

### Theory 4 – Continuity of Professional

- (9) Can you tell me what your views are on seeing the same one practitioner, instead of having consultations with several practitioners?

**Prompts:** *for your MSKD, familiarity, knowing the practitioner, practitioner knowing the patient's name*

### Theory 5 – Scope of Practice

- (10) Can you tell me what sort of services or treatments you would like from your physiotherapist in your General Practice surgery?

**Prompts:** *compared to GP, prescriptions*

- (11) What are your views on physiotherapists being able to prescribe?

**Prompts:** *independently prescribe, GPs check prescriptions, serious condition*

### Theory 6 – Accessibility

- (12) Could you tell me what your views on physiotherapists working in GP practices are if this service was able to reduce waiting times for appointments?

- (13) Can you tell me whether the length of consultations affects your consultation experience, if at all?

**Prompts:** *reduced wait for GP consultation, reduced wait for a physio appointment, convenience of appointment*

### Theory 7 – Role Promotion

- (1) Prior to this interview, had you heard about physiotherapists in a First Contact Practitioner role?

- (2) If yes, where had you heard about the role?

**Prompts:** *family/friends that may have shared experiences, GPs/staff discussing role, media, the internet*

- (3) Do you feel like you need any more information about the role?

**Prompts:** *understanding*

**FIGURE 2** (Continued)

**TABLE 2** Practice contexts

Practice A	Practice B
<ul style="list-style-type: none"> <li>Part of a medical centre which consisted of two sites in the South West of England.</li> <li>Two FCPs in this surgery.</li> <li>Practice team included a community pharmacist and primary care practitioners.</li> <li>Face-to-face FCP appointments after a receptionist triage.</li> </ul>	<ul style="list-style-type: none"> <li>Part of a network of 25 Practices in the CCG catchment area in the North of England.</li> <li>Three FCPs in Practice B.</li> <li>Virtual telephone appointments with community pharmacists and with FCPs (7 days service).</li> <li>Face-to-face FCP appointments were available to all 25 practices. Three practices offered face-to-face appointments.</li> </ul>

Abbreviations: CCG, Clinical Commissioning Group; FCP, first contact physiotherapist.

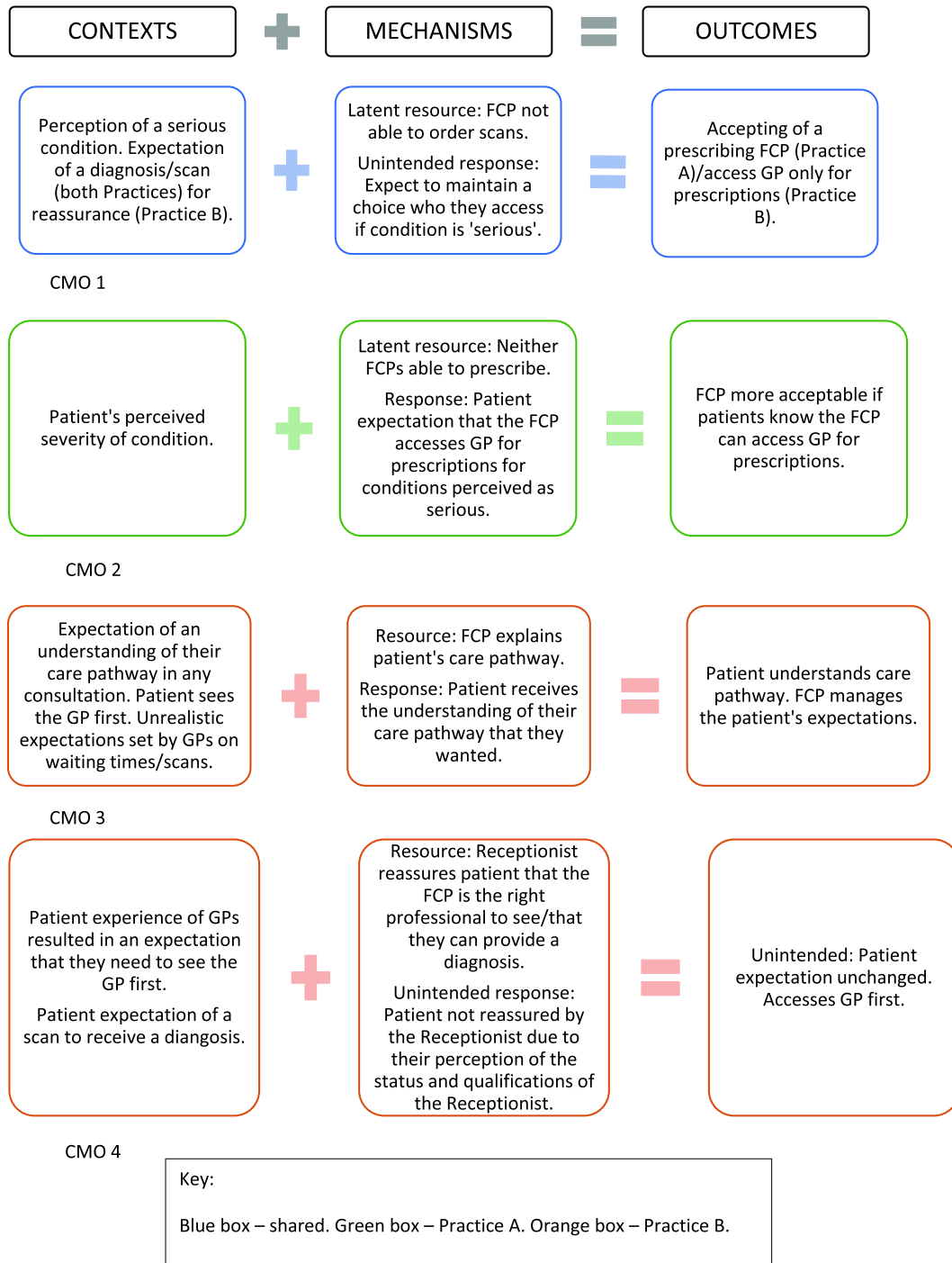


FIGURE 3 Expectations contexts, mechanisms and outcomes

FCP 3, FCP 4 and GP 3 hypothesised that receiving a diagnosis provided patients with reassurance.

'she [FCP] may not know what side effects and things like that, but I'm sure...you know again, if they needed to ask they'd ask [the GP]'. (Patient 5, Female)

### 2.6.2 | Practice A CMO 2: Patient expectation that the FCP accesses GP for prescriptions

Patients 1 and 5 found it more acceptable if a FCP accessed the GP for a patients' prescription if they considered their condition to be serious or complex:

However, neither FCPs were able to prescribe and FCP 2's response stated that only 10%–13% of patients required a prescription and none of the patients interviewed had required a prescription.

### 2.6.3 | Practice B CMO 3: Patient expectation of an understanding of their care pathway

Patients 8 and 10 and FCP 4 highlighted the importance of patients understanding their care pathway:

'I got an idea of what it could possibly be and the routes that we would then take'. (Patient 8, Female)

FCP 4 had managed unrealistic patient expectations set by GPs, through providing an explanation on MSKDs appropriate for scans and expected waiting times.

### 2.6.4 | Practice B CMO 4: The role of receptionists in changing patient expectations

Receptionist 2, FCP 4 and Patient 5 highlighted a patient expectation, based on previous experience, that traditionally the GP was the first contact. GP 2 and Receptionist 2 stated that receptionists could change expectations through reassuring patients that the FCP could provide a diagnosis. This was not always possible due to patient perceptions of the Receptionist's status:

'I don't think she [Receptionist] is qualified to say "oh you don't need to see a GP, you need to see a physiotherapist"' (Patient 6, Female)

## 2.7 | Theory area 2—Promoting the role

This theory area's CMOs are presented in Figure 4.

### 2.7.1 | Shared CMO 5: Patient understanding of the FCP role prior to the consultation

The importance of the Receptionists in promoting the FCP role was emphasised in both Practices. In Practice A FCPs were described as similar to physiotherapists, whereas in Practice B they were called a specialist service. Patient 2 expressed role confusion:

"when you go into the surgery, why aren't there labels up there about what the medical ... what the musculoskeletal practitioner can do? I did not know until I walked into the room." (Patient 2, Male, Practice A)

Practice Manager 1 felt patients may erroneously expect multiple FCP appointments, as they would have with traditional physiotherapy. All the patients interviewed from Practice B called the FCP a physiotherapist, and all except one expected numerous appointments.

### 2.7.2 | Practice B CMO 6: The impact of multiple Practices accessing the role on patient role understanding

A FCP was asked in the respondent validation whether he felt limited communication between GPs (across 25 Practices in the network) and the FCPs impacted on GPs' understanding, he responded:

'Since we cover multiple Practices, the 'home' Practice has a pretty good understanding I think, and the other less so'. (FCP 3, Male)

Patient responses highlighted mixed signposting and explanations amongst the multiple receptionist staff. Whilst some were appropriately aware and briefed on the role, others provided no explanation.

### 2.7.3 | Practice B CMO 7: Patients require information on FCP's qualifications

Patients 8 and 9 expressed acceptance of the FCP prescribing or injecting if they were appropriately trained. Patient 10 stated he would like to have been informed on the qualifications of the FCP to be confident in their skill:

'It would be good if I know what kind of problems he helps with and what education degree he's got'. (Patient 10, Male)

## 2.8 | Theory area 3—Accessibility

This theory area's CMOs are presented in Figure 5.

### 2.8.1 | Shared CMO 8: Decreased waiting times

Staff and patients in both practices discussed the reduced wait to see the FCP compared to the GP. It was felt by FCP 2 that early reassurance could reduce the risk of MSKDs becoming chronic. Patients 4 and 6 felt an earlier appointment would reduce their worry:

'the quicker you're seen the lighter you become in yourself and the worry goes away'. (Patient 6, Female, Practice B)

Practice Manager 1 and FCP 3 stated that there were insufficient FCPs in the practice to meet the demand for face-to-face appointments. There were 19 FCPs carrying out virtual assessments across the 25 Practices, but only three FCPs assessing patients face-to-face.



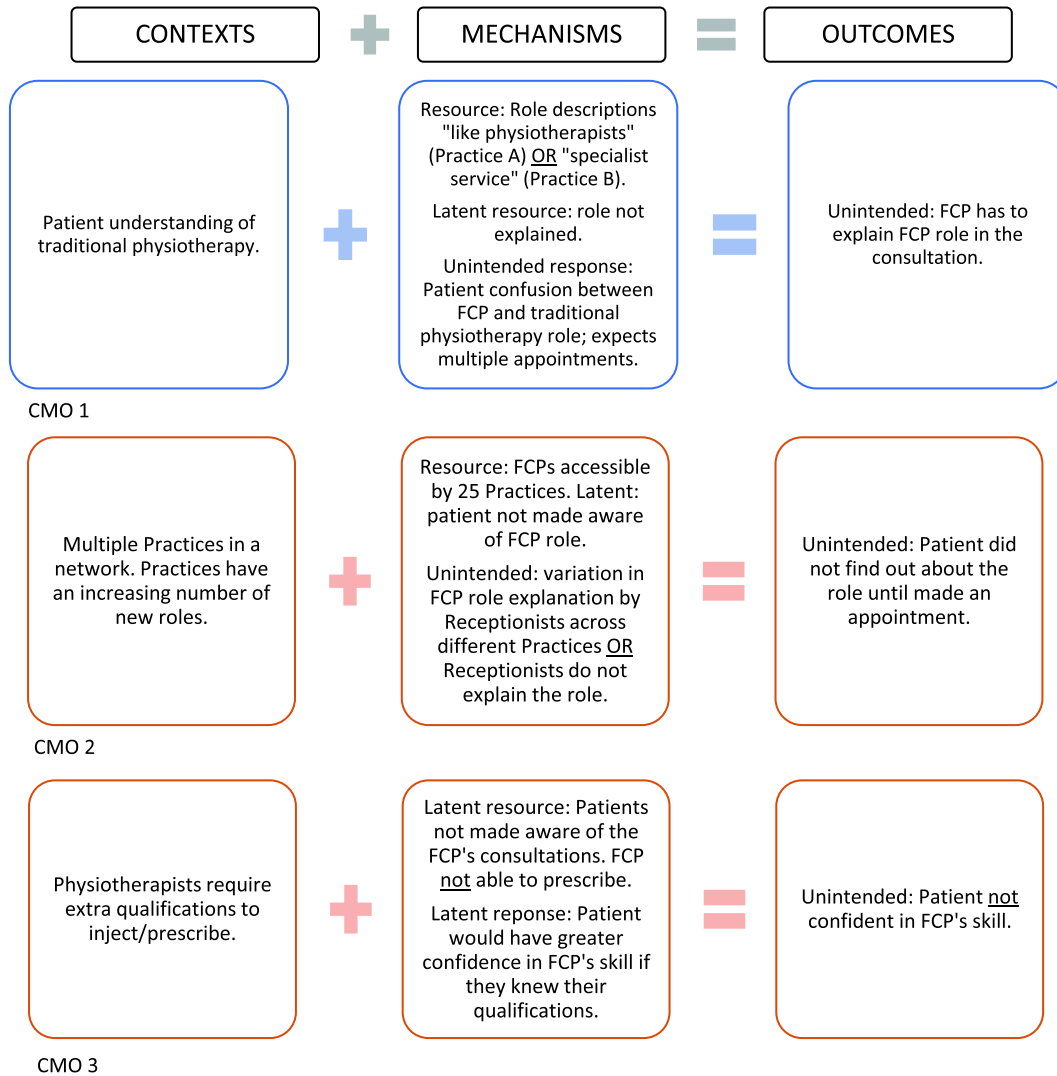


FIGURE 4 Promoting the role contexts, mechanisms and outcomes

### 2.8.2 | Shared CMO 9: Meeting patient needs in one appointment

Providing there were alternative routes for patients to easily receive their prescription, such as FCPs accessing the GP on their behalf or putting the patient on a Community Pharmacist list, it was not essential that the FCP prescribed. Patients 7 and 8 perceived it beneficial for the FCP to inject so that their needs could be met in one appointment:

'If the [FCP] can do it [inject] rather than me going elsewhere it would be better if everything is done there and then rather than booking another appointment'. (Patient 7, Male, Practice B)

There were concerns that sending patients back to the GP for scans (FCP 4) or in more complex cases (FCP 3) would add to the GP workload. However, the GPs highlighted that the FCPs accessed them for authorisations and they were only positive about this.

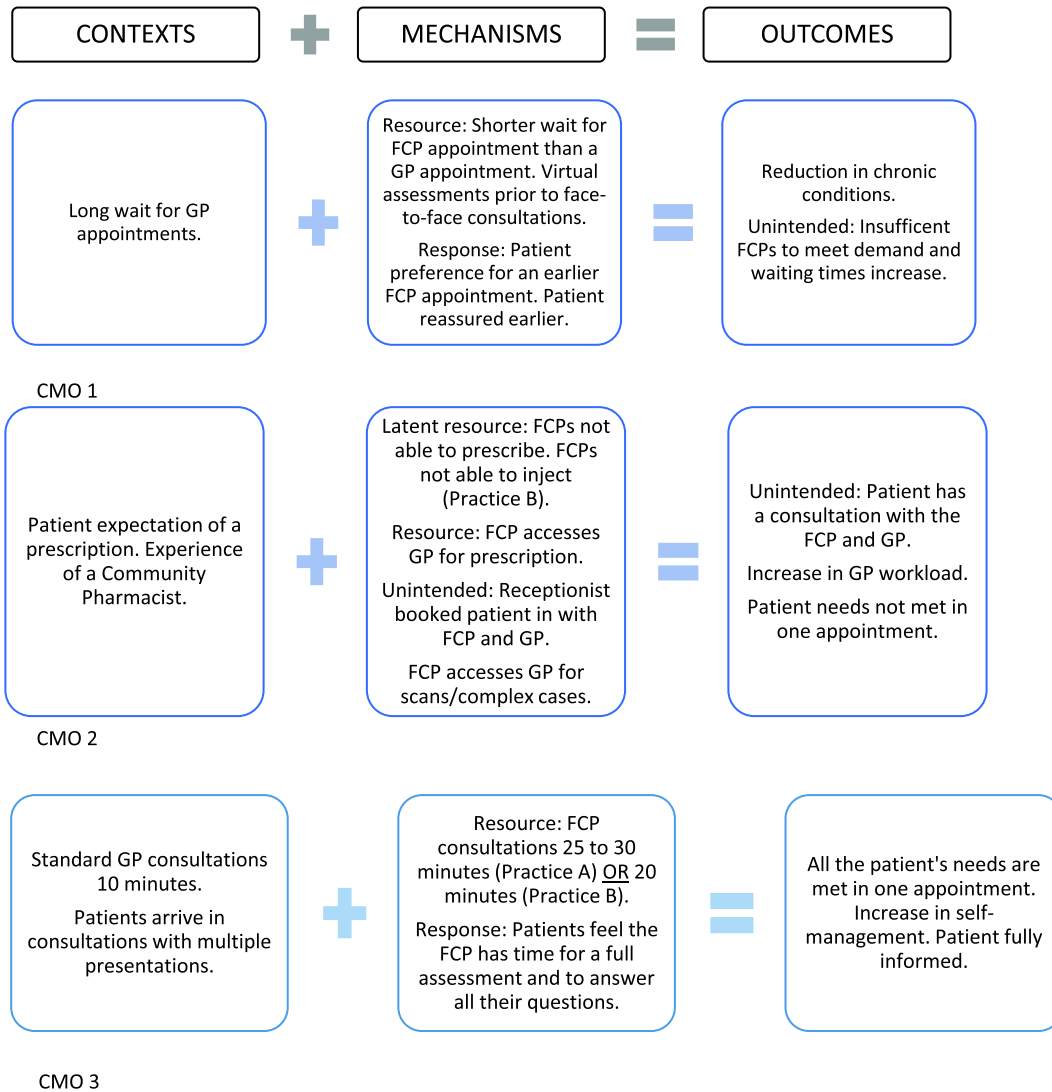
### 2.8.3 | Shared CMO 10: Length of consultations

Patient 4 compared 25 min FCPs consultations to her experience of 10 min GP consultations:

'I think it's absolutely fantastic because so often when you go to the GP you're limited to so many minutes, like three or four minutes'. (Patient 4, Female, Practice A)

Patients 3 and 4 (Practice A) and 9 and 10 (Practice B) felt all their questions could be answered in longer FCP consultations, and Patients 9 and 10 felt they received better explanation of their condition:

'I felt like he was thorough, I felt like he'd got time to talk to me about it and that's what I look for'. (Patient 9, Female, Practice B)



**FIGURE 5** Accessibility contexts, mechanisms and outcomes

Practice A's Management Partner and Receptionist hypothesised that the outcome from these longer consultations were that patients were fully informed.

'increasingly they're used to Practitioner titles, you know, Nurse Practitioners...we have three paramedics at \*Practice A\* so...who will be...what's the title?...Primary Care Practitioners'" (FCP 1, Female, Practice A)

## 2.9 | Theory area overlaps

The theory area's CMOs are presented in Figure 6.

### 2.9.1 | Overlap 'experience' and 'promoting the role'

*Shared CMO 11: The effect of patient experience of APs in patient understanding and acceptance of the FCP*

Practice A had other AP roles including NPs and primary care practitioners (PCPs). FCP 1 felt that contact with these roles meant patients were more familiar with APs:

Patient 4 had a negative experience of traditional physiotherapy and would not access them again. However, she accessed a FCP, suggesting she could distinguish between the roles prior to the consultation, whereas Patient 2 was only made this differentiation after the consultation. This may have been influenced by Patient 4's previous experience of PCPs. FCP 3 theorised that physiotherapy experience could influence expectations of FCP treatment:

'there are some people who've maybe seen us in the past or the people who sort of know what treatment they want anyway that can be quite pleased that they're seeing a physio'. (FCP 3, Male, Practice B)

Patient 3 had expected an injection due to a previous positive physiotherapy experience and was satisfied once the FCP delivered this intervention.

*Practice A CMO 12: Aspects of the FCP role patients were made aware of*

Four patients experienced the Receptionist promoting direct access to a FCP. Patient 1 described the explanation:

“She’s fully experienced and I think she would be better for you to see them in this first instance and she could then refer you to the GP if she thought it was necessary’. (Patient 1, Male)

It was perceived as important that patients understood that the FCP could access the GP for prescriptions. Patients were reassured on accessing the FCP due to a clear explanation by the Receptionist.

### 2.9.2 | Overlap ‘expectations’ and ‘experience’

*Practice B CMO 13: Patient expectation of face-to-face appointments*

FCP 4 hypothesised that frequent GP attenders and patients who required more reassurance often expected face-to-face appointments only:

‘Some people definitely just want to be seen face-to-face no matter what the problem. You can look back in their notes and you generally get that sort of feeling from multiple GP attendances’. (FCP 4, Male)

Patient 7 expressed unease at being advised over the telephone and she was the only patient who expressed having multi-morbidities. It may be that patients with multi-morbidities require greater reassurance.

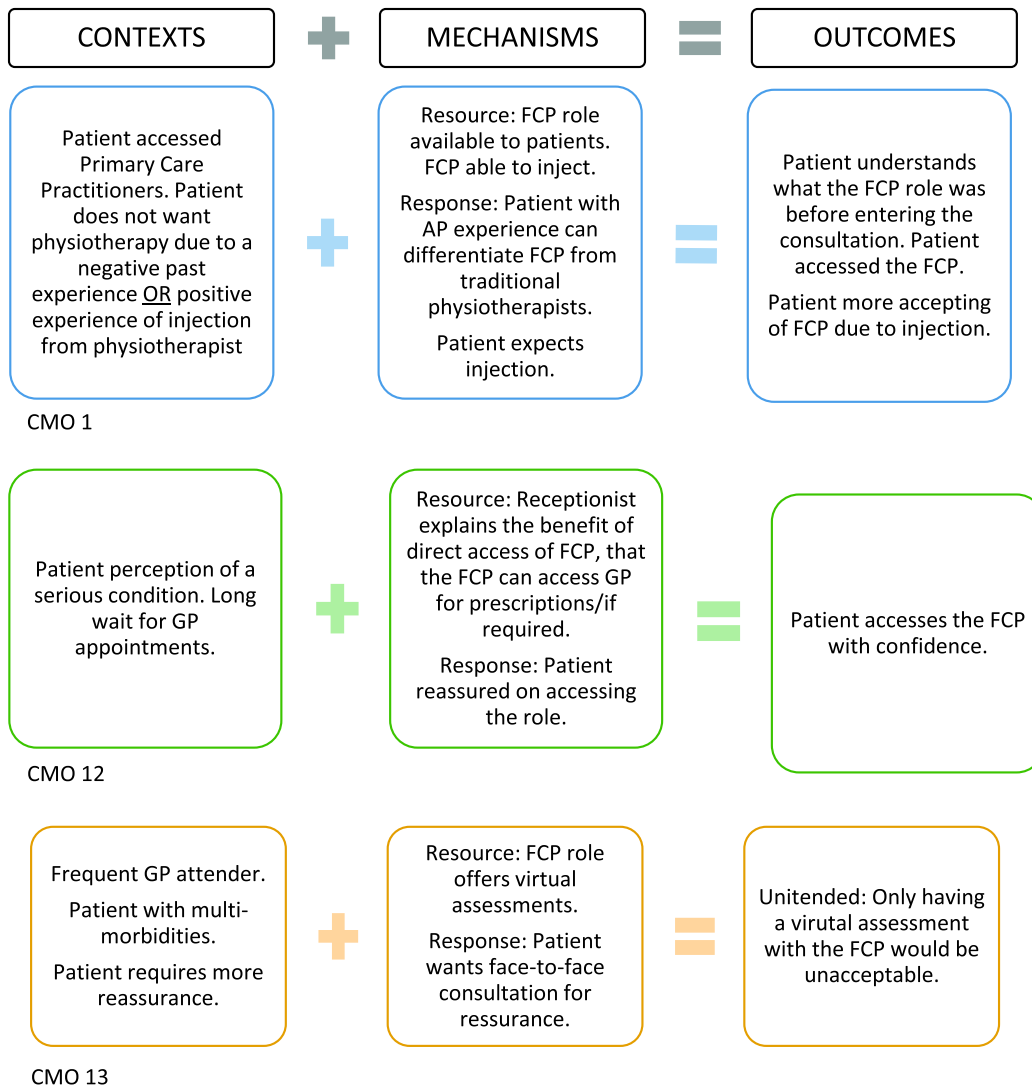


FIGURE 6 Theory area overlaps contexts, mechanisms and outcomes

### 3 | DISCUSSION

Findings demonstrated that patients were accepting of the FCP role, but there was scope to increase acceptability. An essential context for patient acceptance of FCP access and FCPs prescribing was their perception of a serious condition. Previous studies demonstrated that better physical and mental health, including beliefs about condition severity correlated with higher satisfaction of General Practitioner consultations (Palmer et al., 2006; Rosendal, Carlsen, & Rask, 2016). Although this study is unable to quantify the association between condition severity and patient satisfaction with the FCP, it suggests the need for receptionists and FCPs to be cognisant of its influence when triaging patients.

This study highlighted the importance of receptionists in signposting patients to the FCP role, and the frequent expectation that the GP was the first step for assessment, a finding present in wider evidence (Goodwin et al., 2020). However, receptionists are faced with time challenges, preventing them consistently explaining new consultation methods to patients (Brant et al., 2018). Goodwin et al. (2020) found that the receptionist role was effective, but only if they understood the aims of the FCP service. Practice B was in a network of Practices that could access the FCP role, and there were inconsistencies in receptionists' explanations of the FCP role. The majority of the UK practices have formed primary care networks (PCNs), which are approximately 1300 geographical networks of Practices which provide a wide range of services to patients (The King's Fund, 2019). Before expanding to join PCNs and increase FCP access, individual practices must consider the burden on receptionists, and ensure they have sufficient FCP role understanding.

This study elucidated the mechanism of patients having their needs met in one appointment. However, GPs have concerns that if less experienced physiotherapists were placed in the FCP role (this Practice had Band 7 physiotherapists), more work would be 'bounced back' to them (Moffatt, Goodwin, & Hendrick, 2018, 2019, p. 126). This study highlighted the limited need for FCPs to prescribe medication. An NHSE's evaluation of the FCP pilot found that, across six CCGs, only 6% of patients on average required prescriptions (NHSE, 2019). This study postulated a context that may influence the variation in Practice need; this was the ability for patients to be placed on a Community Pharmacist's list, a context which may increase due to the recent introduction of the NHS Community Pharmacist Consultation Service which aims to relieve GP pressures (NHS, 2019a). PCNs should assess the need for FCPs to deliver certain skills for their network's population needs (NHS, 2019b).

Patient responses demonstrated the importance of having adequate time in consultations. Halls et al. (2020) found that 71% FCP consultations lasted 20 min; as Langridge (2019) highlighted they are shorter than traditional physiotherapy appointments, thus, rapid-speed-of-thought was required for safe, clinically effective decisions. There are concerns regarding recruitment of sufficiently qualified physiotherapists (NHSE, 2019). There are uncertainties regarding the required support for FCP skill-development and training—including MSc provision and the role's implications on undergraduate training

(Halls et al., 2020). This study identified that an insufficient number of FCPs could result in an increase in waiting times.

#### 3.1 | Limitations

Only patients who had experienced the FCP role were interviewed and participants retrospectively considered their views prior to contact; this may decrease the findings' interpretative validity (Maxwell, 2012). There was no purposeful sampling of age groups and the youngest patient in Practice A was 66 and non-English speakers were excluded for pragmatic reasons. Inclusion of younger patients and non-English speakers would have increased the sample's representativeness to the general population. This study was informed by an unpublished realist synthesis and, as theory was created through subjective insights (Pawson et al., 2005; The RAMESES II Project, 2017), a different team may have formed different theories. Nevertheless, this would not undermine the findings, but it would increase the amount of Practice contextual differences explored. For publication purposes, selected hypotheses are presented and the extensive findings are presented elsewhere (citation removed for blind review) If possible, all hypotheses should be presented in a realist evaluation (Wong et al., 2016).

### 4 | CONCLUSION

This study has demonstrated that acceptability of the FCP model is impacted by different contextual factors at a micro and macro level, that must be considered when implementing the role within primary care. Important patient contexts included their perception of MSKD severity and their previous experience of APs and GPs, which Receptionists and FCPs must be aware of during triage/assessment. FCPs and Practice Managers must consider the professional skill-mix within their Practice when planning FCP skill-development. As networks grow, commissioners and managers must consider: the current burden on Receptionists who must be able to signpost consistently and appropriately to FCPs; and whether there are sufficient FCPs to sustainably offer reduced waiting times across multiple Practices and thus sustain patient acceptability of the FCP role.

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#### CONFLICTS OF INTEREST

No conflicts of interest.

#### AUTHOR CONTRIBUTIONS

Leah Morris, Nicola Walsh, Pam Moule and Jennifer Pearson conceived the study and contributed to the protocol. Leah Morris carried out the fieldwork and analysed all the data. Nicola Walsh,

Pam Moule and Jennifer Pearson contributed to data analysis and interpretation. Dave Foster was the Patient Research Partner for the study, he was consulted throughout the project. All the authors contributed to manuscript preparation.

## ETHICS STATEMENT

Ethical approval was granted by Westminster NHS Research Ethics Committee (ID: 18/LO/0037) and participants provided both written and verbal informed consent.

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## SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

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