Title: Provision of first contact physiotherapy in primary care across the UK: A survey of the service

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Abstract

Background: First Contact Physiotherapy (FCP) is an emerging model of care whereby a specialist physiotherapist located within general practice undertakes the first patient assessment, diagnosis and management without a prior GP consultation. Despite institutional and professional body support for this model and NHS commitment to its implementation, data regarding current FCP provision are limited.

Objectives: To identify current FCP service provision across the UK, including models of provision and key professional capabilities.

Design: Cross-sectional online survey, targeting physiotherapists and service managers involved in FCP.

Methods: Recruitment involved non-probability sampling targeting those involved in FCP service provision through emails to members of known clinical networks, snowballing and social media. The survey gathered data about respondents, FCP services and the role and scope of physiotherapists providing FCP.

Results: We received 102 responses; 32 from service managers and 70 working in FCP practice from England (n=60), Scotland (n=22), Wales (n=14), and Northern Ireland (n=2). Most practitioners were NHS band 7 or 8a (91%, n=63), with additional skills (e.g. requesting investigations, prescribing). 17% (12/70) worked 37.5 hours/week; 37% (26/70) ≤10hours; most (71%, 50/70) used 20-minute appointments (range 10-30 minutes); varying arrangements were reported for administration and follow-up. Services covered populations of 1,200 to 600,000 (75% <100,000); access mostly involved combinations of self-booking and reception triage. Commissioning and funding arrangements varied widely; NHS sources provided 90% of services.

Conclusions: This survey provides new evidence regarding variation in FCP practice across the UK, indicating that evidence-informed, context specific guidance on optimal models of provision is required.

Contribution of the Paper

- This paper provides published evidence regarding the variation in FCP provision and the professional capabilities of the FCP workforce in primary care across the UK. This adds to the current literature which focuses on England only.
- FCP services are rapidly emerging and expanding throughout the UK in response to the evolving needs of primary care. These new data provide a baseline indicator of current practice (e.g. professional capabilities, service drivers, models of provision), which need consideration to enable effective implementation of policy focused on the delivery of services in primary care.

Keywords (6 words)

First contact physiotherapy; Musculoskeletal diseases; Primary care; General practice

Introduction

Musculoskeletal Disorders (MSKDs) are the leading cause of disability in the UK (1,2) and have vast economic impact: accounting for £30.8 million lost work days annually (3); costing NHS England almost £5 billion per annum (4); with approximately £8.6 billion of personal independence payments attributed to MSKDs annually (5).

MSKDs account for a considerable amount of GP workload (6, 7). In 2014, there were approximately 340 million GP consultations in England, an increase of almost 12% in five years (6, 8); and between 2010 and 2015, UK GP practice lists increased by 15%, while the GP workforce grew by <5% (9). Furthermore, a study reported in 2015 indicated that 13% of GPs aged <50 and 60% of those aged >50 years expected to leave their position within the next five years (10). More recent workforce data continue to indicate high numbers of GPs leaving the profession (11). These issues mean that alternative models of care that are safe, sustainable and can be implemented with relative ease within the healthcare system are required.

An emerging model is First Contact Physiotherapy (FCP), a rapidly developing approach to managing MSKDs in primary care, whereby a specialist physiotherapist located within general practice undertakes the first patient assessment, diagnosis and management without the requirement for prior GP consultation (12). Although the principle of physiotherapy provided at first point of patient contact has been described in the international literature (e.g. 13), this article describes the FCP model specifically within the context of the UK NHS. The emergence of the FCP model was set within the political context of primary care development and redesign plans specific to UK devolved nations (14,15,16). This was followed by nation specific policy briefing documents (17,18,19,20) and subsequent FCP implementation guidance (12,21,22,23), and reinforced in England by the NHS Long-Term Plan and GP Contract (24,25). Although the implementation guidance documents are specific to match the context of each nation and its healthcare systems, all describe a shared challenge with primary care and suggest comparable models of FCP as approaches to managing that challenge.

Pilot schemes and local audits indicate outcomes including freeing up GP appointments, reduction in secondary care referrals, fewer scan requests, increased patient satisfaction, and potential cost-savings (26). A small number of published FCP service evaluations exist evidencing independent management of the majority (63-87%) of patients by physiotherapists, high patient satisfaction, improved patient reported outcome and reduced referrals to orthopaedics (8,27,28). NHS England have also supported FCP roll out through the FCP Mobilisation Plan and through the ongoing national pilot (29,30). FCP is also being introduced across Northern Ireland, within a roll out of multidisciplinary teams to practices.

Promising outcomes, alongside institutional and professional body support for this model and NHS commitment to its implementation have resulted in increasing FCP service provision. However, there remains limited understanding of how FCP services are provided in different settings, and their long-term and whole system impact. As such, a body of work was initiated in 2018 to perform a robust research evaluation of UK-wide FCP services (PROSPERO: CRD42018104939; Research Registry: researchregistry5033) (31). This work is underpinned by realist methods which focus on determining

"what works, for whom, in what circumstances and in what respects, and how?" and are particularly beneficial for services or interventions which are based in complex and varied contexts (32,33). Understanding current FCP service provision is an essential first step of this work and an important baseline on which to demonstrate development of FCP services.

Aims and objectives

The aim was to identify current models of FCP service provision across the UK, including key aspects of professional practice.

Methods

Study design

The study design was an online survey. Ethical approval was granted by the University of the West of England's Faculty Research Ethics Committee (reference: HAS.18.07.204). Informed consent was assumed if surveys were completed and submitted online. An information sheet and General Data Protection Regulation statement were made available. Responses were anonymous unless participants chose to provide contact details in relation to their interest in further evaluation work. All data were anonymised for analysis.

Survey development

A survey was developed to meet the aims of the study, capturing basic demographics of respondents and their FCP services, followed by questions relating to FCP service components including, but not limited to: staffing (hours, grades and competencies); patient pathways; service aims; financial arrangements. As the survey targeted all those involved in FCP service provision, some questions were specific to those working as FCPs while others were relevant for service managers.

A draft survey developed by the research team was piloted with three individuals, working in FCP and/or MSKD commissioning roles, who reviewed and helped revise the draft survey content. The revised content was discussed with the wider research team and edited based on their feedback. Once finalised, the survey was formatted onto Qualtrics, an online survey platform, and a test link to

it was sent to five individuals known to the research team to check for any problems in access (e.g. NHS firewalls, differences across devolved nations) prior to wider distribution.

Survey sample and distribution

A pragmatic recruitment strategy was utilised, involving a variety of non-probability sampling approaches: email invitations to access and complete the survey were sent directly to FCP Development Network members and to professional contacts based in each devolved nation; some individuals assisted in snowballing recruitment (34) by distributing emails to known local FCP leads and others working within FCP services. The survey was also advertised via social media on Twitter (@FRONTIER_FCP) and on the study website (www.frontierstudy.co.uk).

Data management and statistical analyses

Following the closure of the survey, data were downloaded from Qualtrics into Excel. Basic descriptive statistics were used to analyse and report survey data. Free text responses were not analysed using formal qualitative methodology but were used to add context to responses.

Results

During the 4-week survey period (25/10/2018 to 22/11/2018), 102 responses were received; 94 (92%) accessed the survey links sent via email; 8 responded through social media channels.

Respondent demographics

Of the 102 respondents, 31% (n=32) identified their professional role as service managers: 64 identified themselves as physiotherapists, with four others reporting specific physiotherapist titles (advanced practitioner physiotherapist; consultant therapist; telephone triage physiotherapist; consultant physiotherapy), one a “director of clinical integration”, and one left their role unidentified.

Most respondents were based in England (59%, n=60); 22% (n=22) were based in Scotland, 14% (n=14) in Wales, and 2% (n=2) in NI. Four responses (4%) were unidentified regarding geographical location. Survey responses were received from 59% of the 44 Sustainability and Transformation

Partnership regions in England, 50% of the 14 Regional Health Boards in Scotland, 71% of the seven Local Health Boards in Wales and two of the five Health and Social Care Trusts in NI.

Ninety-three respondents described the local area where their FCP service was based as either inner city/urban (35%, n=33), suburban (33%, n=31), or rural (20%, n=19): 10 (11%) indicated that their service was based in an 'other' local area, described as a combination of these options. Forty-eight respondents (47%) provided information regarding the patient population that their FCP service covered. These populations ranged in size from 1,200 to 600,000 patients, 25% (12/48) covered a population ≤10,000, 50% (24/48) between 10,001 and 99,999, and 25% (12/48) ≥100,000.

Role and scope of physiotherapists providing FCP services

Responses to questions regarding hours worked in a FCP role; appointments and time allocation; banding (reflecting professional status) and skills were considered only for the 70 respondents who reported that their professional role was working in FCP practice, and not for those with a managerial role.

Respondents' work in a FCP role ranged from zero to 37.5 hours per week (median=16 hours); 17% (12/70) worked full time in FCP roles (Table 1). Those reporting zero hours were either not currently performing the FCP role or were in a service that was being developed.

Appointment times ranged from 15 to 30 minutes; most lasted 20 minutes (71%, 50/70). Although not asked directly, some respondents indicated planned reductions in appointment times: two from 30-minute appointments to 20-minutes and another indicated dissatisfaction with pressure from their practice manager to reduce from 20-minute to 10-minute slots. Some provided additional details about their FCP service: some were only available to new patients, whilst others provided follow-up appointments, of the same or shorter (usually 10-minutes) duration compared to new patient appointments. Some services operated telephone triage prior to face-to-face appointments. Telephone contacts were reported as being 5-10 minutes, or 30-minute appointments included time for telephone triage and administration. Thirty-one respondents (44%) reported administration time

within their FCP role (range 15 - 80 minutes), although some described time per session, per day or per number of appointments and others indicated availability of a non-specified time for administration.

Of the 69 responses received regarding banding (35) and skills, 91% reported being either NHS Band 7 (n=30) (clinical specialist/team leader) or Band 8a (n=33) (advanced/'extended scope' practitioner); one reported being Band 6 and five, Band 8b+. Of the 66 who provided information regarding additional skills (Table 2), seven (10%) reported having none of the skills listed; 55 (83%) had two or more. The skills most frequently reported were requesting imaging (86%, 57/66), requesting blood tests (68%, 45/66), and ability to inject (67%, 44/66). Of the 27 (41%) who were independent non-medical prescribers, most (74%, 20/27) were able to prescribe directly, four could prescribe through patient group directives or patient specific directions but two were not permitted to use their prescribing capability. Eleven respondents used free text to report other additional skills, including referral to secondary care and ability to perform nerve conduction studies.

FCP role titles were reported by 63 respondents. The most common were variations of 'advanced physiotherapy practitioner'/'advanced practice physiotherapist'/'APP' (n=22) or 'first contact physiotherapist/practitioner'/'FCP' (n=14). Less frequently reported were 'extended scope physiotherapist/practitioner'/'ESP' (n=5), 'MSK physiotherapist/practitioner' (n=5), 'clinical specialist physiotherapist/musculoskeletal practitioner' (n=4) and other variations including 'physiotherapist', 'consultant', 'clinical specialist', 'orthopaedic practitioner', and 'patient direct referral'. Some described using a combination of titles, or that titles used depended on the context, for example, using 'physiotherapist' in patient-facing interaction to facilitate understanding of the role.

FCP service models

Responses to questions regarding FCP service provision were examined for all 102 survey respondents: 93 (91%) provided information regarding service duration, which ranged from 0 months to 9 years (Table 3). Nine (10%) services were currently in development, 30 (32%) were running for less than a year and seven (8%) for longer than three years.

Respondents could select as many responses as relevant regarding drivers for FCP service initiation (Table 4). The most frequently selected was 'To relieve pressure on GPs' (90%, 77/86), followed by 'To provide better care for patients' (76%, 65/86). Additional free-text responses included the improvement of primary care and MSK pathways, population needs (e.g. increasing age and complexity), and 'to conform to current trend'.

Eighty-nine respondents (89/102, 87%) provided information about numbers of FCPs working within their services: 15% (13/89) had one FCP, 16% (14/89) had two, 8% (7/89) reported three, 21% (19/89) reported four, 35% (31/89) had five or more FCPs and five reported that they did not know how many were involved. Information about the hours of FCP provision available per week ranged from four to 763.5 hours, accounting for FCP service provision across both single and multiple GP practices.

Regarding how patients access FCP services, respondents could select as many responses as relevant (Table 5): the majority of the 85 responses received selected more than one option. 'Self-booking' was selected alone (n=2) or with other options (n=26) in 33% of responses (28/85) whereas 'triage at reception' alone (n=34) or with other options (n=78) was selected by almost 92%. Free-text responses illuminated 'other' access routes, including involvement of GPs or other practice staff (e.g. advanced nurse practitioners), telephone-based triage (by FCP's or other healthcare professionals) and walk-in appointments.

In response to questions regarding FCP service commissioning, answered by 84% of respondents (86/102) (Table 6), there was wide variation, from FCPs being commissioned and employed by a single practice, to commissioning by groups of practices, community providers and acute services. Free-text comments mainly related to funding: some services were described as un-resourced or provided within existing budget, while others were funded by multiple sources or for a fixed timeframe, with clear differences between nations. Only 55 respondents provided specific information regarding funding arrangements: 45% of these (25/55) reported block contracts, three

(5%) reported cost per case, and 27 (49%) reported 'other'. In response to the question asking about source of FCP service provision, responses regarding FCP service provision (n=82) (Table 7) indicated that 90% of services were provided by the NHS.

Discussion

This survey provides the first known published evidence regarding the variation in FCP provision across the UK. It describes the professional capabilities of those providing FCP services and the key components of services available late in 2018, which are a baseline for the extension of the provision of these services in primary care. Importantly, it describes FCP practice as reported by those working on the ground. Results are discussed in relation to FCP policy, guidance and considerations for development of the service.

Survey responses indicated wide geographical breadth of FCP provision, yet 55% (n=51) of services had been running for less than 2 years, indicating the newness of FCP provision. This is set to expand given NHS commitment to FCP implementation across all UK nations (12,21,22,23), supported by funding schemes e.g. the GP contract (24,25) and nationally available training resources such as the Health Education England (HEE) e-learning programme (36), and informed by the outputs of ongoing national evaluation packages (29,30).

This commitment to the FCP model has implications on several levels, including workforce – are there sufficient physiotherapists currently working at required levels with a desire to fulfil these roles, and depending on employment models, will this have implications for physiotherapy skill mix in secondary care? It raises questions about the support for of skills development and training, the sufficient numbers of MSc course providers and places, and the implications of emerging roles in primary care for undergraduate training. Furthermore, the profession may ask what the FCP role means for the scope of physiotherapy practice and for professional identity. Whilst the implementation of FCP provides opportunities for the development of physiotherapists and the profession, it is not without challenges. Concerns have been raised regarding recruitment, given physiotherapy vacancy rates in some areas (e.g. 5.2% in NI for all grades), and the potential negative

impact that filling FCP roles may have on the wider workforce with potentially fewer physiotherapists being available to provide services beyond the advanced roles (37). Effort to address such challenges by expanding the physiotherapy workforce to deliver FCP is being made through engagement with universities (38).

In relation to physiotherapy skills and training, it is recommended that those performing FCP roles adhere to the requirements of the HEE Capability Framework (39), and work at Agenda for Change band 7-8a (35). Our results indicate that the banding of those currently providing FCP services is quite consistent with recommendations, with only 9% of our sample falling outside of these. However, there was wide variation in the additional skills reported in our survey; many reported having skills which required additional training and qualifications, such as injecting and independent prescribing. The necessity for such skills for those performing FCP roles is not yet clear and further understanding is required regarding implications for cost and education. A recent paper investigating the skills, competencies and capabilities of FCPs highlighted that physiotherapists working in primary care with advanced skills (e.g. independent prescribing and injection therapy) broadened the domain of physiotherapy practice (40). This has advantages for the profession in terms of widened opportunities for skill development and career progression but the impact of a broadened scope of practice on professional identity is yet to be realised.

Despite these considerations, there is little debate in the literature regarding the value of FCP for patients, as reflected in our finding that the 'provision of better care for patients' was the second most frequently reported driver for FCP service initiation. By widening the offering in primary care, to enable patients with MSKDs the opportunity to consult with expert physiotherapists as first point of contact fully embraces "right person, right place, right time" (29).

FCP shows promise in producing benefits such as reduced costs and referrals and adding value for patients (8,27); it has backing from professional bodies and the NHS; and presents opportunities for the physiotherapy profession by widening the scope of physiotherapy practice. However, a better understanding of FCP services is required to ensure appropriate, effective and safe implementation,

and that the most valuable outcomes are achieved for patients, physiotherapists and the wider NHS. Further research considering the complexity of FCP services is needed, including consideration of contextual variation in service implementation and setting (e.g. sociodemographic characteristics), what is effective, or not, in different contexts, and the mechanisms by which outcomes occur. These aspects will be explored in the ongoing FRONTIER study (31).

Strengths and limitations

To our knowledge, this is new evidence regarding the size and scope of FCP services across the UK. For this exploratory study, it was essential to sample utilising established professional networks in an attempt to target a relevant professional audience. The non-probability sampling approach is however, a key limitation resulting in inability to calculate response rates, comment on sample representativeness, or understand sample bias. As the link to the survey was freely accessible via social media, it was not possible to limit participation therefore it is possible that respondents may not have been working within the UK or involved in FCP service provision. However, this approach allowed the survey to be distributed in a relatively short timescale, and to be accessed and completed quickly by busy professionals. The short availability period may also have curtailed response rates. The responses were anonymised for analysis, to preserve respondents' confidentiality, so results cannot be attributed to specific geographical areas. The variation in services identified is nevertheless relevant to NHS planning.

The self-reported nature of these data is acknowledged as a limitation, as is the cross-sectional nature of this survey. Thus, while providing valuable insight regarding the current FCP landscape, it only provides a snapshot in time that will become quickly outdated, especially given the rapidly developing nature of FCP. However, given the paucity of data regarding FCP services, these data fill a gap in the literature, and are valuable for policy makers as a baseline for FCP development. Additionally, the UK wide focus of this study can be considered as a strength: whilst each nation has separate healthcare policies and FCP guidelines differ, all are experiencing a shared challenge from pressures on primary care and FCP is being implemented as a shared approach to managing that challenge.

Conclusion

This study provides new evidence regarding FCP provision and practice across the UK, an essential baseline from which the further development of FCP services can be demonstrated, and data to inform effective implementation of policy, focused on primary care provision. It considers implications for physiotherapy workforce development, education and training providers, institutional bodies, commissioning groups and those involved in the delivery, implementation and evaluation of FCP clinical services.

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Conflict of Interest: None declared.

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Tables and figures

Table 1: Number of hours per week worked in FCP role (n=70 responses)

Hours worked per week	Count (%)	Range (hours)	Median (hours)
None (0)	3 (4%)	NA	NA
<10	26 (37%)	4 – 10	7.5
11 - 20	15 (21%)	12 – 20	16
21 - 36	14 (20%)	21 – 34	24.5
37.5	12 (17%)	NA	NA

501 **Table 2: Additional skills reported by FCPs (n=66 responses)**

Additional skills	Count (%)
Request imaging	57 (86%)
Request blood tests	45 (68%)
Inject	44 (67%)
Prescribe (independent prescriber)	27 (41%)
Interpret imaging	19 (29%)
List for surgery*	11 (17%)
Other**	11 (17%)
None	7 (10%)

*Unspecified: may include listing patient directly on waiting list for surgery, for orthopaedic appointment, or other. **Free text responses included 'refer to secondary care' (e.g. orthopaedics, rheumatology), 'completing non-medical prescribing training' (n=3) and/or 'injection courses' (n=2), 'ability to perform nerve conduction studies', 'ability to list for spinal injections'

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504 **Table 3: Approximate FCP service duration (n=93 responses)**

Service duration	Count (%)	Range (months)	Median (months)
0 months	9 (10%)	NA	NA
1 – 5 months	13 (14%)	1 – 4	1
6 – 11 months	17 (18%)	6 – 11	6
1 year – 23 months	12 (13%)	12 – 20	18
2 years – 35 months	25 (27%)	24 – 33	24
3 years +	13 (14%)	36 – 108	45

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507 **Table 4: Key drivers to FCP service initiation (n=86 responses)***

Drivers to FCP service initiation	Count (%)
To relieve pressure on local GPs	77 (90%)
To provide better care for patients	65 (76%)
To provide earlier access to specialist services	51 (59%)
To better utilise available workforce	36 (42%)
To save money	26 (30%)
Part of national pilot (England only)	18 (21%)
Other	11 (13%)
Don't know	3 (3%)

*Respondents could select all options that were relevant

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510 **Table 5: How patients access FCP services (n=85 responses)**

	Count (%)
Triage at reception	34 (40%)
Triage at reception and Other*	19 (22%)
Self-booking, Triage at reception and Other*	18 (21%)
Self-booking and Triage at reception	7 (8%)
Other*	4 (5%)
Self-booking	2 (2%)
Self-booking and Other*	1 (1%)

*Free text reports of 'other' included GPs or other practice staff (e.g. advanced nurse practitioners) performing a role, telephone-based triage and walk-in appointments

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513 **Table 6: FCP service commissioning (n=86 responses)**

	Responses (%)
Other	24 (28%)
FCP is commissioned from the CCG	15 (17%)
FCP employed by group of GP practices	13 (15%)
FCP is commissioned from a NHS community service provider	11 (13%)
FCP is commissioned from a NHS acute service provider	9 (10%)
Don't know	8 (10%)
FCP employed by single GP practice	6 (7%)

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516 **Table 7: Model of FCP service provision (n=82 responses)**

	Responses (%)
NHS provider	68 (83%)
Directly by GP practice	6 (7%)
Other	5 (6%)
Single private practitioner	2 (2%)
Social enterprise	1 (1%)
NB We have reported GP practice separately from NHS provider	

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