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A qualitative study to explore the experiences of First Contact Physiotherapy Practitioners in the NHS and their experiences of their First Contact role.

INTRODUCTION

With an ageing population, the demands on primary care will rise (Age UK 2018).

Currently there are 15.3 million people in the UK aged 60 and above (Age UK 2018).

Worldwide, this is projected to grow from an estimated 524 million in 2010 to nearly

1.5 billion in 2050 (WHO 2011). Musculoskeletal (MSK) conditions account for

approximately 30% of general practitioner (GP) consultations in England (Skills for

Health 2018) and is estimated to cost the National Health Service (NHS) £4.76 billion

each year, and is likely to increase (HEE 2020). Despite this, GP numbers are

remaining relatively static (CSP 2018). The Royal College of General Practitioners

have predicted that there will need to be an 8,000 (Full Time Equivalent) increase in

GPs in 5 years to meet the existing shortfall (HEE 2020). In response, a new First

Contact Practitioner (FCP) role has been developed for health professionals with

advanced practice skills to take on many of the musculoskeletal responsibilities

currently carried out by general practitioners (GPs) with the intention of increasing

capacity in primary care, sign-posting patients more effectively and improving the

appropriateness of onward referrals (HEE 2020). As a consequence, FCPs are

required to have advanced skills in assessment and clinical reasoning; ordering and

interpreting investigations, and undertaking complex case management (CSP 2018).

Pilots of this service in the UK have shown that this can reduce the burden on GPs,

inappropriate referrals into secondary care, and improve patient care (CSP 2018). In

Sweden, Bornhöft et al. (2019) found that physiotherapy management of MSK

conditions in primary care was more cost effective, resulted in a reduction in

radiological requests and led to fewer referrals to specialist services, compared to

GP management.

However, FCP roles are new and still developing. Whilst these roles bring opportunities for the physiotherapist and for the profession to be at the forefront of influencing patient access to quality services, they also bring substantial challenges associated with working with risk and uncertainty. Uncertainty is a pervasive presence in healthcare which can affect the quality and safety of care (Pomare et al. 2018). It has been defined as the subjective perception of ignorance experienced by health professionals and elicits a variety of psychological responses (Pomare et al. 2018). One of the main areas of healthcare uncertainty is 'disease-centred', which encompasses uncertainties about diagnosis, prognosis and treatment recommendations (Pomare et al. 2018). As the FCP role in primary care involves seeing patients who are not initially screened, this is likely to increase levels of uncertainty in relation to patient safety and managing clinical risk (Langridge 2019). This may be associated with patients presenting with Red Flags, which are indicators of possible serious pathology (Greenhalgh and Selfe 2009), and masquerading conditions, which may present as MSK pain but is actually referred pain from a visceral structure (Walcott et al. 2011).

With an increase in the number of physiotherapists being involved in litigation (Beswetherick 2019; Birkeland & Bogh 2019), there is a need to understand the complexities of this role to ensure the welfare of the patient and the therapist. Currently there is little research that has investigated the experiences of FCP. The findings from this study could help a variety of stakeholders and other clinicians gain an understanding of the reality and complexities of the FCP role. The aim of this research was to explore the experiences of FCPs working in North West England to

gain insight into the first point of contact service, and their experiences of this developing full time FCP role.

METHODS

The study is reported in accordance with the consolidated criteria for reporting qualitative (COREQ) research (Tong et al. 2007).

Study design

A qualitative design using in-depth semi-structured, face-to-face interviews was undertaken to explore the experiences of FCP providing a first point of contact service full time. The theoretical perspective that informed this research was Gadamerian hermeneutic phenomenology (Gadamer 2013; Laverty 2003). This approach was used as it aims to interpret lived experience and to reveal meaning through a process of understanding and interpretation (Annells 1996; Gadamer 2013), and as such, was appropriate to address the research aim.

Ten FCPs were being recruited by a Clinical Commissioning Group (CCG) to a first point of contact service in a Primary Care setting in North West England. The CCG identified FCPs as being Band 8a, and those in FCP training posts as Band 7 (NHS Employers 2019). These posts were to cover 49 GP practices and a population of 311,000. Each FCP was expected to cover nine sessions (with one session equating to one half day). This CCG was selected as it was implementing a complete system change in the management of MSK conditions across the whole primary care setting

and commissioning 10 full time FCP posts. This setting, therefore, provided a unique opportunity to explore FCP experiences within this new initiative. Furthermore, as this model of implementation may be followed by others, it is important to gain an understanding of any potential barriers and facilitators, prior to further roll-out.

Permission was sought from the FCP manager for the university research team to contact potential participants. In order for the FCPs to make an informed decision whether to participate, they were emailed an invite from the university research team to take part in the study. The invite included a participant information sheet and the contact details of the research team to enable them to ask any questions and to indicate their interest in taking part. When the FCP was happy with all the information provided, they signed a consent form. All FCPs met the eligibility criteria and were invited to take part in the study (Table 1).

Table 1. Eligibility criteria

Inclusion Criteria	Exclusion Criteria
- Physiotherapists working in a FCP role (including FCP training posts) - Providing a first point of contact service - Working in primary care	FCPs who are not physiotherapists working in a musculoskeletal service

Participants consenting to take part in the study were also asked to complete weekly reflective diaries of their experiences for 12 weeks following recruitment to the study (Appendix 1). The diaries were developed from Day et al. (1998) model of reflection

(Appendix 2). The completed diaries were passed to the research team prior to their interview.

Participants were then invited to a face-to-face interview with a member of the research team who was experienced in qualitative interviewing. All interviews were undertaken by the same researcher (SG) at either their workplace or the research teams' University, whichever was more convenient for the participant. Interviews lasted between 60-90 minutes and were digitally audio-recorded. The content of the diaries and a topic guide were used as a prompt during the interview to facilitate reflection on the phenomenon of interest (their experiences as a FCP and their role) to be fully explored. The topic guide was developed from a review of the literature, Day et al. (1998) model of reflection and from critical discussion with the research team (Appendix 3). The topic guide included three topics (expectations of the role, experiences of the role, support in relation to role). Questions were provided as prompts to facilitate reflection on their experience according to Day et al. model (success, difficulties, changes). Data generation continued with open-ended questions about their experiences of being a FCP and their role. Subsequent questions were conversational in nature and drew on what the participant had mentioned in their reply (Creswell, Poth 2018; Maxwell 2013). Therefore, whilst there was some structure enabling the research aim to be fully explored, the interviews were sufficiently open to enable new and unanticipated issues to be investigated. Emerging findings from each interview iteratively fed into subsequent data generation and analysis (Gadamer 2013).

Interview data were digitally recorded and transcribed verbatim by a professional transcriber to ensure the accuracy of the transcription. An inductive thematic analysis framework was used to transform the data and identify key themes (Braun et al. 2018). Thematic analysis can be used as an interpretive strategy to achieve an understanding of patterns of meanings of a studied phenomenon embedded within transcribed interviews and as such, is consistent with the underpinning philosophy (Boyatzis 1998, Gadamer 2013; Ho et al. 2017). The transcripts were read independently by the research team (SG, GY, JS) to gain an understanding of the whole, before analysing the parts (Gadamer 2013). Next, manual open coding of data was undertaken. Patterns across the dataset were then iteratively explored to identify categories. Conceptually similar categories were then grouped together into themes. Critical discussions took place amongst the research team to question our pre-understandings and to verify, modify and refine the themes (Gadamer 2013). In qualitative research the researcher is an integral part of the study and cannot be isolated and bias eliminated, rather the researcher should be reflexive about their own assumptions and subjectivity to ensure trustworthiness (Galdas 2017). Reflexive field notes of the interviewer's role and how this may have impacted on the data generated were made and fed into the analysis of the findings. For example, the interviewer was a consultant physiotherapist with expertise in Red Flags and the FCP role and was also their clinical lead. Social desirability bias may, for example, have affected how the participants responded to some questions, leading some participants to say what they thought the interviewer wanted or did not want to hear. To mitigate this, the interviewer returned to a particular topic where she felt this was possibly the case, exploring sensitive issues in different ways and in different contexts. This enabled her to explore the issues more deeply and to look for

contradictions in the text once transcribed (Creswell, Poth 2018; Maxwell 2013). The data generated revealed a range of experiences, both positive and negative, suggesting this approach was effective to address this potential issue. Finally, respondent validation was employed by sharing the preliminary analysis with five participants to ensure they recognised the validity of their accounts and the interpretive claims made by the researchers (Maxwell 2013).

<u>FINDINGS</u>

All 10 FCPs consented to take part. Four were appointed from Band 6 posts to FCP training posts, nine were male. The mean years qualified as a physiotherapist was 12.8 years (SD 3.19) (Table 2).

Table 2. Participant demographics

ID	Role and band prior to FCP role	Band recruited to in FCP role	FCP training post
P1	MSK, Spine, Band 8a	Band 8a	No
P2	MSK, Band 6	Band 7	Yes
P3	MSK, Band 6	Band 7	Yes
P4	MSK, Band 6	Band 7	Yes
P5	MSK ED, Band 7	Band 8a	No
P6	MSK, Band 6	Band 7	Yes
P7	MCATS, Band 8a	Band 8a	No
P8	MSK, Band 7	Band 8a	No
P9	MCATS, Band 8a	Band 8a	No
P10	MSK, Band 7	Band 8a	No

P = participant; MSK = musculoskeletal; ED = emergency department, MCATS = musculoskeletal clinical assessment and treatment service
See Appendix 4 for information on NHS roles and bands.

The GP practices were located in an ethnically diverse location in North West England. Twenty one percent of people from this borough identified as being from a

black, Asian, and minority ethnic (BAME) group, compared to 14% of the UK population. Approximately 8.5% of the population where the study took place did not have English as their first language. It was one of the 20% most deprived districts in England, with a lower life expectancy than the national average with life expectancy being around 10 years lower in the most deprived areas of this region compared to the least deprived areas (IMD 2015; ONS 2011).

Findings

Data saturation was achieved. From the data, five themes were identified: 1. 'It's the level of clinical complexity that you're dealing with', 2. FCP role – rewards and challenges, 3. Own wellbeing, 4. Professional development and education, 5. Realities of working in practice governed by business. The findings have been presented under these headings; however, many of the findings overlap. Anonymised quotes from the participants have been used to illuminate the findings.

'It's the level of clinical complexity that you're dealing with'

It appeared that all participants were working at Advanced Clinical Practice (ACP) level, demonstrating skills and knowledge underpinned by the four pillars of clinical practice, leadership and management, education and research (HEE 2017):

> *I am seeing stuff that would have gone straight to a rheumatology clinic; but now you're the first person that is picking that up and doing the primary diagnosis. I've had a first diagnosis of multiple sclerosis in clinic; so quite a*

wide range of pathologies, but you need to have the clinical skills to recognise and know how to appropriately onward manage them. So, it's being able to think on your feet quickly and making that decision there, so the patient is managed appropriately… it's the level of clinical complexity that you're dealing with. P1

We're organising arthritis information evenings. We're going to get people involved, get posters; information for anyone with arthritis. We're going to put it out to the whole community, "come on in, have a lecture, have a chat", and do some education. We'll be running that from the GP surgery. P2

Participants felt confident in managing MSK issues. However, most participants felt less confident in managing non-MSK conditions. This included non-MSK conditions masquerading as MSK conditions:

It is all of the other stuff really; the assessment and treatment of kidney disease and the other masquerading things where I need to develop my knowledge. P6

Their confidence seemed to be influenced by their previous physiotherapy experience and role, with those appointed from lower bands (Band 6), generally feeling less confident:

The rest of us, who have only worked in physio departments are almost
starting from scratch really. I mean I've done a little bit [of screening tests for
non-MSK conditions]. P3

With those previously employed at higher bands (Band 7 and above) feeling more
confident in their FCP role:

I think one thing that's made life easier for myself is my career pathway. So,
about a years' worth of experience working in orthopaedics and interface
clinics, at Band 8. So, it wasn't like I was coming into the FCP role cold from a
physio role. I think that a lot of my essential peer support actually came before
I started. P1

Safety-netting, a diagnostic strategy to deal with uncertainty whereby information is
shared with the patient about what they should look out for, what they should do if
their condition does not improve, changes or if they have further concerns
(Greenhalgh et al. 2020), was discussed by most FCPs. They highlighted that safety-
netting was used as a strategy to manage their anxiety in relation to uncertainty:

It comes down to safety netting, not just for the patient but for yourself. I mean
we've all made errors in our careers and you'll never ever forget them, and I
want to make sure that I've learnt from that. I know at some point something
will come back and bite me; that's worrying. P5

This participant went on to add the importance of having peer support, which reflected the views of most FCPs:

> *In previous roles I've worked directly with my colleagues and bounced things off them. I'm finding I can't do that. That can be hard, not having your work colleagues there to support you in ways you're used to. P5*

Participants highlighted that in their FCP role, they were dealing with more complex patients, which they had not anticipated at the outset:

> *What I was quite surprised with is the amount of mental health issues coming through. I was like wow! There is a massive issue with that. I had one guy, who's had osteoarthritis in his hips, just come in and break down, basically. He started crying and saying, "I can't go on like this." You know, having sort of suicidal thoughts. He's lost his job. He's not able to get out anymore. He's really, really struggling. He's on maximum opioids and the issue was he was morbidly obese, so he's been turned down for surgery, so it was just like, whoa, I need to try and sort him out in that session somehow. P10*

Some of the FCPs were working in practices with ethnically diverse populations. This presented with some challenges for the FCP in terms of consultation where the participant did not speak English and having to use a telephone translation service (language line):

I had a week where I spoke to one person that had English as their first language; I'm going to guess out of 65 patients. Language line, by the time you've rang up, waited for the response, and then they've said unfortunately we don't have that language. P4

The FCPs recognised the need for greater understanding and increased cultural competence to effectively meet patients' needs:

It's difficult, because I don't understand enough about health beliefs. It's a massive learning curve. P5

FCP Role – rewards and challenges

All participants felt that the FCP role was positive for the profession:

The good points are the elevation in professionalism; we're taking physio to a new level. This role 10 years ago was unthinkable. It's a positive, it's a drive in the right direction, but it just needs the edges trimming. P4

However, there seemed to be some confusion about their role. This confusion was evident from patients, reception staff and GP.

I think that most people haven't got a clue what first contact practice even means. Everybody I come across; I have to talk to them around the subject. Most people think that it's just like MSK physiotherapy. P6

This resulted in patients often expecting ongoing treatment.

> *Some people expect that they're coming here for a course of physiotherapy with me. P9*

However, when the role was explained to them, patients seemed to welcome the service:

> *The patients think it's an excellent idea. They get to see an expert at first contact. They get really good advice to go away and manage it themselves and if the pain does persist, they get referred on to physiotherapy - so I think the patients really do think that it is an excellent service. P7*

This loss of clarity in their role resulted in some FCPs frequently acting as second contact practitioners, with patients being first triaged by the GP:

> *90% were second contact. So, if anyone comes to see him [GP] with a back problem or a knee problem, he doesn't deal with it, he sends them directly to me. So, I've got a 6-week waiting list, which as a FCP, shouldn't exist, I'm not here in a physio role. And I don't think they get that. P2*

Other issues were highlighted relating to supporting infrastructure such as differences in the NHS IT systems:

The CCG operate from 3 different systems with different passwords to get on the computers. So, I've got six different passwords to get into the 7 clinics. Then I've got another six passwords to get onto their site-specific software. So, I've got a diary full of passwords, and it takes me 15 mins to get on the system! P4

NHS governance was also highlighted as impacting their role:

For example, still to this day, I can't order an x-ray. And we're getting to the point now, where I'm feeling it may affect patient safety. P2

This led to frustration in their FCP role:

It's like boxing with no hands. We haven't got the tools to do the job, the CCG promised us bloods, they promised us. They promised us that we would be getting pulse oximeters and blood pressure monitors, because they want us to take that information on each assessment as a first contact. We haven't got the tools to do the job, we haven't got the education to do the job, currently we're doing a job that we are struggling to do. P4

However, not all FCPs seemed to be having these issues and felt the NHS systems were working well for them:

The other good things, is having access to all the information. Having the GP records, for example, we've got all the old x-ray results within the GP practice.

It's just one click of a button and it's there and we can get on with it straight away because you've got that information. P3

Most FCPs highlighted the satisfaction of working in this role:

It's probably the most rewarding job that I've done. I think that patients feel like they've had a good experience because they feel like they've been looked at and given good advice to take away and manage the problem. You feel like you're really contributing to NHS efficiency and quality of care as well. P1

However, some highlighted that the issues with the role were impacting their job satisfaction:

The job itself is brilliant but you're not actually helping it to be as good as it can be. You've given it your all, but there's always obstacles. There're always things to make your work difficult when actually we could be doing so much more to make more of a difference to patients. My enthusiasm has died. P5

Own wellbeing

The FCP discussed issues related to their own wellbeing. The majority of FCPs felt they were at risk of or experiencing burn-out:

[I'm hanging] By fingertips at the moment. How close are we to burnout? I can't speak for everybody else, but me, I'm not far off. I think I'm running at

about 98% capacity. Yeah, and it's only going to take one little thing to tip me over the edge. P4

This appeared to relate to the work load and case mix exacerbated by a move to having 20-minute appointment slots on most days of the week:

I was speaking to FCPs in [name of English region] and Wales, they were on twenty minutes and they were always overrunning by half an hour, or an hour, every day. Is that good for you to be doing that every day? I know the GPs do that and that is one of the main reasons we're there, because they're struggling to recruit GPs and, because of burnout, they're going part-time. So, if we wanted it to be a full-time FCP, we've got to look after our health and wellbeing as well. P10

Feelings of isolation were discussed by the FCPs. Most of the FCPs felt isolated as they were not part of the practice team:

You can feel quite isolated in your FCP role. Most of my career I've worked in a team and …we need support; emotional support. You know, it's you in your four walls. The GPs they're all very supportive, but they're behind four walls as well. There's very little interaction, there's no meeting on a person to person level. Lunchtimes don't overlap, so, you're not getting to know these people. P8

This made some participants question whether they had made the right decision in taking the FCP post:

If I was given the opportunity to go back two pay grades and be a standard physio, I'd take that opportunity right now. I feel like there's no team ethos, I know we're part of a team, but there's no identity for us. I think emotionally the bad points outweigh the good points, but professionally the good points outweigh the bad points, so it's a very tough place to be right now. P4

Professional development and education

The need for a mentor was discussed by all participants as being important. This participant had a formal mentor in their FCP training role:

I think that I have been lucky to have a good GP practice, a good GP training practice and young enthusiastic GPs. They are more than happy to provide that mentorship. P6

Whilst others struggled to get any mentorship:

The mentorship is zero, and going forward, there isn't any mentorship at all, and there hasn't been a GP set up as my mentor. I've asked one of the other GPs and he's more than happy to do it, but it's more informal and ad hoc because his clinics are always full. P4

It appears that the lack of mentorship may relate to funding:

> *Unfortunately, the practices I work at have said no to mentorship. Initially, they said one of the GPs agreed to do it and then they said, because they don't get funding for that GPs time to do the mentorship, they're not willing to do it. P10*

For some, the practice had ensured that there would always be a GP available during their sessions. This helped the FCP cope with uncertainty in their role:

> *All the GP practices I work in there is always a GP there when we are working … I don't feel anxious about being uncertain, I think because there are GPs nearby that I can ask if I am uncertain. P7*

However, this was not the case for all FCPs, with some undertaking sessions without a GP on site:

> *There won't be a GP on site for me this afternoon. P4*

There was substantial discussion about what training would be most beneficial to a FCP in a training post. Most FCP felt that training should include a master's degree specific for the role. The current musculoskeletal core capabilities' framework for FCP was acknowledged by the FCP as being very helpful, although it did not fully meet their needs (HEE, NHSESH 2018). It was felt that a framework for FCP training posts would be beneficial, which clearly identified the competencies that were

required to progress the physiotherapist from an ACP (Band 7) role to a FCP (Band 8a) role. In addition, it was felt that these competencies should be assessed:

In nursing you need to be an advanced nurse practitioner; you have a clear career pathway, where it's ratified and you demonstrate you have the appropriate skills. Whereas the boundaries between a physiotherapist and a physiotherapist advanced practitioner, are very blurred and there's no clear career pathway. I think there should be a clearer career pathway that is ratified. In the same way that nurses have to do a masters in occupational health to qualify as an occupational health nurse, I think the same should be asked of physiotherapists. I feel it needs to be a [relevant] masters that is ratified, not just any masters. I think it would be much safer if people had a ratified training plan. P1

Realities of working in practice governed by business

All FCPs were conscious that the GP practice was being run as a business, which might impact on their role. The reduction in clinical time slots from 30 minutes to 20 minutes was due to be implemented by the CCG, which the FCPs felt was a decision driven by cost. However, most voiced their concern over this and the impact on treatment quality:

The CSP [UK physiotherapy profession body] seem to really push that we are going to be really great at managing people's health behaviours and we sit

there and go 'how are we going to do that, and differentiate what's wrong with them, and give them initial treatment in 20 minutes?' You can't do it. P5

Twenty minutes is tight. I know that my colleagues do it in twenty minutes, but what's the quality we're giving patients. But, obviously, I understand from a cost and financial point of view that might be the way in needs to go. P10

Several FCPs highlighted how a change in funding had impacted their role, whereby restrictions to undertaking FCP injections had been implemented due to GP practices only being paid if the intervention was carried out by the GP and not by the FCP:

I have been asked to stop injecting and I've been told the reason behind that is the funding. P8

Additionally, a change in Primary Care Network (PCN) funding led to further anxiety relating to the future of FCP in different localities. There was much uncertainty voiced and concern raised whether the FCP role was affordable:

The only thing that would be a negative on the horizon is what's happing, in terms of PCNs and the contracts. I don't think they can afford to keep their own staff on because it's such a big practice. P8

DISCUSSION

This study provides an insight into the lived experiences of FCP, most of whom were new to the role, who were employed in an ethnically diverse and economically deprived area of North West England. This study found that most clinicians considered the role an exciting and positive development for the profession, that benefited the patient and the NHS in terms of quality of care and efficiency. However, to realise these benefits, the participants highlighted a number of issues that require further consideration.

The FCPs in this study felt confident in managing MSK conditions and demonstrated advanced skills in assessment, clinical reasoning, ordering and interpreting investigations, undertaking complex case management and making appropriate onward referrals (CSP 2018). However, they were less confident in managing non-MSK and medical conditions, with many saying they did not feel adequately trained and competent in these areas. Several of the FCPs spoke about diagnosis-centred uncertainty, which can affect the quality and safety of care and can elicit psychological responses (Pomare et al. 2018), such as feelings of burnout described by several of the FCPs in this study and elsewhere (Welford 2018). A lack of preparedness to manage mental ill health and issues of cultural competence were also highlighted as gaps in their knowledge. Therefore, training should include the management of non-MSK conditions, including mental health first aid and cultural competence training.

This study took place in an area with high ethnic diversity and social deprivation, where there was a high percentage of patients who did not speak English. The use of language line and interpreters was one issue highlighted by the participants of this

study and is an important factor when considering appointment time slots (Yeowell 2010). In contrast, pilots for the FCP roles were undertaken in a demographically different area, where these issues may not have been apparent (CSP 2018). Thus, the socio-demographics of the population should be taken into account when considering length of appointment going forward.

There appeared to be a lack of understanding of the FCP role, resulting in some FCPs predominantly working in second contact roles. For the FCP services to be economically viable for the GP Practice, it is important they are the first point of contact, thereby reducing the burden to the GP and ultimately improving the patient experience (Goodwin and Hendrick 2016; Langridge 2019). Therefore, further clarity and promotion of the role is recommended. Furthermore, how GP practices are funded needs careful consideration to ensure the advanced skills of the FCP, such as injecting, are utilised effectively.

There was a lack of consistency around the number of patients and sessions FCPs should undertake in their role. This lack of consistency also related to mentorship and supervision, access to GPs and lone working. This seemed to impact on the wellbeing of the FCPs, with some participants reporting burn-out and feelings of isolation (Zambo Anderson et al. 2015). Furthermore, a decrease of appointment time to 20 minutes, potentially resulting in each FCP seeing in the region of 360 new patients each month could further impact on wellbeing. However, a tension between this and the business needs of the GP practice was evident.

It has been highlighted that underpinning the FCP role is the assurance of competency, capability and governance to ensure that these roles are safe and effective (Langridge 2019). A National Competency Framework (HEE, NHSESH 2018) has been developed for FCPs and based on this, these roles are being developed at an exceptional rate. However, our research found that whilst this framework was an excellent resource, there were some limitations to its use. This study highlighted a lack of consistency in training in relation to its content, supervision and mentorship with no assessment of competency. Without agreed standards of competency to measure against, there is a risk of inadequate training for those embarking on FCP roles. Development of a framework for FCPs in training posts would be beneficial. This should include guidance in relation to the content and the amount of training, supervision and mentorship. The FCP felt that this should include a related master's degree, with ratified competencies relevant to the role.

The robustness of the methodology to explore the phenomenon of interest, including reflective diaries, participant verification and independent data analysis enhanced the trustworthiness of the study. Whilst the participants were recruited from one CCG and as such, their experiences may be different to the experiences of others, due to the richness of the data, it is hoped that these findings may resonate with others.

CONCLUSION

The progress of FCP roles is an exciting and worthy development for people with MSK conditions, the physiotherapy profession, primary care providers, and MSK physiotherapists. Understanding the population to be served is an important step

forwards in local development to provide a more culturally competent approach to meet the needs of the population. Mentorship support, workload, standards of training and practice are important developments when considering future expansion for the sustainability of these roles. It is imperative that this is taken forwards to ensure onward sustainable expansion of these roles to nurture this much needed new way of working in the changing face of society in the 21st century.

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