

Research

Facilitators and barriers regarding the implementation and interprofessional collaboration of a first contact physiotherapy service in primary care in Wales: a qualitative study

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Abstract

Background/Aims Future primary care services in Wales are likely to face higher demand for musculoskeletal ailments because of an ageing population and difficulties retaining and recruiting general practitioners. First contact physiotherapists provide specialist musculoskeletal management within primary care and offer a solution to this issue; however, no studies have yet explored first contact physiotherapist services in Wales. Consequently, little is known about the experience of working as a first contact physiotherapist in Wales. The aim of this study was to explore the experiences of first contact physiotherapists in primary care in the south east of Wales regarding the implementation, interprofessional collaboration and the facilitators and barriers to providing the service.

Methods A qualitative, Heideggerian hermeneutical phenomenological study was performed. A purposive sample of eleven physiotherapists were recruited for the study from an NHS health board in the south east of Wales, comprising three different first contact physiotherapist models. Data were collected through individual semi-structured interviews. Data analysis was conducted via a three-step format.

Results Participants regarded the first contact physiotherapist role as positive as it represented role and career advancement. Participants perceived that patients and the wider multidisciplinary team did not fully understand the role of the first contact physiotherapist. Inappropriate use of services was common, with first contact physiotherapists often acting as the second contact practitioner, leading to duplication of effort and the development of unnecessary waiting lists. The degree of interprofessional collaboration appeared to influence the clarity of the role of the first contact physiotherapist, with a reduced clarity of role in models where first contact physiotherapists were not often present. Burnout was perceived as a risk for participants with low level advanced practice. Participants perceived a lack of specific first contact physiotherapist service aims and ambiguity over who was responsible for service leadership, leading to inappropriate use of services.

Conclusions Clear operational leadership and strategies to increase interprofessional collaboration are required to increase first contact physiotherapist role clarity and ensure service efficacy. There is a need in Wales for first contact physiotherapist professional development, mentorship and governance framework to ensure sustainability and efficacy of first contact physiotherapist services.

Key words

First contact physiotherapy; First contact practitioner; General practice; Musculoskeletal, Primary care

Introduction

It is anticipated that there will be a higher demand on primary care services in the future because of an increasing population age, multiple patient comorbidities (Chartered Society of

Physiotherapy, 2018) and difficulties recruiting and retaining general practitioners (GPs) (Goodwin and Hendrick, 2016). At present, the delivery of health and social care in Wales is not sustainable to meet future patient demand (Parliamentary Review, 2018). To meet this challenge, the Welsh Government proposed a collaborative multidisciplinary model to move services from hospitals into communities where appropriate, emphasising preventative health strategies and early interventions (Welsh Government, 2018). The first contact physiotherapist model is where allied health professions work with general practitioners in primary care settings (Welsh Government, 2020).

First contact physiotherapists are advanced practitioners working in primary care, providing specialist musculoskeletal assessment, diagnosis, and management as the first point of contact, as opposed to a GP, therefore saving GP appointments (Chartered Society of Physiotherapy, 2021a). Musculoskeletal conditions affect muscles, bones and joints and include ailments such as back pain (NHS England, 2021a). It is estimated that 20% of GP appointments in Wales are for musculoskeletal conditions (Digital Health Wales, 2021).

Advanced practice refers to a level of practice that different healthcare professionals can attain when they fulfil the requirements relating to the established practice pillars of clinical, leadership, education and research (Chartered Society of Physiotherapy, 2021b). Advanced practice aims to transform care pathways through educating clinicians to master's (or equivalent) level and increasing their scope of practice by gaining new skills and knowledge to improve patient outcomes (Health Education England, 2022). In England, it is acknowledged that the first contact physiotherapists role represents working within the clinical pillar at master's level; however, all four advanced practice pillars are required to be met to work as an advanced practice first contact physiotherapist (Health Education England, 2020). There has been an increase in first contact physiotherapy services across the UK; however, the evidence base for services is sparse (Goodwin et al, 2020). First contact physiotherapist services have been shown to be safe, achieve high patient satisfaction, displayed clinical improvements over a six month period using the EQ-5D-5L and Global Rating of Change outcome measures (Goodwin and Hendrick, 2016). Furthermore, services have demonstrated that they save money (Goodwin and Hendrick, 2016; Downie et al, 2019).

The majority of first contact physiotherapy services research has been conducted in England; however, there have been no similar studies conducted in Wales. Wales is a devolved nation, with its healthcare delivery system varying considerably to England. In England, commissioners are the budget holders and employ a competition based payment by results system, whereas in Wales competition is not utilised and commissioners are allocated funding based on population size and demographics (Worthington, 2019). This variation in healthcare delivery systems illustrates the need for research to be conducted regarding first contact physiotherapists in Wales, as it is unknown if these variations influence the implementation and efficacy of first contact physiotherapy services.

Moreover, NHS England is aiming for first contact physiotherapy services to be accessible to 100% of the English adult population by 2023–24 (NHS England and NHS Improvement, 2019). The GP contract in England has committed funding for 20 000 allied health professionals, including first contact physiotherapists from 2020–25 (NHS England, 2021b). These first contact physiotherapist roles will be supported by the implementation of the policy '*First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal): A Roadmap to Practice*' (Health Education England, 2020). The roadmap provides quality assurance and governance processes through detailed training, mentorship and educational requirements for transitioning first contact physiotherapists and advanced practice first contact physiotherapists (Health Education England, 2020).

In contrast, Wales does not possess an equivalent specific primary care musculoskeletal first contact physiotherapist framework and there is no consensus on the practice level Welsh first contact physiotherapists are working at, or how they progress to an advanced practice first contact

physiotherapist's level; however, there is a generic allied health professional advanced practice policy through the '*Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales*' (National Leadership and Innovation Agency for Healthcare, 2012). The purpose of this multiprofessional framework is to facilitate the expansion, implementation and evaluation of advanced practice roles through structured methods and suitable governance processes (National Leadership and Innovation Agency for Healthcare, 2012). The document evidences how advanced practice health professionals within Wales have increased the efficiency of the patient pathway and enhanced patient outcomes (National Leadership and Innovation Agency for Healthcare, 2012). Despite this, there is no national or professional policy on how this framework specifically relates to the first contact physiotherapist's role.

The differences between how first contact physiotherapists, primary care advanced practice, quality assurance, professional development and governance processes are arranged in England and Wales may impact on the first contact physiotherapy services delivered in each nation. This emphasises the need for specific research to better understand the experience of working as a first contact physiotherapist in Wales. The differences in policy also highlight the need to specifically explore the experiences of first contact physiotherapists, as opposed to other key stakeholders, such as patients and GPs. Primary care first contact physiotherapy services represent a significant change in working practices in Wales, particularly compared to the traditional secondary care physiotherapist roles. Therefore, there is a need to specifically explore the impact of this change on physiotherapists.

Aims

The purpose of the study was to explore participants' experiences of:

1. How the first contact physiotherapy service has been implemented within primary care
2. The nature and extent of interprofessional collaboration of first contact physiotherapists with other healthcare professionals within primary care
3. The facilitators and barriers associated with providing a first contact physiotherapy service within primary care

Methods

Design

A Heideggerian phenomenological design was selected, as it gains an understanding of the essence of a lived experience (Creswell, 2007). A Heideggerian hermeneutical methodology encourages an investigator to play an active role in exploring and understanding a phenomenon (Sloan and Bowe, 2014). Moreover, hermeneutical phenomenology encourages the researcher and participants to co-create data to understand the phenomenon under investigation (Laverty, 2003).

The lead author was a first contact physiotherapist working in the health board at the time of the study, and consequently felt unable to bracket their personal knowledge concerning first contact physiotherapists

Setting

Within an NHS health board in south east Wales, there are three different first contact physiotherapist service models. *Table 1* displays the different first contact physiotherapists models (with the lead author working in model 3).

Service model 1, referred to as a primary care operational support team, was funded by the health board and involved the placement of a multidisciplinary team into GP surgeries who had difficulties recruiting and retaining GPs. This model took place in two GP surgeries, where daily morning sessions were provided by one of three first contact physiotherapists.

Similarly, service model 2 provided daily morning sessions by one of three first contact physiotherapists; however, in contrast to service model 1, it was independently funded by a GP practice. Finally, service model 3 was funded by a GP cluster comprising 25 GP surgeries, where six first contact physiotherapists provided input into each surgery.

To manage issues regarding conflict collusion of working with colleagues in service model 3, the sample population was increased to include all eleven first contact physiotherapists working in different service models across the health board. Further strategies employed were the use of a reflective diary to reflect on my own thoughts, opinions, and beliefs with all avenues of bias and how to mitigate and manage these, being discussed with my co-author, who supervised the study.

Within each service model, the number of sessions allocated to each GP surgery was based on the GP practice population. One first contact physiotherapist session equated to a morning or afternoon clinic. Individual appointments within the session were 20 minutes long. First contact physiotherapists were expected to see 11 patients in a morning session, and nine patients in an afternoon session, with a 20-minute administration slot at the end of each session.

Ethical approval

NHS health board and Cardiff University (Cardiff University, 2020) ethical approval was obtained. Participant anonymity and confidentiality was secured using pseudonyms, devised by the participants, based on the purpose of the study and their perceived contribution to the study. Written informed consent from participants was gained before the interviews began. Participants were informed they could stop the interview at any point and had the right to withdraw from the study at any point, without prejudice.

Participants

A total of 11 physiotherapists working within three different first contact physiotherapist service models were purposively recruited from an NHS health board in south east Wales in 2020.

In 2020, the lead author sent an email to all potential participants who met the study inclusion criteria of being a band 7 physiotherapy first contact physiotherapist working in one of the three service models and were fluent in English. The email stated the purpose of the study via a participation information sheet and requested initial expressions of interest. All eleven first contact physiotherapists stated that they were interested in participating and therefore a mutually convenient time and NHS location was agreed for interviews to take place.

Table 1. First contact physiotherapist service models in the health board in south east Wales

	Model 1	Model 2	Model 3
Details	Primary care operational support team	GP surgery	GP cluster
Funding agent	Health board managed practice	GP surgery	GP cluster
Number of first contact	3	3	5

physiotherapists			
Number of surgeries covered	2	1	25
Weekly input	Every morning	Every morning	Ranged from two sessions a week (one session in the morning or evening) to one session every 2 weeks per GP surgery

Participant demographic data can be seen in *Table 2*. All participants were NHS band 7 clinicians, with banding decided by the health board as there is no policy guiding role banding first contact physiotherapists at present. The participants possessed full investigation rights and were able to order X-rays, magnetic resonance imaging, ultrasound and blood investigations. Three of the participants had completed injection training and administered injections within primary care; however, none of the participants were prescribers.

Table 2. Participant demographics

Participant	Sex	Age range, years	Years qualified as a physiotherapist	Years worked as a band 7 or equivalent	Years worked as an FCP	Model of FCP service provision	Number of surgeries work in
1	M	51–60	20+	16–20	1–2	1*	1
2	F	51–60	20+	6–9	1–2	1	1
3	M	21–30	6–9	1–5	1–2	1	2
4	M	41–50	20+	6–9	1–2	3	3
5	M	31–40	10–15	1–5	1–2	3	5
6	M	31–40	10–15	1–5	1–2	3	4
7	F	31–40	10–15	1–5	1–2	3	4
8	M	21–30	6–9	1–5	1–2	3	4
9	F	21–30	6–9	1–5	1–2	2‡	1
10	F	41–50	10–15	1–5	<1	2	1
11	F	41–50	16–20	1–5	1–2	2	1

*Primary care operational support team; †Cluster model; ‡Independent GP surgery model. FCP: first contact physiotherapist

Data collection

Data were collected via audio recorded semi-structured in-depth interviews. The lead author conducted all the interviews using an interview schedule that (Moffatt et al, 2018; Langridge, 2019; Greenhalgh et al, 2020; Goodwin et al, 2020; Igwesi-Chidobe et al, 2021 and Ingram et al, 2020) and informed by the study aims. Nine of the interviews were conducted face to face prior to COVID-19 restrictions and two virtually because of COVID-19 restrictions. The interviews were conducted in private quiet rooms within NHS hospital premises as opposed to the GP surgeries the participants worked within, due to ease of accessibility, with an average duration of 65 minutes.

Data analysis

Data analysis was conducted using a three-stage method (Lindseth and Norberg, 2004). The first stage comprised naïve reading – repeatedly reading transcripts to gain an understanding of the text in its entirety. The second stage was structural analysis, involving gaining an understanding of the text through a methodical format, separating the data into meaning units and then editing and organising the data into themes and sub-themes. The third stage involved reflecting and summarising identified themes and sub-themes relating to the study purpose.

The hermeneutical circle was used during data analysis (Laverly, 2003). Data analysis was conducted by the lead author, with the second author validating two individual transcript analysis and the overall study findings.

Results

A total of six themes were found:

1. New ways of working
2. First contact physiotherapists' purpose
3. Interprofessional collaboration
4. Inappropriate use of services
5. Operational leadership
6. Professional development

New ways of working

Overall, nine (82%) participants acknowledged having a positive experience of being a first contact physiotherapist, as it represented career development and advancement.

‘I think it was not only was it a new service, but also a new role for me, which meant I could then, had the opportunity to order investigations and dictate a patient’s management plan if you like from the beginning to the end.’ (Ray Mears)

Burnout

A total of five (45%) participants reported that they were often exposed to medical conditions that was not musculoskeletal related, which required a broader knowledge base to identify that it was not a musculoskeletal issue. The impact of this exposure led some participants to lack confidence in managing patients independently, leading to heightened stress.

A total of six (55%) participants commented that they often overran within clinics, which was commonly related to patient presentations; five of these participants worked in service model 3. Acute soft tissue injuries were easily manageable, whereas difficulties arose when patients had multifaceted issues, such as widespread pain. In those instances, further advice from a physician was needed to order appropriate investigations and complete paperwork, which frequently led to overrunning:

'I think you can handle stress, I think you can get yourself through difficult situations and I think some of those actually aid your learning, in really helpful ways. I think when it's all the time every time and you wake up and dread the entire week, that's not sustainable, that's your burnout territory.' (Daniel Lion)

First contact physiotherapist purpose

A total of eight (73%) participants remarked that there was a lack of understanding of the first contact physiotherapists' role, primarily among GPs, who perceived that first contact physiotherapists were offering secondary care physiotherapy services within primary care:

'I feel that some GPs almost think of it of first contact physiotherapists as there being a physiotherapy service within their surgery, rather than a screening or triage service.' (Mr Rookie)

This caused duplication of care, with GPs providing musculoskeletal management in one appointment and then referring to the first contact physiotherapists for the same issue. Some six (55%) participants also expressed that their patients did not understand the role. For example some participants stated that patients expected to receive a course of hands-on treatment, which was not provided, often leading to patients feeling frustrated as their expectations were not met.

'its difficult for them to understand that role at the beginning, its difficult to get away from somebody's understanding of what a physiotherapist does in that a lot of people hold a view of their own experience of having physio maybe or having treatment or having hands on treatment or whatever their view is...' (Pathfinder)

There was ambiguity concerning the purpose of the service, with most of the participants reporting at least two purposes. Overall, five (45%) participants reported that the aim of the service was to provide accelerated care, resulting in improved patient outcomes. Five reported that the aim was to provide efficient care through patients seeing the right professional at the right time, reducing inappropriate secondary care referrals. Finally, three felt that the purpose was to reduce GP workload by acting as the first contact:

'So for us we take in the 20% the theory the theoretical 20% from them (20% musculoskeletal GP workload) and we're easing their burden and we're always really full so I think actually we really do see the right percentage there.' (Wilma Rudolph)

However, the aim of being the first contact and unburdening GPs, was apparently not a service aim which the participants felt was shared by GPs. They participants perceived that GPs [AQ: GPs?] were not necessarily concerned that the physiotherapists were working as the first contact, as they still saw value in them saving subsequent follow up appointments with the GPs.

Interprofessional collaboration

A total of four participants commented that the relationships they possessed within primary care lacked depth, with communication often via electronic notes or in corridors:

‘It was quite difficult to find the time to form those relationships as best as you could... It would be a hello and how are you doing in the corridors rather than maybe a discussion at lunchtime...’ (Dora)

The impact of effective interprofessional collaboration was discussed significantly more by six participants in models 1 and 2, where daily first contact physiotherapists cover was provided. Effective collaboration was thought to increase first contact physiotherapists’ knowledge base, benefiting patients. A greater awareness of medical conditions and the investigations required to diagnose them meant that healthcare efficiency was increased:

‘I think beneficial to me because working with GPs obviously they do have a wealth of experience about not necessarily musculoskeletal presentations, but a wealth of other things that you don't normally get the knowledge of working in physio service...I think beneficial to patients because it hopefully provides them with better care sort of earlier on, so you know maybe more efficient referral either for investigation or to somebody else for care...’ (The Informer)

The impact of ineffective interprofessional collaboration was discussed exclusively by participants in model 3, with four commenting on it. In model 3, first contact physiotherapy sessions were provided to an individual surgery once a week, or once every 2 weeks, depending on the practice population. The perceived impact of ineffective interprofessional collaboration was decreased knowledge of other professionals’ management options, leading to poorer patient outcomes, poorer quality first contact physiotherapy referrals and slower first contact physiotherapists development.

‘The impact is that we don't develop as much as we could, or it might take a much longer time... if there is a patient with a particular condition where I think physiotherapy options, perhaps treatment they've had in the past might kind of been exhausted...I'm not fully aware of all the things that perhaps a GP could offer in addition. Perhaps in terms of medical management, perhaps in terms of other routes such as counselling, mental health support, particular medication routes and so on. So there's a lot of things that I think I know about what a GP does in their role, but I'm sure there's still a lot that I haven't discovered as well, that could benefit the patient and myself.’ (Mr Rookie)

Several first contact physiotherapists discussed factors that facilitated or might help facilitate interprofessional collaboration including observed assessments and participating in clinical meetings

‘They were quite good (staff meetings) because there's a you know a few different staff there, it kind've, people can put in their, you know their thoughts as well, again you go back to that collaborative working, they can say actually I may have seen a similar case to this before, or I may have seen this patient before, perhaps we should do this, or perhaps people may say just reaffirm what you've already said...’ (Michael James)

Inappropriate use of services

All five participants in model 3 commented that they had long waiting lists, which was not described by participants in models 1 and 2. Two of the participants felt that the waiting lists had developed because musculoskeletal demand outweighed capacity, preventing the participants working as the first contact.

‘So because we were in the GP practices so infrequently, that next appointment slot might be three or four weeks down the line, and they [GPs] would just book it [having seen the patient], but then the patient was waiting to see us for three or four weeks which stopped it

being first contact [no availability for first contacts] and started it just being a physio waiting list.’ (Daniel Lion)

Seven (64%) participants in models 1 and 3 stated that they were often reviewing patients as the second contact, which was not mentioned by participants in model 2. GPs often wishing to gain a second musculoskeletal opinion by the first contact physiotherapists contributed to the waiting lists in model 3. The impact of acting as the second contact was that GP clinic slots were not saved as patients were being seen by both the GP and first contact physiotherapist for the same issue. This was thought to cause a delay in patients receiving the correct advice and unnecessary duplication of effort. Strategies were discussed to increase the proportion of first contact appointments, such as GP education and ensuring a proportion of first contact physiotherapists slots could not be booked into by GPs and were on-the-day appointments.

Operational leadership

Overall, five (45%) participants noted that it was unclear who was responsible for leading the first contact physiotherapy service. Of the five participants in model 3, four felt that the service ownership fell on them, which was not articulated by participants in models 1 and 2. The impact of this expectation, while also negotiating a steep learning curve, was felt to be too high. Moreover, it was felt that a central operational voice would have been a more effective way of managing service issues, such as the waiting list in model 3:

‘... taking on lots of new skills, lots of clinical encounters that are far more complex than you probably had to deal with as a band 6 clinician, you are no longer just [passing it on as it is complex], you’re dealing with it, to handle the clinical learning curve as well as start bossing around GPs in their own practice [how service should be running], that’s a big ask.’ (Daniel Lion)

In contrast, three (27%) participants felt that the GP surgeries were leading the first contact physiotherapists service as they were funding the services, and two (18%) participants commented that it was the physiotherapy managers leading the service as they managed operational processes.

Professional development

Five (45%) participants stated that they felt there was a lack of appropriate training and mentorship available. These statements were more prevalent in the participants who were transitioning from band 6 to band 7 first contact physiotherapist roles. The training that they did receive provided a useful baseline; however, it lacked sufficient depth, with difficulties applying the theory to a first contact physiotherapy environment, where quick decisions, in a short time frame, was required. Participants felt that practice-based learning would have been more appropriate, where they would have benefited from observational assessments from a professional such as a GP or experienced first contact physiotherapists.

‘No no I think it had difficulties at the beginning, I think there was no mentoring structure we had a couple of PowerPoint presentations to begin with, which I think were good, gave us a base line level of knowledge. But I think it's hard to apply that in a situation of a clinical context when there’s so many other variables, time pressures, different environment, different phase of presentation that sometimes those presentations you need that practise based learning and that was never the consideration or necessarily an option for us.’ (Ray Mears)

For two (18%) participants, mentorship was available within the surgeries in practice meetings where peer support occurred; however, this was not routine practice. The impact of inadequate training was that the transition from band 6 to band 7 role was difficult:

‘Training was inadequate, we were left to learn on the job...(felt) Isolated and scared. We did have some support, its wrong to say that we had nothing, I don’t want to be critical of them [physiotherapy and primary care staff], because if I asked for help, there was an overwhelming desire to help me. However you had three back to back complex cases straight away in an FCP job, you know you can't pick up the phone and get all the answers quickly...’ (Daniel Lion)

Discussion

Findings from this study suggest that first contact physiotherapists were often acting as the second contact, with long waiting lists present in certain models, and were therefore not saving GP appointment time, as was their intended purpose (Welsh Government, 2020). Existing literature has identified that patient groups do not understand the role of the first contact physiotherapist (Goodwin et al, 2020; Styner et al, 2020; Igwesi-Chidobe et al, 2021), which prevented first contact physiotherapists being the first contact. However, this study, in contrast, as corroborated by Greenhalgh et al (2020), indicates that GPs also possessed a lack of understanding about the first contact physiotherapist’s role, with many apparently believing that services largely represented comparable secondary care services. Similar findings of reduced role understanding were identified when pharmacists were introduced into primary care, with educational strategies used to increase clarity (Jorgenson et al, 2014), which could be adopted by first contact physiotherapist services.

Despite this it is uncertain whether first contact physiotherapist services are suitable for managing the primary care musculoskeletal population. The physiotherapists in this study only managed a small proportion of the population. As previously stated, NHS England have committed to funding first contact physiotherapist services with the aim of achieving 100% of the English adult population by 2023/2024 (NHS England and NHS Improvement 2019). Wales currently does not have an adequately sized healthcare workforce (Social Care Wales and Health Education and Improvement Wales (HEIW 2021), to duplicate this aim.

Welsh Government do plan to produce a Welsh health and social care multi-professional workforce strategy to facilitate the primary care workforce (Social Care Wales and Health Education and Improvement Wales (HEIW) 2021). However currently there is no national Welsh allied healthcare professional workforce funding stream (Strategic Programme for Primary Care 2021). It is difficult to envision therefore how Welsh first contact physiotherapist services can be expanded and sustained without sufficient governmental financial commitment.

Findings from this study suggest that first contact physiotherapists service model may affect interprofessional collaboration, with increased first contact physiotherapists capacity and presence resulting in increased interprofessional collaboration and perceived better quality of patient care. [

In first contact physiotherapy service models where physiotherapists are not often present, strategies are required to increase interprofessional collaboration, such as attending regular team staff meetings (Jorgenson et al, 2014; Supper et al, 2014), which would also result in an increase in understanding the role of the first contact physiotherapist (Looman et al, 2021). This may however presents logistical difficulties.

Welsh Government have stated there is a need for a primary care multi-professional professional development framework (HEIW 2022). Moreover, a multi-professional governance framework and advanced practice interprofessional competencies framework will be produced and implemented (Social Care Wales and HEIW 2021). This represents a significant policy difference in how England and Wales plan to manage primary care musculoskeletal conditions. England are driving a specialist musculoskeletal first contact approach, whilst Wales are driving a ‘generalist specialist’ approach for its primary care staff (Strategic Programme for Primary Care 2021).

The Health Education England roadmap (2020) is undeniably comprehensive, providing clear competency expectations and governance processes to ensure high quality musculoskeletal care. Despite this, completion of the roadmap represents a significant time and resource commitment. Interprofessional training has been identified as a method to increase primary care interprofessional collaboration (Rawlinson et al 2021). A primary care multi-professional professional development framework may represent a more prudent way of upskilling the Welsh primary care workforce, and a realistic strategy to increase interprofessional collaboration.

Findings from this study suggest that clinician burnout is a possibility, as corroborated by Greenhalgh et al (2020). However, in contrast to Greenhalgh et al (2020), burnout was an issue for clinicians in model 3 who possessed lower levels of advanced practice experience and completed 4 sessions a week in multiple surgeries, with minimal presence in each surgery. In Greenhalgh et al (2020), burnout occurred irrespective of experience levels, where participants completed nine sessions a week in multiple surgeries. The long waiting lists seen in service model 3 may also have inadvertently contributed to burnout, preventing access to first contact acute presentations, which FCPs deemed comfortable to manage within an appointment. Ensuring waiting lists do not exist in FCP services, may therefore reduce the risk of burnout.

Participants in the study expressed uncertainty over who was leading the service, with participants in model 3 stating that they felt responsible. A strong relationship exists between physician burnout and how effective a leader is perceived to be (Shanafelt et al, 2015). The lack of a recognised leader may also have contributed to the perceived burnout described by participants in model 3.

Strong leadership has been identified as a facilitator to interprofessional collaboration through increasing role understanding (Sangster-Gormley et al, 2013; Supper et al, 2014). Participants in this study believed first contact physiotherapist services lacked specific aims and vision, which has been recognised as a barrier to providing integrated care (Kozłowska et al, 2018). Therefore, first contact physiotherapists services require strong, clearly defined leadership to produce shared valued service aims, decrease inappropriate use of services, and facilitate role understanding through interprofessional collaboration.

The participants in the study reported that training and mentorship processes were inadequate for first contact physiotherapists transitioning from band 6 to band 7 roles, which is a barrier to integrating services (Kozłowska et al, 2018). Health Education and Improvement Wales and Social Care Wales (2021), stated that professional development investment to upskill health and social care workers will be in place by 2030 to fulfil the needs of future populations. However, there is no formal timeline as to when this will be implemented.

Strengths and weaknesses

A strength of this study was that it explored first contact physiotherapists' experiences within three different service provision models in south east Wales. However, several of the findings discussed were the perceptions of first contact physiotherapists participants regarding key stakeholders such as GPs. Although insightful, these perceptions would need to be clarified with the stakeholders to ensure accuracy. Finally, because of the size and nature of the sample group, findings cannot be assumed to be representative of the wider first contact physiotherapist population.

Conclusions

This study sought to explore how a first contact physiotherapists service in Wales had been implemented within primary care, the nature and extent of interprofessional collaboration and the facilitators and barriers associated with providing the service. The study has identified that first

contact physiotherapist services possessed inadequate professional development, clearly defined service purpose and operational leadership. A lack of role clarity existed, often leading to first contact physiotherapists acting as the second contact and the development of long waiting lists in some models, resulting in perceived inefficiencies that caused frustration. Increased interprofessional collaboration resulted in increasing first contact physiotherapists' role clarity but was informed by the type of service model. Finally, burnout was perceived as a risk factor for first contact physiotherapists possessing limited advanced practice experience, working in a model providing input for multiple surgeries weekly, with a low presence and capacity.

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Conflicts of interest

The author declares that there are no conflicts of interest.

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