First point of contact physiotherapy: a realist review and evaluation

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Abstract

Background

General Practice, the cornerstone of the National Health Service (NHS), is experiencing increased patient demand and overstretched resources. Musculoskeletal health disorders (MSDs), such as back pain and hip pain, are common conditions. Almost all patients with MSDs consult their general practitioner (GP) as a first point of contact (FPC). Evidence exists that physiotherapy is an effective intervention for most MSDs.

First point of contact physiotherapy (FPCP), for patients experiencing MSDs, offers an alternative to the GP as FPC. FPCP has demonstrated clinical efficacy, patient and GP satisfaction and indications of financial benefit. Patients have been able to refer directly to a physiotherapist, without a referral from a doctor, since 1977. However, uptake of FPCP has been poor with patients continuing to default to their GP. FPCP has the potential of helping alleviate some of the pressures in general practice. This is likely to remain unrealised if patients continue to default to a GP in this way.

Physiotherapy, as an occupation, has been engaged in a professional project over the course of the last century. A professional project is the processes and developments whereby a distinct occupational group seeks to legitimise its monopoly in the market and its social order. The research in this thesis conceptualised the FPCP initiative as the latest manifestation of physiotherapy's professional project. FPCP could be seen as encroaching into traditional GP jurisdiction. The sociology of the professions literature informs us that this encroachment could incite interprofessional tension.

This research explored the process whereby FPCP was implemented into the complex general practice system. The question addressed in this research was:

- If FPCP constitutes a professional project what are the reactions and responses of the multiple stakeholders to this, why are their reactions constructed as such, how are they articulated, in what circumstances and how do they influence operationalisation?

Methods

The research employed realist methodologies; both realist review and realist evaluation. The realist approach is concerned with developing, testing and refining programme theories by exploring the interactions of contexts, mechanisms and outcomes. Four initial programme theories were developed systematically through stakeholder engagement. These theories were tested against the existing body of literature through the realist review approach. The databases searched were MEDLINE, CINAHL, EMBASE, PsychINFO via OVID Databases and Web of Science and sixteen pieces of literature retained for data extraction and review. This resulted in eight refined theories which were themselves tested by conducting eighteen individual interviews and eight focus groups with stakeholder members. The forty-one participants included physiotherapists, GPs, commissioners, administration staff and patients. A thematic analytical approach was used employing a hybrid of inductive and deductive coding to theme development which informed the qualitative analysis. The output of the research was a series of transferable guidelines that inform future service development and research.

Results

Synthesis of the data revealed the following findings. An overview of the theory development is presented in figures 1 and 2.

1. Understanding

   The public were aware of physiotherapy as an established profession. Understanding of the clinical application of physiotherapeutic interventions

for MSDs was confused and generally misaligned with clinical practice. Public awareness and understanding of FPCP was negligible. The methods of marketing FPCP were shown to be ineffective. There was no evidence of any systematic planning in the design or implementation of the marketing strategies used to advertise FPCP services. There was no evidence that the effectiveness of any marketing strategies had been evaluated.

2. Signposting

   Signposting by administration staff was the most effective method of facilitating patient access to FPCP. This role was sometimes resisted by patients. Administration staff welcomed the signposting role despite the additional stress it could cause. Signposting provided education and ensured patients received the best care. The challenges in the signposting role could be ameliorated with adequate training, staff experience and peer support.

3. Embedding

   As a FPCP service embedded it became normalised in the general practice and for patients. The service became more visible to patients who became more familiar with it as a resource and patient access increased. Administrators became more confident to signpost and GPs became more confident in physiotherapist competence as FPCP embedded.

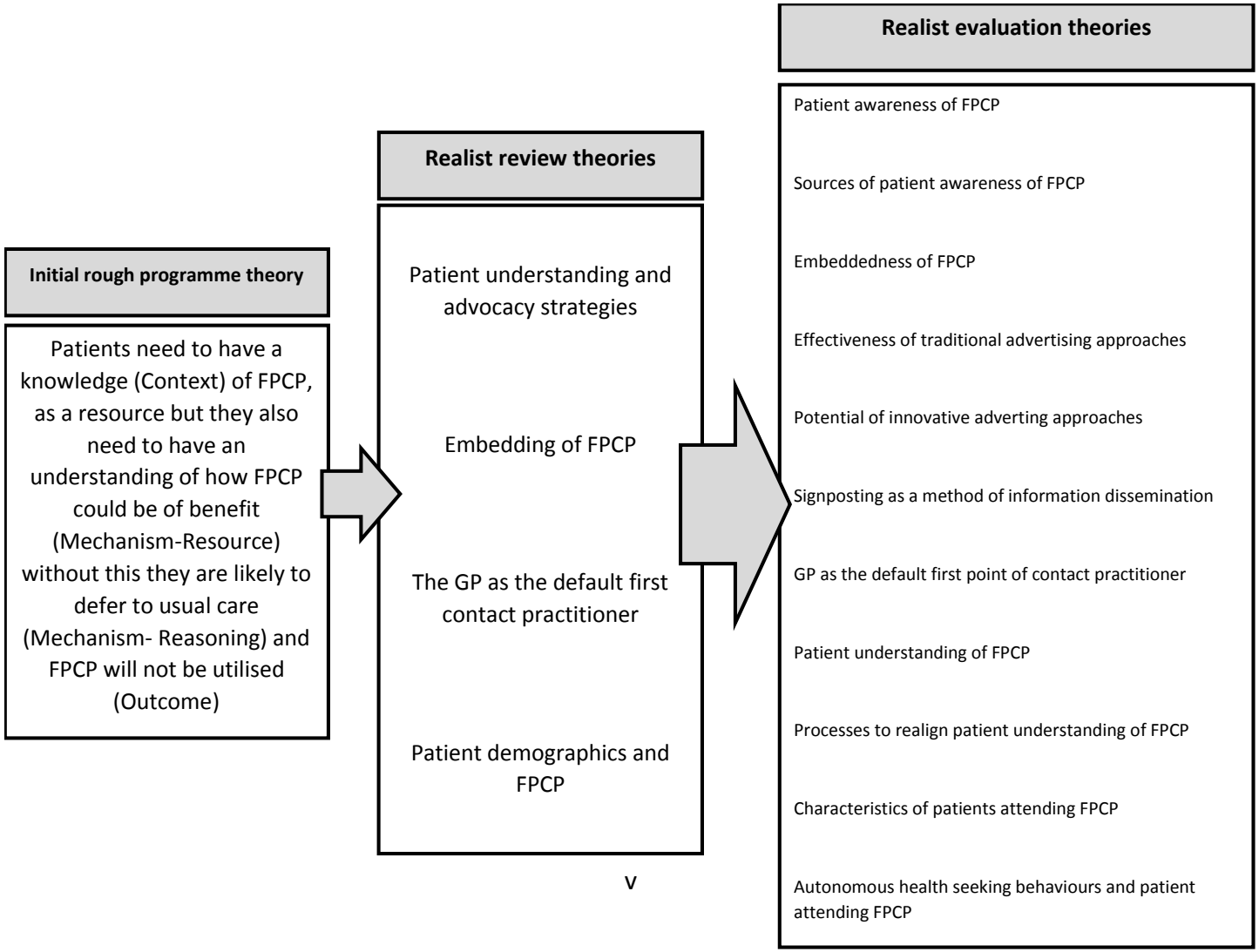
4. Professional project

   FPCP was a professional project set against the historically established dominance of medicine. Patients were predisposed to default to their GP as the FPC. GPs were aware of the need for their role, and general practice, to evolve in the face of increasing pressures. GPs spoke supportively of the FPCP initiative while, at the same time exhibiting a controlling role over the definition of role boundaries and professional jurisdictions. The relationship between GP and physiotherapist enhanced when they worked alongside one another.

Conclusion

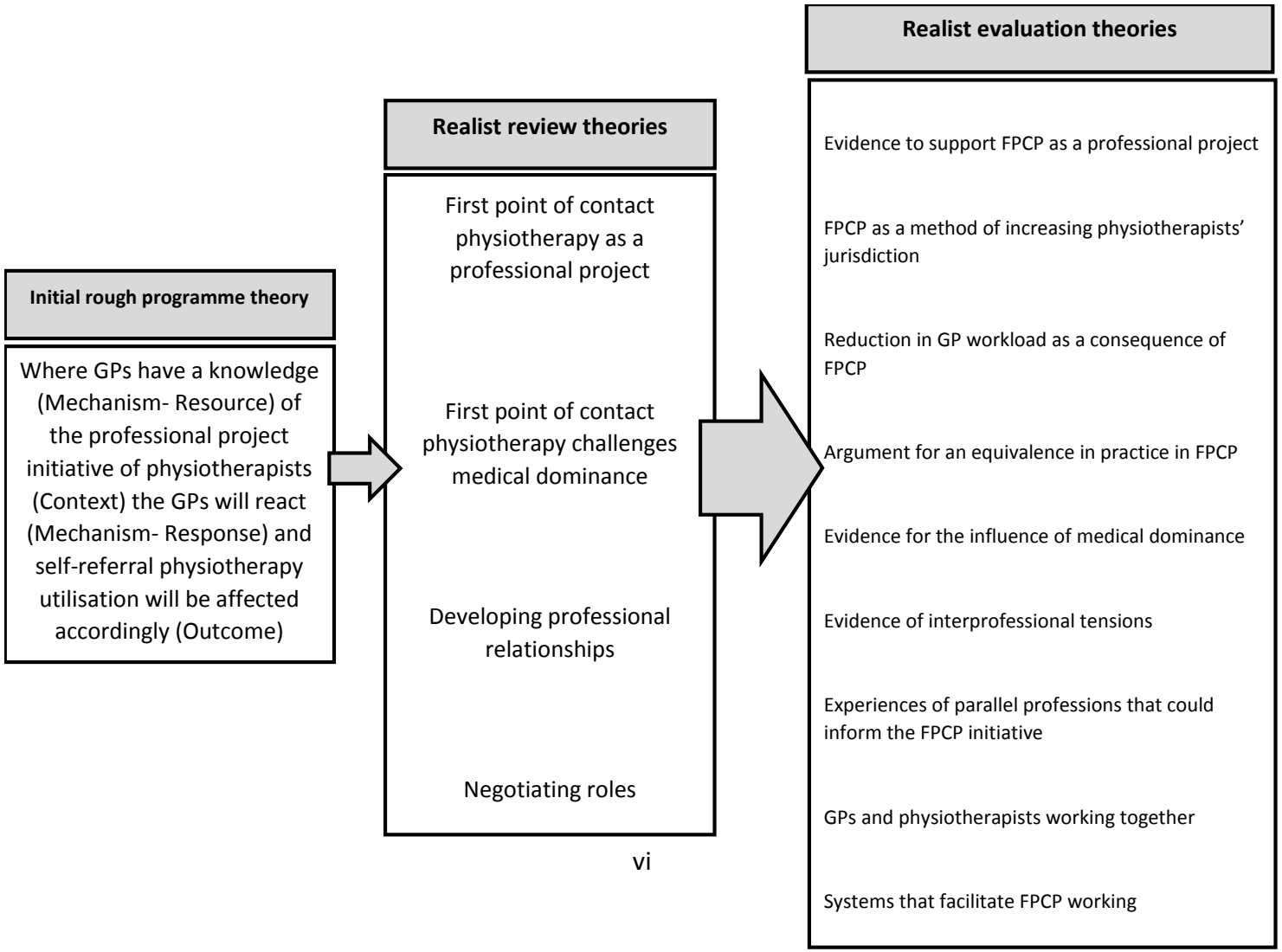
This realist review and evaluation produced a number of key findings. Six key lessons, generated from the results, are presented that inform future service development. In summary, despite evidence of clinical efficacy, patient and GP satisfaction, FPCP has not been implemented with sufficient capacity to result in a noticeable impact. This research synthesised a number of implementation guidelines and future research opportunities.

Figure 1: Theory development overview: Patient understanding



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Figure 2: Theory development overview: Roles and boundary definitions



Dissemination and awards

Associated Publications

- Goodwin, R.W. and Hendrick, P.A., 2016. Physiotherapy as a first point of contact in general practice: a solution to a growing problem? Primary health care research & development, 17(5), pp.489–502.

- Goodwin, R., Logan, P., Hendrick, P., Moffatt, F. and Chadborn, N. 2016. Self-referral physiotherapy for patients with musculoskeletal (MSK) conditions in primary care as an intervention; how do issues of the professions influence implementation? A realist review protocol. PROSPERO 2016 CRD42016043963 Available from: http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42016043963

- Goodwin, R., Moffatt, F., Hendrick, P. and Logan, P., 2017. Sociocultural challenges faced in implementing self-referral physiotherapy in primary care – a qualitative evaluation of staff opinions. Physiotherapy, 103: p.e6.

- Moffatt, F., Goodwin, R. and Hendrick, P., 2018. Physiotherapy-as-first-point-of-contact-service for patients with musculoskeletal complaints: understanding the challenges of implementation. Primary health care research & development, 19(2), pp.121–130.

- Goodwin, R., Hendrick, P., Moffatt, F. and Logan, P., 2019. First point of contact physiotherapy for patients with musculoskeletal conditions: how do professional issues influence implementation? A realist review. Physiotherapy, 105: pp.e89–e90.

Presentations

- Chartered Society of Physiotherapy (CSP) Congress 2015, Liverpool– poster presentation: Physiotherapy as a first point of contact; we can help if you want us to?

- BSA Medical Sociology Group Annual Conference 2016, Aston University – platform presentation: Socio-cultural challenges faced in implementing self-referral physiotherapy in primary care – a qualitative study of staff opinions.

- Royal College of General Practitioners (RCGP) Annual Primary Care Conference 2016, Harrogate UK – poster presentation: Self-referral physiotherapy for musculoskeletal complaints – a 1-year evaluation of a true first point of contact service.

- Harnessing the Value of Allied Health Professionals, The Kings Fund, London – platform presentation: First point of contact physiotherapy in primary care; we can help if you want us to?

- CSP Congress, 2017, Birmingham International Convention Centre – platform presentation: Socio-cultural challenges faced in implementing self-referral physiotherapy in primary care – a qualitative study of staff opinions.

- Sue Watson Oral Presentation, 2018. University of Nottingham, School of Health Sciences, Royal Derby Hospitals: First point of contact physiotherapy in primary care: issues in implementation and uptake – a realist review.

- Realist Interest Group, 2018 (March), School of Medicine, University of Nottingham: Introduction to Critical Realism.

- East and Midlands sustainability and transformation plan (STP) Event, 2018 (March), Planned and Urgent and Emergency Care Workshop, Victoria House, Cambridge: Physiotherapy as a first point of contact in general practice: A solution to a growing problem.

- Salford University Physiotherapy Conference, 2018. Salford University, Invited guest speaker, platform presentation: Socio-cultural challenges faced in implementing self-referral physiotherapy in primary care – a qualitative study of staff opinions.

- Linkoping University, Sweden, 2018, invited guest speaker: Physiotherapy as a first point of contact in general practice: A solution to a growing problem.

- Linkoping University, Sweden, 2018, invited guest speaker: Socio-cultural challenges faced in implementing self-referral physiotherapy in primary care – a qualitative study of staff opinions.

- Academic Orthopaedics, Trauma and Sports Medicine, Lunchtime Seminar Programme, 2018 (June), invited guest speaker: First point of contact physiotherapy for patients with musculoskeletal conditions; how do professionalism issues influence implementation? A realist review 25th June 2018: 1300–1400.

- East and Midlands STP Event, 2018 (July), Elective Care Midlands and East MSK and Orthopaedics, Workshop, Coventry: Physiotherapy as a first point of contact in general practice: A solution to a growing problem.

- NHSE/CSP First Contact Practitioner Mobilisation Conference, 2018 (September), London: facilitated the workshop session on Patient Flow.

- CSP Congress, 2018, Birmingham International Convention Centre – platform presentation: First point of contact physiotherapy for patients with musculoskeletal conditions: how do professional issues influence implementation? A realist review.

Awards

1. University of Nottingham, Graduate School Research Showcase 2016:
    - Awarded 1st Prize overall competition
    - Awarded 'Highly commended' Artistic Flair

2. University of Nottingham, Medicine and Health Science Faculty postgraduate research forum – poster presentation and '2 minute impact statement'
    - Awarded 'Best poster'

3. Sue Watson Oral Presentation, University of Nottingham, School of Health Sciences, Royal Derby Hospitals: First point of contact physiotherapy in primary care; issues in implementation and uptake – a realist review
    - Awarded Second prize overall

4. Grant, FIRST CONTACT PRACTITIONER EVALUATION, Chartered Society of Physiotherapy's tender to undertake phase three of the national First Point of Contact Physiotherapy (FPCP) evaluation in year one, extending to other sites and UK countries in year two:
    - PI on Nottingham University qualitative evaluation
    - Grant value £236,000

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I would like to thank my family and friends for their support and love. The very last thank you goes to Katie. I am sure I have been somewhat absent over the last few years so thank you for stepping up to fill the gaps I left, and for your patience, your continued support and your love. Once again, it is not an understatement to say that without you I would not be here.

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Abbreviations

ANP	Advanced Nurse Practitioners
BPS	biopsychosocial
BMA	British Medical Association
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CSP	Chartered Society of Physiotherapy
FPC	First point of contact
FPCP	First point of Contact Physiotherapy
GP	General Practitioner
MCP	Multispecialty community providers
MDT	Multidisciplinary Team
MSD	Musculoskeletal health disorders
MSK	Musculoskeletal
NHS	National Health Service
UK	United Kingdom

Chapter 1 – Introduction

This thesis, submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy, brings together two contemporary concepts, combining them to address a pressing concern. These two concepts are:

- The role of the first point of contact (FPC) physiotherapist as a FPC healthcare practitioner, for patients with musculoskeletal health disorders (MSDs) in general practice.
- The application of realist methodologies in the research that follows.

The intention of this introduction is to situate the researcher within the investigations that follow and provide an outline of the structure of the thesis, as a guide to the reader.

1.1 – Personal reflection

Situating myself in this body of work seems like essential to provide context to the reader. I sought this research opportunity and, more so, the chance to focus a lens on the topic of first point of contact physiotherapy (FPCP) within general practice. As such I own, and I am embedded within, the work that follows. This disclosure is important for a number of reasons; it foregrounds the theme of professionalism and in doing so it challenges the concept of altruism and it introduces the possibility of bias. I will now consider these three issues.

As a clinical lead physiotherapist I have responsibility for the development, implementation and evaluation of clinical patient pathways. As such, in 2014, I approached the clinical commissioning group (CCG), responsible for the physiotherapy service, with a proposition aimed at alleviating a number of concurrent issues in general practice; diminishing resources, subsequent increasing waiting times, increasing patient demand and challenges faced by the GP workforce.

As a physiotherapist, FPCP seemed a common sense proposal; physiotherapists competently assess and treat patients with MSDs as a core competence and the proportion of a GP's caseload, with MSDs, was estimated as anywhere up to 30 per cent (Margham, 2011). My motivation was heightened by the apparent disproportionate emphasis attributed to the struggles faced by the GP workforce rather than the potential solution FPCP provided. This apparent imbalance in the rhetoric ignited my enthusiasm to explore how issues of professional boundaries and role jurisdiction influenced innovative health service development, implementation and the associated impact this might have on subsequent patient care.

Acknowledging this introduces the potential for researcher partiality in this thesis. Furthermore, the methods I chose to apply were predominantly qualitative and as such inherently interpretative and iterative. Finally, the qualitative data collection methods – interviews and focus groups – were undertaken by me alone. These declarations have been made to demonstrate an awareness of this potential partiality with the intention of reassuring the reader. It is hoped that this reassurance will address any concerns via the processes of transparency, rigour and reflexivity.

Transparency was applied throughout the thesis in terms of the acknowledgement of personal motivations and, beyond that, in the methods and approaches used in the research. This transparency extended to the application of methods to ensure rigour throughout.

Reflexivity was a consistent theme during the course of the research project. This was realised through personal reflections – facilitated by the use of a reflective diary– during the data collection process, and at project group reflections during supervision meetings. Furthermore, the use of robust methodology and the recurrent reference to, and benchmarking against, existing literature ensured methodological and evidence-based reflexivity.

This reflection is written as I move towards the end of the PhD journey and my enthusiasm for the clinical and research initiative, that is FPCP, remains unabated. As a consequence of the reflexivity and self-reflection applied throughout I have been reassured in terms of my positionality within the process, the validity of the research methodology and in the validity of the findings.

1.2 – Setting the scene

The FPCP initiative advocates an alternative to the default situation in the National Health Service (NHS), whereby most people, seeking health care, consult their general practitioner (GP) as a first point of contact (FPC). Specifically, this thesis applies a lens to the evaluation of a physiotherapist, working in general practice, providing care to patients experiencing MSDs, as an alternative to this default. The timeliness, relevance and importance of this endeavour is evidenced by the current political and organisational interest in the operationalisation of the FPCP (NHS England, 2019; CSP, 2018a; HEE, 2018).

Realist methodologies derived from the realist philosophical interpretation of the natural and social worlds (Bhaskar, 1975). Realist methodologies are an emerging, but increasingly popular, approach to the review and evaluation of complex systems (Wong, 2018, Wong 2018a). Originality is ascribed to this project as the application of realist methodologies within physiotherapy research is novel.

The provision of FPCP, as an alternative to GP care, challenges traditional professional boundaries. Specifically, in assuming the FPCP role, physiotherapists can be interpreted as challenging the a priori jurisdiction of GPs who normally provide care for this cohort of patients. There is evidence to suggest that this challenge, to GP jurisdiction, could present a potential obstacle to the implementation of FPCP. Evidence from parallel fields suggested that the role flexibility, inherent in such initiatives, can lead to disputes around interprofessional role boundary jurisdiction (King et al., 2015, Ferlie et al., 2005, Borthwick et al., 2015, Timmons, 2011) and hinder innovation implementation.

Furthermore, it would seem reasonable to postulate that the FPCP initiative constituted a professional project (Larson, 1977), with the profession of physiotherapy seeking to increase its jurisdiction. However, there is little known about stakeholder understanding of the professionalisation of physiotherapy in general, or FPCP specifically, and this thesis goes some way towards drawing these concepts together.

1.3 – Structure of the thesis

Chapter 2 – Literature review

This chapter outlines the exiting literature pertaining to relevant topics relating to the research. Initially, an introduction to the sociology of the professions is provided. Within this section the main sociological concepts will be outlined. Following this, a brief exposition of the professionalisation of physiotherapy will be described. Within this historical review the antecedents for the FPCP initiative are explored and the evidence that exists relating to FPCP will be described. The FPCP initiative sat within the hierarchical professional system that existed in the NHS (Hugman, 1991) and alongside the historical dominance of the medical profession (Willis, 1983). This positionality was felt to be an important consideration and is reviewed. This foregrounds the following evidence relating to the redistribution of professional work within health services, dynamic professional boundaries and jurisdictional disputes.

Chapter 3 – Methods

This chapter provides an explanation of the philosophical underpinnings for the empirical research applied in this thesis. Deciding on, and expressing, the chosen methodology and its philosophical underpinnings is an essential component of any research project design (Wilson and McCormack, 2006). It is suggested that doing so provides the reader with evidence of rigour and transparency (Appleton and King, 2002). However, this clarity is often absent making it difficult for the reader to judge for consistency between philosophical commitment and chosen methodology (Wilson and McCormack, 2006, Lipscomb, 2008).

This chapter addresses this disparity with an initial introduction to the philosophy of critical realism. Subsequently, an outline of the realist approaches is given. Realist approaches are advocated as providing the link between philosophy and practice while, at the same time, addressing the issues of complexity and providing outcomes that are transferable and subsequently useful (Wong, 2018, 2018a).

Chapter 4 – Methods II

This brief chapter is fundamental to the described commitment to transparency. The application of realist approaches presented a number of challenges and it is suggested that they are demanding for novices (Pawson et al. 2004: 38) and a substantial undertaking (Hewitt, Sims and Harris, 2014). This research project was no different. It was apparent that the breadth of the planned investigation was unrealistic and likely to result in a compromise to the depth and quality of the results.

A fundamental reason behind the selection of realist methodology was the depth of the explanations generated. Taking into account the counsel, in terms of expectations (Pawson et al., 2005), the research focused on two of the initial four rough programme theories. The process by which this decision was made is described in this chapter. This is presented in a commitment to the principles of reflexivity, rigour and transparency.

Chapter 5 – First point of contact physiotherapy as a professional project; a realist review

This chapter presents the initial piece of empirical research in the form of a realist review (Pawson et al. 2005). Realist reviews are the application of the realist approach to existing published data. The outcomes of a realist review are explanations of how and why something works focusing on the causative mechanisms and taking into account the particular contexts.

In this chapter the realist review method was applied to the existing evidence relating to FPCP with a focus on issues of professionalism. FPCP was constructed as a professional project (Larson, 1977; Timmons, 2011). More specifically, the lens is focused on patients' understanding of FPCP and the roles and boundary definitions in the FPCP initiative. The findings of this review were presented as modified programme theories which were subsequently used to inform the evaluation that followed.

Chapters 6, 7 and 8 – First point of contact physiotherapy as a professional project; a realist evaluation

Chapter 6, 7 and 8 describe how the modified programme theories, developed in chapter 5 via the realist review, were taken and examined through empirical qualitative research methods and the application of a realist evaluation approach. Data collection methods included interviews and focus groups.

Chapter 6 describes the methods used. Chapter 7 presents the findings relating to programme theory one. Chapter 8 describes the findings relating to programme theory 2. Chapter 8 goes on to discuss the findings of the evaluation, describe the strengths and weakness of the evaluation and draw conclusions relating to the realist evaluation.

Chapter 8 – Discussion

This chapter summarises the findings from the overall research project and presents the transferable lessons generated. In doing so an account is given of the contribution of this work, to the research agenda and clinical practice. The strengths and limitations of the research are considered, both methodologically and theoretically. Finally, opportunities for future research are explored and transferrable lessons are presented.

Chapter 2- Background literature review

2.1 – Introduction

This chapter presents the background literature relevant to this research. The overarching objective of this thesis was to consider the implications of the FPCP initiative on the work of those professions and occupations associated with it. As a result, it was inevitable that the professions were a focus for the investigation. To situate the research that follows this chapter begins with an examination of the sociological analysis of the professions. The sociology of the professions is presented, from early to more contemporaneous concepts. This account considers the central characters in the profession's evolution from an image based on their positive features, such as altruism and specialised knowledge, popularised in the 1950s and 1960s (Wilenksy, 1964; Saks, 2016, Adams and Saks, 2018), to ones that understand the professions less deferentially and more so based on their powers and interactions (Saks, 2016).

Having contextualised the theoretical milieu of the sociology of the professions, the occupation of physiotherapy will be examined. Evidence will be presented that justifies the application of the title of profession to this occupational group and a brief history of the professional development of physiotherapy will be outlined.

The research focus of this thesis was the FPCP initiative. As such, the nature of, and evidence pertaining to, FPCP will be described. The evidence supports the assertion that the FPCP initiative was a contemporary response, by the physiotherapy profession, to provide evidence-based rehabilitation in response to the modern-day pressures experienced by the profession. The creation of new roles such as FPCP, threaten to unsettle established interprofessional boundaries (Currie et al. 2012). Evidence relating to interprofessional boundary work and jurisdictional negotiations are explored. The chapter concludes with a summary and a brief outline of the research aims and objectives.

2.2 – Sociology of the professions

The origin of the professions has proved challenging to determine (Susskind and Susskind, 2015). For some the professions have existed since time immemorial, for others they owe their birth to the craft guilds, while others situate their origins more recently, as a by-product of the Industrial Revolution. A particular interest in the sociology of the professions arose in the second half of the twentieth century. This corresponded with the immediate post-War sociopolitical culture where leading professional groups of the time, like doctors and lawyers, were shown great respect (Saks, 2016).

The following section outlines the evidence for a number of the main theories in the sociology of the professions and will be largely chronological. The approaches taken to classify the professions have been many and varied (Pekkola et al., 2018). For this analysis, in broad terms, the theories will be divided into early deferential approaches, subsequent more critical approaches and finally adjunctive, more modern theories. There is considerable overlap in these distinctions and the evidence described strengths and weaknesses in each of the approaches. Physiotherapy, as an occupation exhibits characteristics that crossed these definitional boundaries.

2.3 – Deferential theories of the professions

The early sociological interest in the professions, in the 1950s to 1960s, drew researchers' attention to the special characteristics of the professions compared to other occupations (Evetts, 2013, Saks, 2016). These early approaches employed a taxonomic approach with lists of characteristic traits and functions of the professions. The assertion was that these approaches were built on the prevailing post-war culture of the time and the classic social scientific work of functionalist writers such as Carr-Saunders and Wilson (1933) and Durkheim (1957) who saw the professions as a stabilising force in society.

The hope was that the professions would provide the moral discipline required to stabilise society and provide moral boundaries. Durkheim was convinced that the professions could be the force to act against that of rampant

capitalism (Light, 2010). There were two main manifestations within the taxonomic approach; the trait and functionalist approaches.

2.3.1 – Trait approach

The trait approach was primarily focused on constructing lists of the core characteristics of the professions and most of this early work was done on the archetypal professional groups of the time such as doctors and lawyers (Macdonald 1995; Saks, 2016). The weakness of the trait approach was evident in the wide variation in the traits identified across studies (Adams, 2010; Saks, 2016). Indeed Millerson (1964) identified twenty-three attributes that could be assigned to a professional group.

Any consensus appeared to emphasise characteristics such as a systematic knowledge base, evidence of a formal training structure, and an altruistic orientation to their work (Millerson, 1964; Greenwood, 1957; Wilensky, 1964). These lists were strongly criticised as reflecting a picture of the professions they, themselves wanted to display (Johnson, 1972; Adams, 2010).

2.3.2 – Functionalism

Functionalism sought to define how the professions met the needs of society (Macdonald, 1995; Saks, 2016). Central to the functionalist approach was how a profession contributed to society and fundamental to this was their altruistic inclination. A consequence of this was the exchange of a professions esoteric knowledge for high socioeconomic privilege (Saks, 1995).

There was widespread criticism of both the trait and functionalist approaches as a consequence of their assumed deferential analysis. Conversely, they did highlight some, often overlooked, insights. For example Wilensky (1964) identified the procedural nature of ‘professionalisation’, the concept commonly used to describe how an occupation becomes recognised as a profession and establishes its status, a theory that is still relevant today (Neal and Morgan, 2000). In this way Wilensky (1964) identified a typical chronology, suggesting professionalisation began with the emergence of a full-time occupation, followed by the founding of a training school, a university school, a local association, a national

association, the passing of state-level licensing laws and the establishment of codes of professional ethics (Wilensky 1964, Evetts, 1999). Implicit in this procedural nature, if not necessarily articulated by Wilensky, was the possibility of backwards, as well as forwards, travel in this professionalisation process. As such professional status can never be entirely immune to becoming destabilised. This highlights the need for professional vigilance in occupationally competitive environments. This is clearly relevant to this research project that is set in an environment which is increasingly multidisciplinary.

Despite widespread criticism of his assumed functionalist, deferential analysis of the professions, Parsons (1939) described it as implausible that the motivations of the professionals were so different to those of business executives (Light, 2010). Evetts (2003) defended Parsons against criticism suggesting he was one of the first to describe the role of the professions alongside the state and capitalist economy. The evidence suggests the claims of naïvety, directed at the early approaches, were perhaps a little overzealous. In his early seminal work Freidson (1970) was a vociferous advocate of a more critical interpretation of the professions. However, by the time of his later work Freidson (2001) appeared to have reconsidered his position, resonating with Durkheim's positioning of the professions as the 'third logic' and setting *"professionalism next—in fact, against the logic of the market and of bureaucratic managerialism—as the third organizing principle of the division of labour"* (Larson, 2003: 458). Despite these reflections, and the contribution these early theories can still make, the trait and functionalist approaches fell from regard and received considerable critique, suggesting they portrayed a naïve 'ideal type' profession and failed to consider the broader dynamics sufficiently.

2.4 – Critical theories of the professions

In the early 1960s some sociologists refused to unquestioningly accept the ideologies of altruism and trust and turned a more critical eye to the professions in line with the 1960s and 1970s counter culture. To a great extent this more critical inclination continues to date. The main depictions within this approach are now

considered. Although most authors, who reviewed this period attempted some form of definitional typology there is considerable overlap in the approaches.

2.4.1 – Interactionist approach

Symbolic interactionism was a micro-level theory that focused on the relationships amongst individuals within a society and was the earliest of the more critical approaches to the professions (Macdonald, 1995). Everett Hughes (1958) was probably the first to suggest that the difference between professions and occupations was a matter of degree rather than kind. As such, the question moved from what 'was' a profession to what were the circumstances that allowed an occupation to turn into a profession. The link that Hughes made between occupations and professions resulted in a number of ethnographic studies of professionalisation in the workplace and the methods by which occupations established and maintained a professional status. This process was interpreted as dynamic and involved interactions between the professionals and their clientele to control the tensions inherent in the search for a stable professional base (Timmermans, 2008). Subsequently, interactionism was criticised as a consequence of its micro-level focus (Saks, 1995, 2016). Nevertheless, it had articulated the significance of power in the study of the professions which was carried forwards into subsequent analyses.

2.4.2 – Marxist approach

Friedman (1962) attacked the professions and their striving for monopoly-power at the expense of workforce diversity, and client choice. It was claimed that this striving was inherent to the capitalist project and this inevitably opened up the opportunity for a Marxist perspective of the professions. Marxist sociology of the professions was primarily structuralist (Macdonald, 1995) and focused on the relationship between the state and the professions. The professionals were interpreted as being either susceptible to manipulation by the state to fulfil the functions of capitalism, or pictured as the proletariat, gradually losing their skills and power (Braverman, 1998). For some the professions were part of the state machinery and representatives of the capitalist regime (Saks, 2016). The other view

was of a 'proletarianisation' of the professions as a response to bureaucratisation and market power (Braverman, 1998; Macdonald, 1995). Regardless of variation in approach, adherents of the Marxist interpretation agreed that the professions played a significant role, as agents, in the capitalist agenda (Saks, 1995). This was an insight later expanded by Johnson (1995).

2.4.3 – Neo-Weberian approach

During the 1970s the neo-Weberian approach to the analysis of the professions emerged. This approach centred on Max Weber's concept of social closure (Macdonald, 1995; Saks, 2016; Adams and Saks, 2018). The main advocates of this approach were considered Freidson (1970), Johnson (1972), Larson (1977), and Abbott (1988) although each also contribute elsewhere. Saks (2016) was a strong adherent of the neo-Weberian approach suggesting it addressed the weaknesses of the earlier approaches. Firstly, it afforded a less deferential, idealistic perspective. Secondly, it transcended the micro-level lens applied by the interactionists. Thirdly, the restrictive structural boundaries of the *"rigid conceptualizations of the functioning of the capitalist state"* (Saks, 2016: 6) were avoided. Finally, Saks (2016) suggested the neo-Weberian approach was eminently compatible with systematic empirical analysis. What linked the various iterations of the neo-Weberian approach was their commitment to the power dynamics inherent in the professionalisation of an occupation.

Freidson (1970) was the first sociologist to systematically analyse the relationship between the professions and the state. Freidson based his work on the American medical profession and described how the profession had obtained dominance through the combined subordination to state regulation while, at the same time, maintaining professional autonomy through this very same state affiliation. The power of the profession was maintained as long as it could establish and maintain control over the 'technical' aspect of its work. As such Freidson described the profession operating from a state sponsored, protected 'shelter' which provided a method through which it was secured from competition. Nevertheless, this novel analysis portrayed doctors as *"wielders of power, not*

servants of the social good" as had so often previously been the case (Macdonald, 1995: 4).

For Johnson (1972) the power of the occupations lay in their professional structures; collegiate (power exercised intra-professionally), patronage (power exercise between members of the profession and those who commission it) and mediated (power exercised by a mediator between the profession and its service users) (Hugman, 1991). Through the interplay, and negotiation, between the professions, the state and the service users these powers were exercised (Hugman, 1991). Unsurprisingly, Johnson has also been associated with the Marxist perspective (Macdonald, 1995). Where Freidson had spoken of professional autonomy, Johnson had spoken clearly of power. However, in both cases the question, once again, moved from if an occupation was a profession to an analysis of professionalism and how that occupation sought to professionalise. Building on his earlier work Johnson went on to ascribe a link between the professions and Foucault's concept of governmentality (Johnson, 1995). Foucault rejected the idea of the singularity of a monolithic state power, suggesting 'governing' was situated in day-to-day social practices. Within these practices was the *"institutionalization of expertise"* (Johnson, 1995: 9), a mechanism through which the professions were subsumed into the state process of governing.

Another predominantly neo-Weberian, with interactionist, Marxist and Foucauldian inclinations, was Larson (1977, 1990). From a Marxist perspective Larson has been described as viewing the process of professionalisation as principally the *"construction of a market"* (Johnson, 1995: 145). From a Foucauldian perspective Larson's later work stressed the historically situated nature of the professionalisation process and the institutionalised nature of expertise which acts as part of the governing structure. However, Larson was principally acknowledged as a result of her influential processual interpretation of the 'professional project' (1977). Larson's professional project built on the earlier work of Freidson (1970) and synthesised aspects of Marxian tradition along with Weberian principles of social stratification, economic and social order. The position a profession attained was not

seen as coincidental and was interpreted as the outcome of the 'professional project' (Macdonald, 1995). This project constituted:

> *[An] attempt to translate one order of scarce resources—special knowledge and skills—into another—social and economic rewards*
>
> Larson, 1977: xvii

The professional project included both the pursuit of market control and social mobility (Larson, 1977). According to Macdonald (1995) this required the possession of a body of expert knowledge which was susceptible to practical application, in a given socioeconomic climate. Larson (1977) also recognised that the quest for market control and social status converged in the 'institutional areas of the market' and this has been picked up in later analytical approaches to the professions. Larson also acknowledged the collective, as well as individual, search for upward mobility in the professional project (Macdonald, 1995; Evetts, 2003). In doing so Larson transcended her interactionist origins through a broader analysis of occupational and class structures. Finally, the consequence of these tactics in the search for economic and social rewards was the generation of *"tensions and contradictions which we find, unresolved or only partially reconciled, in the contemporary model of profession"* (Larson, 1997: xvii).

Abbott (1988) developed his explanation of the process of profesionalisation by considering the dynamics between different professions and their jurisdictions (Abbott, 1988, Evetts, 2003, Saks, 2016). For Abbott, the professions existed as a system, quarrying and maintaining their jurisdiction through continuous competition with the objective of achieving a monopoly (Evetts, 2014). The occupational boundaries were permeable and as such professional territories and areas of responsibility were delineated through continuous claims and counter-claims for jurisdiction. This interprofessional competition extended to *"existing, emergent and vacant areas of expertise"* (Johnson, 1995: 17).

These more critical approaches to the analysis of the professions were useful in that they challenged the previously lauded, ideal type, traits and functions of the professions and they continue to contribute considerably to the sociological

analysis of the professions. The following section reviews contemporary, complementary approaches to the professions.

2.5 – Contemporary theories of the professions

The following section is not exhaustive but briefly outlines a number of the complementary theories of the professions.

2.5.1 – Foucauldianism

Reference has already been made to French philosopher Michel Foucault (1926–1984) through the Foucauldian interpretation of the professions by Johnson (1995) who described a singularity of state and the professions. As such the professions became part of the:

> *ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security*
>
> Burchell, Gordon and Miller, 1991: 102

Larson also drew on Foucault's concept of governmentality and Foucault's concern with the relationship between knowledge and power (Larson, 1990; Macdonald 1995). Others have extended Foucauldian concepts to the professions. Fournier (1999) suggested that the autonomy sought by the professions provided a 'disciplinary logic' that governed the conduct of the individual professional and the broader profession. However, at the same time there was an ideological appeal to professionalism through its association with dedicated services and autonomous decision-making (Evetts, 2013). Adams (2012) furthered Foucault's contribution by constructing professionalism as an episteme.

Foucault defined an episteme as:

> *a constantly moving set of articulations, shifts, and coincidences that are established, only to give rise to others…The episteme makes it possible to grasp the set of constraints and limitations which, at a given moment, are imposed on discourse*
>
> Foucault, 1972: 191

The reference to 'articulations' provides a link to the work of other social scientists who retreated from structural investigations to an examination of the professions through discourse analysis (Saks, 2016).

2.5.2 – Discourse analysis

The use of discourse analysis resonated with the earlier interactionists, focusing on the ways that vocabulary was used to develop linkages, for example between professions and discipline (Fournier, 1999). Discourse coming from 'within' the profession had the objective of establishing identity and subsequently leveraging this to customers and the state. Alternatively, professional discourse constructed from outside (or above), however appealing this might at first appear to the profession, was often a mechanism for managerial control (Evetts, 2014). Adams (2012) suggested that the discourse of professionalism transcended the workplace to pervade the family, politics and culture more generally. Discourse occurred at micro, meso or macro levels of society and can be persuasive in bringing about organisational and institutional change (Suddaby and Viale, 2011). This acknowledgement led some authors to take an institutionalist approach to the study of the professions.

2.5.3 – Neo-institutionalism

Institutional change, since the 1980s, has been profound, driven by neoliberal and associated managerial tendencies (Martin et al., 2015; Pekkola et al., 2018a). Markets and organisations became more important and professional work was seen to be changing because of these organisational contexts (Evetts, 2009; Noordegraaf, 2016). For Evetts this resulted in two contrasting forms of professionalism. Evetts

described how New Public Management (NPM) constructed a professionalism 'from above', *"manifested by a discourse of control, used increasingly by managers in work organizations"* (Evetts, 2009: 248). At the same time the professions constructed their own professionalism 'from within'. Evetts (2009) contrasted these two forms as organisational professionalism (from above) and occupational professionalism (from within) suggesting this provided a novel method of examining the tensions inherent in the coexisting professional and managerial systems. However, for some authors this organisational focus was too narrow. They suggested that not only did professions contribute to organisational change but beyond that to broader institutional change (Suddaby and Viale, 2011; Muzio, Brock and Suddaby, 2013). Indeed, Martin et al. (2015) identified professionalism as an institutional logic suggesting, as did Freidson (2001), that professionalism can stand against the logic of the market and bureaucratic managerialism. For Light (2010) the countervailing powers framework, and Freidson's (2001), attempts to reconstruct professionalism as an antidote to profit driven efficiency, were wrong and the professions did not embody a higher moral code.

These institutional interpretations emphasised the unrelenting, dynamic nature of professional boundaries and jurisdictions (Suddaby and Viale, 2011). This is consistent with Abbott's systems approach to jurisdictional conflicts (Abbott, 1988, Saks, 2016). Furthermore, these neo-institutionalist authors argued for the application of the theory of the professional project (Larson, 1977) to extend beyond the understanding of the process of professionalisation to broader projects of institutionalisation (Suddaby and Viale, 2011). Within this approach professional groups are striving to preserve their position when set against other professional groups but also other institutional forms such as corporations and nation states. This has led to the conceptualisation of these competing dynamics as an ecological approach (Suddaby and Viale, 2011; Saks, 2016).

2.5.4 – Eclecticism

Saks' review of theories of professions (Saks, 2016) demonstrated the interrelatedness of the theoretical approaches to the study of the professions. The mainstream theories are summarised in table 2.1.

Table 2. 1: Mainstream social; scientific theories of professions, organisations and society, from Saks, 2016: 13.

Theories of professions	**Organisations**	**Society**	**Main time period**
Trait approach	Classificatory so little interest in organisational role of professions	Professions not typically located in wider social structure	1950s–1960s
Functionalism	A key focus is on the link between professions and organisations	Perceived functional trade-off between professions and society	1950s–1960s
Interactionism	Professions viewed as socially negotiated label in organisations	Little interest in wider structures of power or historical processes	1960s–1970s
Marxism	The class-based organisational context of professions is critical	Professions seen as engaging in social control under capitalism	1970s–
Foucauldianism	Interest in rationality of progress in organisational contexts	Professional incorporation into state governance is central	1970s–
Neo-Weberian	Concerned with tensions between professions and organisations	Professional interests and power structures linked to social closure	1970s–
Discourse analysis	Focus on discourse in professional culture in organisations	Analysis not usually pitched at macro societal level	1990s–
Neo-institutionalism	Professional service firms and other organisational contexts are key	Professions are part of global ecology of competing institutions	2000s–

Saks was an advocate for Neo-Weberian approaches, supplemented by the more recent neo-institutionalist approach. However, he also acknowledged the continued utility of the other approaches as "*each has a capacity to stimulate fresh thinking in*

combination with neo-Weberianism and neo-institutionalism" (Saks, 2016: 12). In doing this Saks advocated an eclectic approach to the study of the professions.

In summary, there was a long and rich history in the evolution of study of the professions which has been briefly reviewed. It was clear that these theories related to individual occupations and their professionalisation through their own professional project. Furthermore, professions were engaged in constant struggles with other professions and the inherent interprofessional tensions in the search for a stable professional base. As such the sociology of the professions literature is relevant to physiotherapy, in its journey to professional status, and the subsequent analysis of FPCP as a professional project. The following section will highlight the principle features that align the occupation of physiotherapy with the archetypal image of a profession.

2.6 – Physiotherapy as a profession

The following section does not attempt a detailed history of the development of physiotherapy as a profession. More so, the following sections draw on significant events in the history of physiotherapy with reference to the sociological theories described above. In terms of definition, according to the UK governing body, the CSP (CSP, 2019):

> *Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them remain independent for as long as possible*

2.6.1 – The early years

The management of health complaints through organised systems of physical treatments have their origins in ancient civilisations (Nicholls, 2018). For the purpose of this thesis the starting point of the history of the modern-day profession of physical therapists can be dated back to 1894. At this point in time a small group

of nurses optimised an opportunity to establish the Society of Trained Masseuses (STM). A number of overlapping events combined to create this opportunity. These events included the transition from classical to modern liberalism and the subsequent increased involvement of the state in governing the populace. Amongst the new concerns of the government was an increased attention to the health of the nation (Nicholls and Cheek, 2006). Coincidently, but associated with the wider public health agenda, and of particular relevance to the embryonic profession of physiotherapy, was growing attention to the application of massage as a practice. On the one hand massage was associated with prostitution and the concomitant spread of disease endemic amongst the prostitute population. On the other hand there was an upsurge of interest in massage as an intervention believed to have profound medical effects (Nicholls and Cheek, 2006).

Aware of this controversy, the nursing profession had tried to distance itself from the less wholesome aspects of massage. At the same time the medical profession took the opportunity to utilise their growing influence, helped by the emergence of the professionalisation of expertise, by emphasising the moral corruption inherent in the massage industry. As a predominantly female occupation they simultaneously challenged women's growing social mobility of the time (Nicholls and Cheek, 2006).

A number of theories of the professions converge in these early, fundamentally important, years. Medicine was one of the three original 'learned' professions, along with law and the clergy, with the Royal College of Physicians (RCP) established in 1518 and the British Medical Associations (BMA) in 1832. However, the turn of the twentieth century saw further empowering of the medical profession. The Medical Act of 1858, in an attempt to abolish quackery, established the General Council of Medical Education and Registration of the United Kingdom (later the General Medical Council (GMC)). The remit of this organisation was to exercise control over the syllabus for the education of doctors and to keep an up-to-date record of those registered to practice (Roberts, 2009). In addition, the emergence of bacteriology in the 1870s accelerated the efficacy of medical interventions (Freidson, 1970; Larson, 1977). There were parallel improvements in

anaesthesia and asepsis. For the first time there was the likelihood of greater benefit, than harm, from medical intervention. As such medicine had already achieved the government regulated autonomy, and 'market shelter', which is a key component necessary to the process of professionalisation (Freidson, 1970; Kenny and Adamson, 1992).

In conjunction with these developments was medicine's role, alongside that of the state, in showing an increased interest in the welfare of the populace at this time. Applying Foucault's concept of governmentality the state increasingly sought to 'govern from a distance' and medicine became both part of the state and part of its apparatus (Johnson, 1995).

The state's attempts to distance itself from direct control had the corollary consequence of encouraging the development of professional organisations as part of its extended apparatus. The professionalisation of medicine, and the state patronage that accompanied this, afforded it the protected 'shelter' (Freidson, 1970) required to challenge the unscientific practice of massage and in doing so augmented medicine with a role in the process of governing.

However, the founders of the STM also utilised the government changes of the time to their own ends. According to Foucault there exist occasional *"[c]hronological gap*[s] *[decalage]"* (Elden, 2017: 10) that allow an opportunity for a readjustment in the dynamics of power. Nicholls (Nicholls and Cheek, 2006; Nicholls, 2018) used Foucault's genealogical lens to analyse this period in the development of the STM. The first tactic seen in the professionalisation of the STM was in their alignment with the medical profession. They sought this through their application of biomechanical discourses applied to the practice of massage. In doing so they hoped to distance themselves, and marginalise, alternate discourses linking massage with pleasure and sensuality while, at the same time, establishing the practice of massage as respectable (Nicholls and Cheek, 2006).

Further legitimacy was established to the practice of massage via the establishment of regulations of education, training, registration and the development of a code of practice. These tactics were evident, and consistent,

throughout the literature pertaining to the sociology of the professions and the process of professionalisation (Wilensky, 1964; Freidson, 1970; Larson, 1977). However, any profession, in its search for autonomy, required the support of the state. Indeed, *"[t]he attitude of the state toward education and towards monopolies of competence is… a crucial variable in the development of the professional project"* (Larson, 1977: 15). The founders of the STM consciously, or otherwise, exploited this association. If we take Johnson's (1995) definition of governmentality to mean that medicine had become subsumed into the state then the STM placated both the government and the medical profession in their alignment with the public health agenda, the medicalisation of massage and their regulatory processes (Larkin, 1983; Nicholls, 2018).

Nichols (2018) noted that the STM's commitment to publish literature exclusively in nursing, or medical, journals enhanced their project as did their assertion that the STM would be run by women, for women. This further distanced the practice of massage from pleasure and sensuality. These two tactics were essential in promoting the profession to, and recruiting from, a particular class of woman and protecting the reputation of the masseuses (Parry, 1995, Nicholls, 2018).

However, it also appeared evident that the founders of the STM were themselves in a privileged starting position. What does not appear to have been emphasised was the social privilege that this group of women had. Through their associations the founder members had direct access to influential decision makers in the government and medicine, in a way that perhaps rival organisations did not. As Nichols stated the strict rules and regulations, alone, cannot explain the successful project of the STM, where others failed. He goes on to suggest, *"[t]he founders (probably using Rosalind Paget's social and political connections) worked assiduously to obtain medial signatories"* (Nicholls, 2018: 49).

2.6.2 – The intervening years

The professional project of physiotherapy continued through the intervening years. A number of historical events contributed to the dynamic evolution of the

physiotherapy profession. Alongside the development of physiotherapy was the continued growth in the power of the medical profession. As such physiotherapy was pragmatic and continued to court medical patronage (Larkin, 1983); further 'gaps' were created for physiotherapy with the outbreak of World War I (1914–-1918). Medicine focused on technological advances in surgery and medicinal management of health and as a consequence turned away from the application of physical medicine techniques.

Physiotherapy received important exposure to the general public during World War I. Prior to World War I it was mainly the social elite who accessed physiotherapy but the war, and the contribution to the war effort by the profession, allowed it to act (and be seen to act) in a *"noble cause"* (Nicholls, 2018: 61). Not only did this expose the wider population to physiotherapy but it necessitated an exponential recruitment policy. Through this exposure physiotherapy had gone some way to securing public support, essential to any profession project. According to Freidson a profession cannot be *"a true consulting profusion until its ministrations seemed to the public to answer its needs"* (Freidson, 1970: 350).

Tensions between physiotherapy and medicine were evident and physiotherapy's professional project required skilful navigation and manipulation of a tripartite ecology of State, medicine and physiotherapy (Larkin, 1983). Physiotherapy had established itself as a component of the state's distribution of healthcare resources as part of its welfare reforms and the establishment of the NHS in 1948. As such physiotherapy could reasonably be considered part of the state apparatus in the government of the population (Johnson, 1995). Alongside this, and despite their own challenges, medicine continued to dominate the modelling, organisation and delivery of health services (Sandstrom, 2007).

Physiotherapy professionalised in the shadow of, with the conditional support of, and very much in the model of medicine (Freidson, 1970). This was evident in the attainment of royal patronage or royal charter (1916, 1920), specialisation (1922) and state registration (1960; the Professions Supplementary to Medicine Act establishes the Council for the Professions Supplementary to

Medicine (CPSM) to regulate the initial training, fitness to practise, and the conduct of physiotherapy and other allied health professions).

Despite the notable and significant achievements physiotherapy remained ostensibly dominated by the medical profession (Larkin, 1983). Regardless of this subordination, which was clearly nothing new and had undeniably helped secure the project to date; by the 1970s physiotherapy was a diverse and nationally supported profession (Nicholls, 2018).

2.6.3 – The modern era and challenges to the professional project

Most histories of physiotherapy describe the mid-1970s as the point whereby the profession began to lose some clarity (Sandstrom, 2007; Kell and Owen, 2008; Nicholls, 2018). This is somewhat surprising as it was not until 1977 that physiotherapy, in the UK, became an autonomous profession with patients no longer dependent on a doctor's referral. The consensus was that this was an indication of the influence of wider government policy and the neoliberal reforms of the 1970s (Kell and Owen, 2008).

The defining principle of neoliberalism was minimal state interference, accompanied by decentralisation of power and the promotion of private initiatives in the context of free markets (Pownall, 2013). Earlier sociologists had positioned the professions as standing against the market (Light, 2010) but by the 1970s, the more critical analyses, had cast the professions as self-serving monopolies operating within protected markets (Freidson 1970; Larson 1977; Light, 2010). The literature on public sector reform distinguished the reforms of the 1970s as NPM (as opposed to Traditional Public Administration (TPA) from the 1960s until the late 1970s and New Public Governance (NPG) since the late 1990s) (Hendrikx and van Gestel, 2017).

Physiotherapy was not immune to these policy reforms. The NPM philosophy of market competition, resource management, cost improvements and productivity inevitably resulted in challenges to previously-taken-for-granted professional. As the individual and collective autonomy of a profession was being challenged, the trust in both individual professionals and their profession

concurrently eroded (Timmermans, 2008). The professions generally, and medicine specifically, were accused of being self-serving in terms of salary, status and market monopoly. More so, medicine was accused of inefficiency and wide variation in, and efficacy of, clinical practices (Timmermans and Oh, 2010; Bleakley, 2013; Noordegraaf, 2016). These challenges were exacerbated by a number of widely publicised scandals (Kell and Owen, 2008; Francis, 2013). Alongside, and intrinsic to, the neoliberal drive for efficiency was the associated advocacy of patient choice (Nicholls, 2018).

Inevitably, when faced with increasing managerial accountability, threats to autonomy and calls for transparency, methods of restoring trust were required. One such measure was the implementation of the 'effectiveness agenda' and the evidence base medicine (EBM) movement (Kell and Owen, 2008, Nicholls, 2018). Physiotherapy enthusiastically embraced medicine's EBM agenda (Kell and Owen, 2008; Kerry, 2017; Nicholls, 2018). The growth of the EBM paradigm led to a proliferation of clinical guidelines that sought to standardise clinical practice, throughout all medical professions, and allowed for more explicit regulation of practice (Waring, 2014). There was consensus that this surveillance, via quality measures and audit, resulted in a weakening of traditional professionalism (Light, 2010; Adams, 2010, Martin et al., 2015). For others the professions responded though hybridisation; an interweaving of managerial and professional practices (Noordegraaf, 2015). The consequence of the increased bureaucratic influence on professional work led some to assert that *"sociological focus on professions is increasingly obsolete from a conceptual and theoretical perspective"* (Adams, 2015; Saks, 2016: 2). However, Adams (2015: 159) countered this suggesting the sociology of the professions was experiencing *"a resurgence of interest"* and indeed the professions maintained their central significance in the field of work.

Physiotherapy was caught up in the influence of these neoliberal reforms. The rationalisation of healthcare services, the pursuit of quality improvement and the increase in 'consumer' choice was accompanied by a concomitant increase in individual responsibility (Nicholls, 2018).

Physiotherapy responded to these sociocultural changes in a number of ways; adherence to the EBM paradigm, specialisation in clinical practice or the movement towards degree level entry requirements (Sparkes, 2002; Nicholls, 2018). Nevertheless, despite these changes there was a sense that physiotherapy essentially operated in a model that remained consistent with that of its founders despite the very different economic, political and social contexts. As such, the marketisation and rationalisation of health services meant the contemporary questions faced by the profession changed. Faced with jurisdictional challenges of its own, from emerging professions, physiotherapy was now being asked to explore its values and practices (Nicholls, 2018).

Despite the initial pessimism in this vision, the flexibility and adaptability that physiotherapy had demonstrated throughout its history produced an equal sense of optimism that this respected profession would once more adapt to survive. For some this adaptability is evident in a move away from the traditional body-as-machine paradigm that served it so well in the twentieth century (Nicholls, 2018). For others it is the move away from the EBM movement with its *"reduction of…practice to a series of routinized steps"* (Kell and Owen, 2008: 161) to a research vision that embraced real world complexity (Kerry, 2017). According to Kell and Owen (2008) to remain relevant physiotherapy needed to engage innovatively and collaboratively with other health professions and the state.

2.7 – First point of contact physiotherapy

The FPCP initiative is presented as a response by physiotherapy to the challenges above. FPCP demonstrated all the professional flexibility intrinsic to the procedural theories of Freidson (1970) and Larson (1977) and the systems theory of Abbott (1988) in the sociology literature. The healthcare workforce is expected, in the neoliberal climate, to demonstrate flexible professional boundaries and this was emphasised in the recent NHS Long Term Plan (NHS, 2019). This flexibility frequently requires a degree of professional specialisation that could be considered an expansion, broadening or extension, of roles. Some concern had been expressed about the fragmentation associated with the specialisation agenda (Nancarrow and

Borthwick, 2005; Kell and Owen 2008). Specialisation is described as an extension of role beyond those of core training (Nancarrow and Borthwick, 2005).

The nursing profession led the way in the development of specialised, advanced practice, or extended scope, roles and the lessons learned from the nursing experience were valuable to the physiotherapy project (Ruston, 2008). The advent of the development of the advanced practice nurse can be dated to the mid-to-late 1990s (Bryant-Lukosius, 2004). Research and evaluation provided evidence to support advanced nursing roles (Stasa et al., 2014) although there was confusion and inconsistency with regards to the title itself and the responsibilities and roles incorporated therein (Bryant-Lukosius, 2004; Stasa et al., 2014).

There have been a number of systematic reviews exploring advanced, or extended scope, physiotherapy roles (Stanhope et al., 2012; Desmeules, 2012; Thompson, Yoward and Dawson, 2017). The majority of this literature explored extended physiotherapy in secondary care services. The evidence suggested extended roles were clinically efficacious with extended scope physiotherapists providing equal, or better, care in comparison to physicians in terms of diagnostic accuracy, use of healthcare resources and patient satisfaction. There was wide variation in the roles undertaken by extended scope physiotherapists and inconsistent training for the extended role (Stanhope, 2012).

Of particular interest to this thesis was the finding reported by Desjardins-Charbonneau et al. (2016). Their online survey reported high levels of acceptability and confidence in physiotherapists as advanced, primary care practitioners. However, they also discovered that:

> *The current role of physiotherapists is not always well understood, and the choice to consult a family physician first remains predominant for an important proportion of respondents*
>
> Desjardins-Charbonneau et al., 2016: 405

2.7.1 – Introduction to first point of contact physiotherapy

Physiotherapy achieved autonomy in 1977 and this negated the need for a doctor's referral (CSP, 2011). As such, FPCP can be considered an extension of the traditional role of the physiotherapists. The achievement of autonomy was a success in physiotherapy's professional project. In recent years there has been a wider growing interest in the term first point of contact (FPC) practitioner as a generic term applicable to any professional who provides the FPC for a patient's care. As such, in the context of this thesis, the terms self-referral physiotherapist and FPC physiotherapist by definition were synonymous. Earlier literature predominantly used the term self-referral physiotherapy while more recent discourse has spoken about FPCP.

Much of the early literature relating to self-referral physiotherapy emerged from a National project in Scotland. From the very first evaluations it was apparent that there was a rhetoric attempting to articulate the benefits of self-referral as professional leverage. This Scottish project took place between 2002 and 2005 when self-referral was not routine practice in the UK. A number of publications arose from the project demonstrating clinical effectiveness with patients reporting lower symptom severity on discharge (Ferguson, Griffin and Mulcahy, 1999; Holdsworth and Webster, 2004; Holdsworth and Webster, 2006; Holdsworth et al., 2007). Further evidence reported that self-referral physiotherapy was supported by GPs and physiotherapists (Holdsworth et al., 2008). The investigations extended to the types of patients most likely to use self-referral (Holdsworth at al., 2006a), their attitudes towards self-referral and their sociodemographic characteristics (Webster et al., 2008; Holdsworth at al., 2006a). Despite the emerging evidence self-referral physiotherapy provision in the UK remained patchy, and in 2015 was only available in 31 per cent of England's 211 CCGs (CSP, 2015).

A drive to invigorate the self-referral project became evident in 2013. Initially, the argument was developed on a wider European and global scale (Bury and Stokes, 2013, 2013a). These surveys sought to establish the extent of provision of self-referral physiotherapy globally. Furthermore, they sought to highlight World Confederation of Physical Therapy (WCPT) member organisation's perceptions of

the barriers and facilitators to the introduction of self-referral physiotherapy. Not only did these publications broaden the argument form a national one to a global one, they also clearly identified some interprofessional tension inherent to the project. Member organisations perceived the medical profession as the main barrier to self-referral physiotherapy (Bury and Stokes, 2013, 2013a). These interprofessional tensions were acknowledged by Foster, Hartvigsen and Croft (2012: 211) who stated *"it is time to have this debate with openness, dialogue, and curiosity and to set aside professional tensions and traditional hierarchies"* (Foster, Hartvigsen and Croft, 2012: 211). They went on to suggest that *"although such [interprofessional] tensions are understandable, focusing on them draws attention away from the primary goal, namely to improve the care of patients with musculoskeletal problems"* (Foster, Hartvigsen and Croft, 2012: 211).

This exposed the potential tensions inherent in the extension of physiotherapists' jurisdiction into traditional GP domains. There appeared some naïvety in the suggestion that attention to these professional issues was counterproductive. Indeed, the assertion within this thesis was that attention to these interprofessional issues was essential to understand the FPCP initiative.

2.7.2 – Justification for first point of contact physiotherapy

Alongside the re-emergence of the self-referral professional project was an increasing sociopolitical consensus that the conventional delivery of health services in primary care in England, in the guise of the traditional general practice, was under unbearable strain (NHS England, 2014). It was clear that in a climate of ever tightening budgetary restraint, innovative approaches were required. These remained a cornerstone of central government recommendations (NHS England, 2014; NHS England, 2016; NHS England 2017; NHS England 2019). The direct implication of this for physiotherapy, and the FPCP initiative, was evident in the most recent NHS Long Term Plan which states, *"[w]e will expand the number of physiotherapists working in primary care networks, enabling people to see the right professional first time, without needing a GP referral"* (NHS England 2019: 73).

A number of coexisting issues were evident and subsequently used as leverage to support the FPCP initiative. It was suggested that as the population aged it would be inevitable that they acquire, and live with, the long-term health conditions and that these accounted for 70 per cent of the expenditure of the NHS (Goodwin et al., 2011). The challenge of the ageing population, while significant, was not the only health challenge facing the NHS. Despite public health initiatives to date, whether aiming to decrease levels of smoking or increase levels of activity, the overall health of the population of England continued to deteriorate (Goodwin et al., 2011, NHS England, 2014).

Set alongside the predicted increase in demand were the acknowledged workforce issues in general practice. In 2008 a report by the NHS Workforce Review Team (NHS Workforce Review Team, 2008) identified a risk of the existing system failing due to a number of countervailing issues. A significant proportion of existing GPs were in the age group 55-65 and, as such, were described as approaching retirement. In addition, they identified changes to the working patterns of the GP workforce with partnership opportunities scarce and approximately one third of the GP workforce consisting of sessional doctors. These concerns were echoed by the Centre for Workforce Intelligence report in 2014 (Centre for Workforce Intelligence, 2014) and the 2015 National Audit Office report 'Stocktake of general practice access in England' (National Audit Office, 2015). These influences were compounded by the unprecedented financial challenges faced by the NHS as a whole, at the time (NHS England, 2014). In the context of this evidence it was apparent that creative solutions to improve efficiency were required. Physiotherapy saw a part solution via the widespread implementation of FPCP for patients with MSDs.

2.7.3 – Musculoskeletal health complaints and first point of contact physiotherapy

MSDs were predicted to rise, in association with the ageing population (Picavet and Schouten, 2003; Urwin et al., 1998). Degenerative joint conditions, as a disorder predominantly of old age, would rise in parallel with the ageing population

(Department of Health, 2006, Margham, 2011). The burden of MSDs globally has been consistently reported as being exceptionally high; ranking second only to mental health problems in total years lived with disability (YLDs) (Woolf and Pfleger, 2003; Storheim and Zwart, 2014; March et al., 2014). In terms of impact, in the year 2013, 131 million work-days were lost in the UK due to sickness and 31 million of these were associated to conditions of the back, neck and/or muscle pain accounting for more days lost than any other cause (Office for National Statistics, 2014).

Most MSDs are managed in a primary care setting with 10.1 million patients in 2006 consulting a primary care health care professional with a MSDs. The estimated cost of these consultations was £1340 million ranking third behind diseases of the respiratory system and diseases of the circulatory system (March et al., 2014). The default position is for these patients to consult their GP as the FPC (Foster, Hartvigsen and Croft, 2012).

The management of MSDs has been a cornerstone of physiotherapy practice (Nichols, 2018). The scope of research exploring the efficacy of physiotherapeutic interventions for the management of MSDs is wide and varied (Moseley et al., 2011). Evidence for physiotherapy has been demonstrated in a wide range of settings and for a wide range of health conditions ranging from shoulder pain (Klintberg et al., 2015) to knee pain (Fransen et al., 2015) to low back pain (Lewis, Morris and Walsh, 2008). Patients have been consistently highly satisfied with MSK physiotherapy delivered across outpatient settings (Hush, Cameron and Mackey, 2011).

2.7.4 – Patient understanding and first point of contact physiotherapy

The Scottish self-referral project had demonstrated that patients continued to predominantly choose their GP as the access point for their health care despite the option of a physiotherapist. As few as 20 per cent of patients were reported to have accessed physiotherapy directly (Webster et al., 2008). The potential impact of FPCP would not be realised if this tendency for patients to default to their GP continued. The project team acknowledged, and were committed to exploring, the role that

patient awareness and understanding might play. Webster et al. (2008) reported a number of studies exploring public perceptions of physiotherapy from Canada, Australia and Singapore with each reporting a lack of public awareness. Their own empirical research confirmed poor patient knowledge with less than 5 per cent of patients reporting themselves as very knowledgeable about self-referral physiotherapy. There was little other previous research exploring public understanding of physiotherapy and none pertaining to FPCP.

The wider evidence was consistent with this research in that understanding of the clinical application of physiotherapy practice was poor (Ogiwara and Nozoe, 2005; Dissanayaka and Banneheka, 2014). Shoemaker (2012) concurred with this perception, stating that physiotherapy was not well known to the public. However, this perception was somewhat contradicted by Webster et al. (2008) who described a report by the CSP, as early as 2004/5, revealing 88 per cent of respondents, to a public poll, were supportive of self-referral to physiotherapy. Evidence from non-physiotherapy literature suggested a lack of understanding of roles had the potential to undermine service (Pullon et al., 2011: 128).

2.8 – First point of contact physiotherapy: jurisdictional conflict

Most patients with MSDs saw their GP as a FPC. As such, the FPCP initiative was encroaching into the traditional jurisdiction of GPs. The sociology literature suggested that jurisdictional tensions might arise as a consequence of this (Abbott, 1988).The following section explores the interprofessional rhetoric around the FPCP professional project and the techniques and strategies used by the physiotherapy and medical professions at the time. Evidence was considered from the wider healthcare literature that related to jurisdictional disputes and the influence on service innovation and implementation.

2.8.1 – Interprofessional rhetoric

A significant amount of interprofessional rhetoric, surrounding FPCP, was evident. Towards the end of 2015 the term first contact physiotherapy began to replace the more traditional term of self-referral. The first sign of this shift appears to have

been the Swedish evaluation of physiotherapists as 'primary assessors' of patients with MSDs (Ludvigsson and Enthoven, 2012). UK evidence emerged, via vanguard sites, at a time when NHS England were advocating multidisciplinarity in what they described as multispecialty community providers (MCPs) in the Five Year Forward View (NHS England, 2014).

The CSP campaigned to increase awareness of the FPCP initiative with Karen Middleton, Chief Executive of the CSP, embarking on a programme of profile-raising. This campaign targeted the physiotherapy membership itself (CSP, 2016), the GP workforce and the wider public (Middleton, 2015; 2016; BBC, 2016). The immediate response to this initiative, from the medical profession was to express their concerns in terms of risk to patient safety and the practicalities of delivering this type of service (Chan, 2015; BBC, 2016). The honorary treasurer of the Royal College of General Practitioners (RCGP), at the time, suggested FPCP could *"have the unintended consequence of swamping physiotherapy services and putting patients at risk"* (Bley Griffiths, 2015). The RCGP also used evidence from previous self-referral schemes that were overwhelmed with referrals and subsequently failed, leaving GPs to pick up the pieces (Bley Griffiths, 2015).

The first empirical data that aligned with the project and made explicit reference to the term FPCP was published in the same year (Goodwin and Hendrick, 2016) with a further piece exploring the challenges of implementing FPCP (Moffatt, Goodwin, and Hendrick, 2018). These evaluations corroborated the previous self-referral evidence, and demonstrated that FPCP was safe and efficacious. Furthermore, FPCP appealed to staff groups and patients. In addition there was tentative evidence to suggest that FPCP had potential positive financial implications to the health economy (Goodwin and Hendrick, 2016).

Evidence of physiotherapy's attempt to secure state support came in the form of direct CSP representation to the House of Commons, Health Select Committee in 2016 (House of Commons Health Committee, 2016). The Health Select Committee concluded that *"self-referral to physiotherapy…into general practice teams should be enabled and accelerated"* (House of Commons Health Committee, 2016: 33). With regards to attaining this objective it was recommended

that Nursing, Pharmacy and Physiotherapy *"urgently review…training curriculums with a view to increasing the exposure to primary care for healthcare professionals in training"* (House of Commons Health Committee, 2016: 48).

The sociology literature demonstrated that, to professionalise, state support was required (Freidson, 1970; Johnson, 1972; Larson, 1977). There were clear signs of the CSP attempting to secure support of the government as part of the FPCP initiative. The effectiveness of this strategy was evident in the reference made to allied health professionals in the Five Year Forward View (NHS England, 2014), and the GP Forward View (NHS England, 2016a). This government commitment accelerated with more explicit reference to FPCP in the NHS Long Term Plan (NHS England 2019). Reference was also made to the associated, ongoing pilot project of FPCP that was commissioned throughout England in the autumn of 2018. There was emphasis on *"creating genuinely integrated teams of GPs, community health and social care staff"* (NHS England, 2019: 6) and making general practice less doctor-centric.

However, a brief, non-systematic review of the popular national press revealed a continued predominance of doctor related rhetoric. Throughout the time period where physiotherapy was championing FPCP there was a parallel narrative related to GP workforce shortages. The primacy, and dominance, of the medical profession was evident in the traction this narrative consistently gained in mainstream national press.

A recent review (Barry and Greenhalgh, 2019) identified 403 newspaper articles between late October 2016 and early October 2017 making reference to GPs. In summary, they suggested a predominance of these articles attributed the crisis in general practice as being the responsibility of GPs themselves. They suggested that this could account for the falling rates of GP recruitment and public opinion. The authors acknowledged the limitations inherent in making an association between the press narrative and the opinions of the general public (Barry and Greenhalgh, 2019: 1). No mention was made of the access to such a widespread media platform afforded to the medical profession and the power inherent, therein. Without a doubt such access was beyond the realms of any other

healthcare professional group. In a time of clickbait (Bazaco, Redondo and Sánchez-García, 2019) and the power of headlines, at the expense of content, it would be interesting to see if these articles had, indeed, influenced public perception in the way they described.

The political commitment to multidisciplinarity evident in the political policy could be indicative of a challenge to the medical hierarchy. Medicine is the dominant healthcare profession and the FPCP initiative could be interpreted as challenging this position. The following section will briefly consider the concept of medical dominance.

2.8.2 – Medical dominance

Dominance of the medical profession has been widely discussed and written about and it is only briefly considered here. Starr (1982) provided a definition, articulated as the power of doctors to control the actions of others, deriving from their medical knowledge, and subsequently controlling them through commands and authority. Coburn (2006) suggested the principle stimulant and enduring interest in the sociological analysis of the medical profession was due to the seminal work of Freidson (1970). For Freidson professional dominance implied a control, by medicine, over the content of their own work, the work of other occupations and the concurrent patronage of the state and the public (1970). However, it was also asserted that the nature of medicine's work, so fundamental throughout the lives of the population, provided the profession with a platform for unrivalled dominance. Nevertheless, medicine has not been exempt from the pressures of healthcare reform. As the government sought to distance itself from direct control an opportunity arose for the development of professional organisations (Johnson, 1995). The so called para-medical professions sought to professionalise alongside medicine. As well as physiotherapy, other professions such as ophthalmic opticians, radiographers, chiropodists and occupational therapists were similarly engaged in their own professional projects (Larkin, 1983).

Physiotherapy's challenge to medicine was evident throughout the twentieth century. Physiotherapists were gradually, but systematically, absorbed into hospitals from 1914 (Larkin, 1983) and with the nationalisation of health service in 1948 physiotherapy further sought to establish its own autonomy. Physiotherapy's autonomy slowly increased through steps such as state registration (1960) and direct referral (1977). However, according to Larkin (1983) those occupations that pursued autonomy failed to *"attain the fundamental autonomy characteristic of doctors"* (Larkin, 1983: 184). This suggests a hierarchy in the medical division of labour and also a market susceptible to challenge and change (Abbott, 1988). Although this fluidity, and boundary flexibility, of the medical division of labour was evident in the mobility of occupational groups it only exemplified the hierarchical organising principles of the division of labour without the dominant group losing power (Larkin, 1983).

The neoliberal reforms of the 1980s further tested the a priori dominance of medicine. The emphasis on controlling rising costs, associated with health care, and the paralleled increase in medical regulation challenged their dominance (Allsop, 2006). This repeatedly raised the question as to whether medical dominance had decreased alongside these changes. Allsop (2006) stated that despite many attempts to evaluate the changes in medical dominance there was no consensus and concluded that despite managerial and bureaucratic controls medical dominance had transformed rather than declined.

It would appear, throughout this period of challenge that medicine has managed to maintain its control over medical knowledge and its influence over government objectives. As Johnson (1995) stated, the alliance between profession and state is so entangled that each must manoeuvre carefully so as to not damage their own interests. The government has been fearful to disregard medical knowledge, and abandon medical authority, and some suggest medicalisation of healthcare, and medical dominance, has increased in line with neoliberalism (Benoit et al., 2010). Furthermore, despite the cases where doctors have caused harm or death to their patients public trust in doctors remained high (Allsop, 2006). This contradicts the recent work by Barry and Greenhalgh (2019), described above. It

would appear that medical dominance has been challenged but the concept remains important and particularly relevant to studies of interdisciplinary practice.

Dominance of the medical profession continued to act as a barrier to the professional projects of other professions. Wranik and Haydt (2018) explored various financial models associated with the implementation of interdisciplinary teams in primary care. Although this research was situated in Canada the primary care reform described, and the move to interdisciplinarity, mirrors the reforms in UK health policy. The authors concluded that the unique position of the medical profession negatively affected interdisciplinary work (Wranik and Haydt, 2018). Their findings were consistent with previous studies which demonstrated medical dominance hindered the development of other health care professions and could lead to interprofessional conflict and this was clearly counterproductive to interdisciplinary objectives (Wranik and Haydt, 2018).

Having briefly considered medical dominance the following section builds on the acknowledgement that this dominance can both hinder interdisciplinary working- clearly a feature inherent in the FPCP project- and lead to interprofessional conflict.

2.8.3 – Interdisciplinary conflict

There was some novelty in the provision of FPCP as an alternative to GP care for MSDs; that is as a FPC for the patient. It offered an alternative to the traditional model of management of MSDs in primary care – that of GPs as the FPC. As such, FPCP challenged both the a priori dominance of medicine, the traditional professional boundaries located in general practice and required role flexibility.

Evidence suggested that role flexibility challenged established hierarchies and this could lead to disputes around interprofessional role boundary jurisdiction (King et al., 2015; Ferlie et al., 2005; Borthwick et al., 2015; Timmons, 2011; van Bochove et al., 2018). Furthermore, this could hinder innovation implementation (Ferlie et al., 2005). Where interdisciplinary working had been attempted there was evidence of professionals adopting strategies such as “discrediting, problematising and ignoring competitor professions” (van Bochove et al., 2018: 396).

In their work exploring the mediating role of the professions in the non-spread of innovations, Ferlie et al. (2005) suggested that high professionalisation inhibited the diffusion of innovation. They suggested that complex organisational systems frequently involved different professional groups with their own distinct communities of practice and these distinct professional parameters retarded the spread of innovations. In such environments, professional groups created their own strong social and cognitive/epistemological boundaries, which were difficult to influence from outside that professional group (Ferlie et al., 2005).

Ferlie et al. (2005) went on to suggest that where the barriers were overcome, it was through social interaction, trust and motivation. More often than not the propensity was to 'default' to uni-professional silos. There was challenge, debate and dispute where social and epistemological paradigms collided. As such, they advocated paying attention to the boundaries between professional groups, (Ferlie et al., 2005).

King et al. (2015) explored contested role boundaries and identified some common strategies that underpinned boundary disputes such as the positive self-narrative from the incumbent professions with respect to their own competence, training and expertise. Equally, professions seeking to increase their jurisdiction made claims of similarity in practice and made reference to the evidence supporting their agenda. A common theme that they derived from the literature was attempts to discredit the competing profession, based on their general approach, the clinical skills or competence (King et al., 2015).

Similar findings and were reported elsewhere and attempts to develop an interdisciplinary acute pain services were hindered by professional boundaries and subsequent interprofessional tensions (Powell and Davies, 2012). This qualitative evaluation of acute pain services extended the professional project model (Larson, 1977), suggesting is was not solely about acquiring new jurisdictions but also resisting new areas of work (Powell and Davies, 2012). They also demonstrated that some of the subordinate profession's concerns were around their own ability to assume the new roles. Indeed, some of the sentiments expressed were less about extended roles and power and more about professional and individual weaknesses

and anxieties. The authors suggested these concerns arose as a consequence of having worked in environments where support was not forthcoming leaving the individuals with a sense of vulnerability. Unsurprisingly, when this was combined with a dominant profession resistance to change, it resulted in the non-realisation of boundary spanning roles.

Niezen and Mathijssen (2014) reinforced the potentiality of professional boundaries hampering task reallocation. They discovered that a feature that limited boundary spanning role development was the sense of responsibility that the doctors had for the roles that they previously 'owned'. Their reservations about the qualifications of nurses, when combined with this sense of responsibility for roles within their jurisdiction, resulted in a resistance to 'let go' of them. Doctors felt the nurses' education was generally inadequate and there was a subsequent lack of trust in the nurses' ability to provide good patient care. This reinforced the sociological principle whereby a profession is required to demonstrate its credentialed status (Wilensky, 1964, Freidson, 1970). Consistent with previous literature their findings this reinforced the medical profession's resistance to boundary encroachment and the transfer of medical knowledge.

Nancarrow and Borthwick (2005) also examined dynamic boundaries in the healthcare workforce. They constructed a framework that described four directions of change for established workforces: diversification, specialisation, vertical and horizontal substitution. This framework arose from an earlier examination of the impact of intermediate care on the role boundaries of service providers where joined up, flexible, seamless, interdisciplinary team working was seen as fundamental (Nancarrow, 2004). According to this classification, diversification and specialisation involved the expansion of professional boundaries within the profession itself while vertical and horizontal substitution involved the movement of boundaries inter-professionally, with one profession taking on tasks normally performed by another profession. Vertical substitution possibly involves the most radical workforce transformation and the authors state that the extent of any role substitution is traditionally controlled by the dominant profession. As they state, *"[h]istorically in the UK at least, the medical profession has had the power to*

determine the scope of practice of other groups" (Nancarrow and Borthwick, 2005: 910).

The marketisation of healthcare challenged traditional medical dominance although there was no evidence to suggest a major decline in medical power. Furthermore, recent analyses using broader organisational and institutional models reinforced the flexibility of the elite professions as key in the organisation of institutional work (Suddaby and Viale, 2011; Currie et al., 2012; Martin et al., 2015). It appeared that despite the changing environment the professional elite had adapted to leave *"professional institutional arrangements relatively untouched, and in some cases [it] even enhances the social position of the professional elite"* (Currie et al., 2012: 957).

The FPCP project appeared to satisfy all of Nancarrow and Borthwick's (2012) professional boundary work. Within the profession of physiotherapy there is evidence of both diversification and specialisation with the assumption of advanced/extended roles of practice such as non-medical prescribing and the administration of soft-tissue and joint injections. Furthermore, by pursuing the role of FPC practitioner, physiotherapy is substituting both horizontally and vertically. While physiotherapy had attained the prime-non-doctor-provider position for MSDs in the NHS there are many other 'horizontally' associated professions providing care for people with MSDs in primary care. While there are some osteopaths and chiropractors within the NHS the majority remain outside, in private healthcare. Furthermore, there are approximately 3,000 private physiotherapists in the UK (Physio First, 2019). FPCP was also, quite clearly, an example of vertical substitution in that it is encroaching into traditional GP jurisdiction.

Physiotherapy satisfied Nancarrow and Borthwick's (2012) criteria through its identification of a new market – that of FPCP, as an alternative to the default position of the GP. It has envisaged a new way of delivering existing physiotherapy practice by situating services within GP practices. It has introduced the potential for new types of practice such as medication prescribing and injection therapy. Finally, as discussed, physiotherapy had changed the nature of the discourse from self-referral to, predominantly, FPCP.

The majority of the boundary dispute, and conflict, research pertains to the professions of medicine and nursing (Adamson and Kenny, 1993; Adamson et al., 1995; Churchman and Doherty, 2010; Powell and Davis, 2012). There is similar evidence amongst medicine and non-nursing healthcare practitioners (Bacon and Borthwick, 2013, Borthwick et al., 2015, Borthwick et al., 2010; Timmons, 2011). The significance of these disputes is not just of theoretical interest to the sociology of the professions. There are important practical considerations as these disputes have the potential to impact service implementation and, by association, patient care (Powell and Davies, 2012).

The following lengthy quotation from Niezen and Mathijssen (2014: 166) demonstrates the complexity in new role development in healthcare.

> *"[I]nnovation…is not a linear process. One should expect that the implementation of new professional roles or the extending of existing roles requires changing the system at various levels, ranging from the individual level and the professional communities to the organisational environment and its outer context, the institutional environment. In other words, the introduction [of new roles] in healthcare not only requires organizational redesign, but also the reframing of professionalism and professional boundaries at the multiple layers of the healthcare system"*

The background literature reviewed in this chapter, summarised above in the quotation by Niezen and Mathijssen (2014), provided justification for the research that follows. The evidence demonstrated that physiotherapy, as an occupation, had embarked, over the last century on a professional project. Like all professions the maintenance of this professional status has required continual evaluation, adaptability and evolution. A number of contemporaneous circumstances, or decalages (Elden, 2017), afforded physiotherapy the opportunity to repeatedly reinvigorate its professional project (Martin et al., 2015). The latest iteration of this professionalisation is evident in the FPCP initiative. The evidence demonstrated that healthcare systems are complex, with actors at all levels of society permeating across fields from organisations to institutions (Suddaby and Viale, 2011; Currie et al., 2012; Martin et al., 2015).

The following research explored FPCP, as a professional project, and the impact this project had on the main stakeholders and the subsequent effects their responses had on FPCP implementation. The likelihood of continued challenge and change in the UK NHS is inevitable. The hope is that the findings of this research can be applied beyond the FPCP initiative to inform future innovations.

Chapter 3 – Methods

3.1 – Introduction

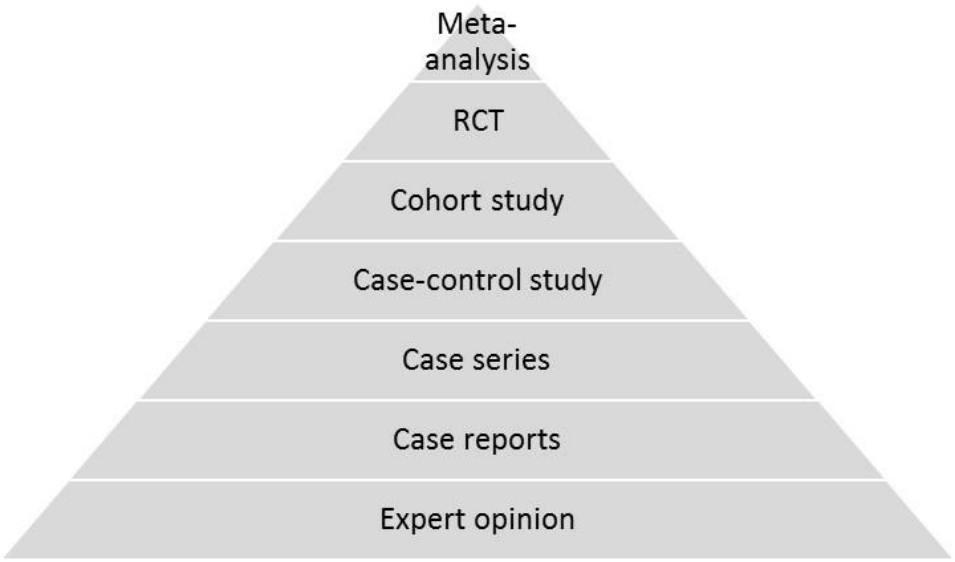
The previous chapter outlined the literature relevant to this research project. This chapter outlines the realist methodological underpinning for the investigations that follow. Initially, the importance of undertaking this process is outlined and justification for the chosen methodology is made through a brief critique of the prevailing positivist research paradigm. The antecedent philosophical paradigm of critical realism (CR) (Bhaskar, 1975) is then reviewed. Finally, the fundamental concepts of realist approaches are considered, defining both realist synthesis/ review (Pawson, 2006) and evaluation (Pawson and Tilley, 1997; Pawson, 2013). The important constituent components of realist approaches are outlined and finally the limitations of realist approaches are considered.

Deciding on, and expressing, the chosen methodology and its philosophical underpinnings are recommended as an essential component in any research project design (Wilson and McCormack, 2006). Doing so provides rigour to the research project and transparency to the reader (Appleton and King, 2002). Nonetheless, evidence suggests that this clarity is often absent, providing little for the reader to judge for consistency between philosophical commitment and chosen methodology (Wilson and McCormack, 2006, Lipscomb, 2008).

Traditionally, research within a healthcare environment has focused on whether an intervention works or not (Brush and Halperin, 2016; Greenhalgh, Howick and Maskrey, 2014; Kerry 2017; Marchal et al. 2013). As a consequence the philosophical paradigm that has predominated has been positivist (Goldenberg, 2006). Within this paradigm an association has been made between cause and effect along the lines of a Humean model of causation (Marchal et al. 2013; Kerry, 2017).

This paradigm has also dominated the world of physiotherapy research (Kerry, 2017) and remains the mainstay of health services research (Craig et al., 2008, Greenhalgh, Thorne and Malterud, 2018) preserving its position atop the EBM hierarchy (Djulbegovic and Guyatt, 2017), see figure 3.1.

Figure 3. 1: The evidence-based movement programme pyramid of evidence, from Djulbegovic and Guyatt, 2017: 417.



However, repeatedly the outcomes from research within the positivist paradigm have failed to transfer out of the laboratory and into the real world (Greenhalgh, Howick and Maskrey, 2014; Fava et al. 2015, Deaton and Cartwright, 2018, Subramanian, Kim, and Christakis, 2018, Horton, Illingworth and Warburton, 2018). This is attributed to the complexity of the real world that the interventions are implemented in to (Plsek and Greenhalgh, 2001; Greenhalgh and Papoutsi, 2018).

The real world is complex with multiple agents, with multiple motivations, decisions and actions situated in a multiple contexts. With this complexity in mind it is unsurprising that there has been a *"mismatch between the 'patient in the guideline' and the 'patient in the bed'"* (Greenhalgh and Papoutsi, 2018: 95). For example, the empirical evidence from a closely controlled trial that demonstrated exercise was efficacious in the management of knee pain was likely to be less certain in a context where patient access to physiotherapy and necessary resources was limited. It was clear from the conception of this project that the investigation

was exploring far more than a simple intervention. Indeed, if physiotherapy offered a 'treatment intervention' then it sat within the 'healthcare programme' of FPCP which itself sat within a 'healthcare service' delivery. The research conformed to the explanation of a complex service intervention (Pawson et al. 2005; Wong et al., 2016) fulfilling all seven criteria thereof (Pawson et al., 2005).

The overarching questions that this research project sought to answer were:

- If FPCP constituted a professional project what are the reactions and responses of the multiple stakeholders to this, why are their reactions constructed as such, how are they articulated, in what circumstances and how do they influence operationalisation?

- Were there any lessons that could be taken from the investigation with regards to the design, implementation and utilisation of FPCP that could provide transferable lessons for future practice?

This investigation did not seek to investigate whether the treatment approaches, provided by physiotherapists, working in FPCP services brought about improvements in patients' health. There was evidence for the efficacy of physiotherapy for MSDs as described in chapter 2. The focus of interest was the implications of the FPCP initiative on the multiple associated stakeholders situated in primary care. What did these stakeholders know about the FPCP initiative – what were their interpretations of the initiative and how did this subsequently make them feel and behave? The outcome of the FPCP initiative was seen to be dependent of the *"reasoning and volition"* (Astbury and Leeuw, 2010: 370) of these actors who had the capacity, based on their interpretations, to make things happen. It is people who choose to make programmes work but this is influenced by their respective context (Pawson and Tilley, 1994).

When considering the research questions it was clear that any model of FPCP service sat within a maelstrom of complexity. As such, it was apparent that an alternative research paradigm, to the prevailing positivist approach, was required.

An approach was required that sought to adequately interrogate the research question and uncover the choices and subsequent behaviours of the actors integral to the FPCP initiative. The alternative was found in the application of realist methodologies (Pawson and Tilley, 1997). There appeared a consensus that realist approaches had their roots in the philosophy of CR (Pawson and Tilley, 1997; Pawson, 2013; Rycroft-Malone et al., 2012) and as such, a brief introduction to CR follows.

3.2 – Critical Realism

The term CR has been applied to the work of a number of philosophers, perhaps the most prominent and influential of those being the Indo-British philosopher Roy Bhaskar (1944–2014). Nevertheless, it is acknowledged that Bhaskar was not alone in the development of CR (Maxwell, 2012). CR was Bhaskar's response to his frustration with the constrictive limitations of the, pre-eminent, positivism that had *"usurped the title of science"* (Bhaskar, 1975, p xxix). Bhaskar's overarching objective was to resituate ontology that, he felt, had been lost, and in doing so argue for a unity of method in the natural and social sciences (Cruikshank, 2004). As such, it is from Bhaskar's work on original CR that the philosophical underpinnings for this project, and realist approaches, are drawn. CR is a heterogeneous series of philosophical positions (Archer et al., 2016) and, although there are a pool of scholars to draw from (Bhaskar, 1975, 1979, 2016 Archer, 1982, Archer et al. 2013; Collier, 1994, Gorski, 2013) there is no single framework. As such: *"Critical realism is much more like a series of family resemblances in which there are various commonalities that exist between the members of a family"* (Archer et al., 2016: 4).

The first commitment of critical realism was to a realist ontology. Primarily, and contrary to the veiled, contradictory, implicit realism of positivism and constructivism, Bhaskar was explicit about his emphasis on a real-world ontology. He demonstrated the shortcomings inherent in the epistemic fallacy and argued that all knowledge had, in advance, some form of realism. According to Bhaskar, critical realists and realist methodologists, a real world exists independent of our knowledge of it.

Bhaskar conceived three layers of reality in his stratified ontology (Table 3.1): the actual, the real and the empirical. The domain of the real consists of all of the entities that exist in the world including, importantly, all of the causal mechanisms – both exercised and unexercised. The domain of the actual consists of those mechanisms exercised resulting in events actualised whether these events are observed or not. The domain of the empirical consists of those events actualised, experienced and observed – events understood through human evaluation (Bhaskar, 1975, 1979; Fletcher, 2017).

Table 3. 1 Stratified ontology from Bhaskar, 1975.

	Domain of the Real	**Domain of the Actual**	**Domain of the Empirical**
Mechanisms	✓		
Events	✓	✓	
Experiences	✓	✓	✓

Through this model Bhaskar moved from the successionist view of causation, which underpinned positivism (Pawson et al., 2005) whereby cause (X) leads to effect (Y), to a generative model of causality. Within this model of causation, to infer a causal outcome (O) between two events (X and Y), one needs to understand the underlying mechanism (M) that connects them and the context (C) in which the relationship occurs. The item(s) of interest are those mechanisms (M) that connect the events (X and Y) (Pawson et al., 2005, Byng, Norman and Redfern, 2005).

These causal mechanisms are the interest of science and, indeed, these causal mechanisms may exist exercised, unexercised or exercised but unrealised. That is not to say the unexercised or unrealised mechanisms are any less real. This proposition allows for the much deeper, and richer, explanation of reality that is seen in Bhaskar's stratified ontological model (Bhaskar 1975).

Bhaskar was committed to the real nature of the world and the independence of these objects of knowledge (the 'intransitive objects of knowledge') (Bhaskar, 1975). Within this body of intransitive objects are the causal mechanisms contained within the domain of the real. These mechanisms may challenge the usual conception of 'things' and may be powers, forces, characteristics, reasoning or relationships.

Critical realism's second commitment was to a relativist epistemology. CR acknowledged the social construction of science. Therefore, the outputs of scientific investigation are theories about the nature of the world. These theories are considered the 'transitive objects of knowledge'. These theories can be shown to be fallible, leading to revised theories and deepening understanding, they can coexist and they are situated historically. The objective of this research was to illuminate the 'real' characteristics, reasoning, relationships and interpretations that stakeholders constructed, socially, with regards to the FPCP initiative. These insights, which focused on the generative mechanisms that influenced stakeholder choice-making when exposed to the FPCP initiative, would lead to new knowledge that would inform future practice developments.

The final pillar of CR is that of judgement making. The propositions put forward by CR, through epistemic relativism, acknowledge that human beings produce knowledge, that knowledge is historically positioned and can change over time; earlier knowledge can be shown to be mistaken (Collier, 1994). Despite this Bhaskar does not *"commit it to judgmental relativism, i.e. the idea that all beliefs are equally valid in the sense that there are no rational grounds preferring one to the other"* (Collier 1994: 90). Critical realists attest that it is possible to rationally judge between competing theories. As such, the third pillar of CR, indeed the criticality within CR, is that of judgmental rationality.

Of particular importance in the application of the critical realist philosophy was the intrinsic 'open' nature of society. Not only did this make the empirical regularity approach to causation inapplicable, it committed science to the development of theories that must be explanatory and non-predictive.

By laying out the fundamental, underlying principles of CR, justification for this philosophical approach has been made. It could be argued that CR does indeed provide an *"Enlightened Common Sense"* (Bhaskar, 2016). Critical realism, positioned as it is in the middle ground between positivism and constructivism, *"appeals to a wide audience as it relates to how many of us think about the world"* (Williams, 2017: 2). As such, the practical application of CR has been embraced in a range of disciplines, particularly where the research acknowledges the complexities of the social world. The use of CR, as a philosophical underpinning to research activity, can be seen in design and management, organisational studies, social science and economics (Houston, 2001, Hodgkinson and Starkey, 2012, Fleetwood and Ackroyd, 2004, Connelly 2001) but an historical paucity of CR has been described in the health sciences (Williams, 2017).

FPCP was clearly implemented into open, complex, active social systems. As such, the success, or otherwise, of the provision of FPCP is influenced by, and has influence on, dynamic actors (healthcare professionals, patients, managers, commissioners) whose reasoning influences whether the programme works. The evaluation of such a multipart social system required a philosophical approach that embraced, rather than negated, such complexity. Furthermore, it required an approach that was committed to explanations of the rich causal mechanism tapestry in these systems and it appeared that CR satisfied these requirements.

Some suggested that while CR promised much there remained a gap between the philosophical justification and guidance as to how the philosophy can be applied in practice (Williams, 2017). Indeed Yeung (1997) described CR as a philosophy in search of a method. Williams (2017) suggested that realist approaches provided bridge between philosophy and practice.

3.3 – Realist research approaches

Realist approaches provide the link between philosophy and practice while, at the same time, addressing the issues of complexity and providing outcomes that are transferable and subsequently useful (Wong, 2018: 2018a). Realist approaches go

beyond the question of what works to ask 'what works, for whom, in what contexts, to what extent, how and why?' (Wong et al., 2013; Wong et al., 2016). This is achieved through an investigative emphasis on mechanisms that exert their influence, in various contexts, leading to particular outcomes. For the realist researcher this is represented through the illustrative heuristic of the context + mechanism = outcome (CMO) configuration (Pawson and Tilley, 1997).

FPCP was considered a complex programme implemented within a complex social system. Understanding the professional project that was FPCP and the consequences of its implementation went beyond the question of whether it worked or not. FPCP was clearly a complex programme, providing assessment and treatment for a range of MSDs to a wide cross-section of people, with a wide range of expectations and requirements, set a wide variety of clinical environments with diverse arrangements of clinical and nonclinical staff and delivered in an assortment of geographical locations. The argument had been made elsewhere for the applicability of realist approaches to the investigation of complex interventions (Fletcher et al., 2016; Lamont et al., 2016; Shearn et al., 2017). The most recent UK Medical Research Council (MRC) framework placed an increased emphasis on evaluation and theory development to understand causal mechanisms (Craig et al., 2008, Fletcher et al., 2016). Indeed, Craig and Petticrew (2013) suggested approaches such as realist evaluation could become routine with Fletcher et al. (2016) providing evidence of realist approaches being used across all phases of the MRC framework.

The realist researcher has two methods at their disposal; the realist review, or synthesis (Pawson, 2006), terms that are synonymous, and the realist evaluation (Pawson and Tilley, 1997; Pawson, 2013).

Realist review/synthesis is the application of a theory driven approach to the synthesis of published evidence. This evidence could take the form of any number of documents ranging from policy documents through to empirical studies and even editorials or letters.

Realist evaluation is a theory driven approach to the assessment of primary data collected by the evaluator themselves.

The realist reviewer and/or evaluator has access to reporting and quality standards and training materials (Wong et al., 2013; Wong et al., 2013a; Wong et al., 2014; Wong et al., 2014a; Wong et al., 2016). The transferability of the outcomes from realist approaches lie in the claims that the researcher is able to make with regard to those generative mechanisms exposed through the course of the review/evaluation (Wong, 2018). These claims are, in and of themselves, theories. Quite clearly a consistent theme between CR and realist approaches is that of the primacy of theory. The central role of theory is considered.

3.4 – The importance of theory

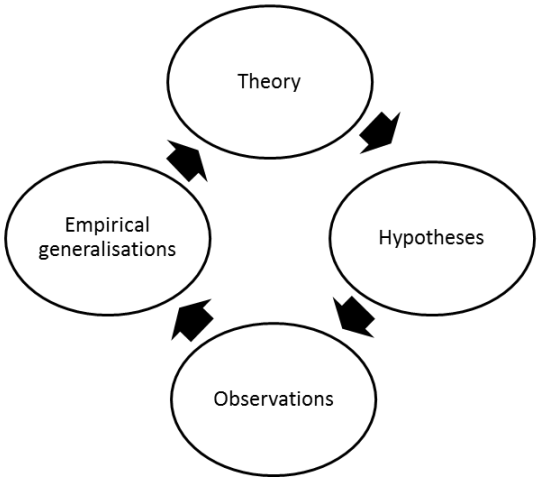
The objects of interest to the realist evaluator are social programmes (Pawson and Tilley, 1997, Pawson et al., 2005, Pawson, 2013). Social programmes are, in and of themselves, social systems, consisting as they do of multiple actors, institutions and structures. However, they are a subsystem of the overall social system in which they sit. Without a doubt, the implementation of FPCP, in general practice, was seen as a healthcare/social programme. It was also evident how wider social systems influenced this program. For example, the state of UK financial austerity acted as a driver for FPCP (NHS England, 2014; Goodwin and Hendrick, 2016) Furthermore, corollary impacts of FPCP can be hypothesised. An example might be the added burden placed on administrative staff through the assumption of additional responsibilities and the impact this may have, both emotionally and practically in the way this new role changes how they execute their pre-existing duties. As such, a methodology that attempted to explore such complexities was both applicable and desirable.

The realist approach advocates that the social programmes under investigation, were *"theories incarnate"* (Pawson, 2006: 25). Preceding any intervention is the implementers' conception, or theory, of how that intervention will elicit change. The perception being there are problems within the existing social

system which the intervention can right (Pawson, 2006, 2013). Consequently, all realist work is 'theory driven'. Pawson and Tilley (1997) attribute the conception of this notion to Chen (1990). Chen and Rossi (1983) and Chen (1990) attempted to look beyond what 'works' to why it works; i.e. all the theoretical assumptions that underpin the initiative responsible for the change it brings about (Byng, Norman and Redfern, 2005; Marchal, Dedzo and Kegels, 2010). Of course, in the real world the intended objective of the intervention may not be realised. Therefore, the realist evaluator needs to have, not only an awareness of the initial theory but the vision to imagine competing theories that may stall the intended goal.

The unit of analysis in realist evaluation is programme theory – the proposed theory, or theories, about what makes an intervention work (Pawson, 2006, 2013). The objective of the realist researcher holds firm to realist philosophy, positioned as it is between experimental empiricism and social constructivism. Rather than aspire for specification or generalisation, realist approaches seek to cumulate knowledge for *"the continual betterment of practice"* (Pawson and Tilley, 1997). For this accumulation to occur programme theories are tested, (retrospectively via realist synthesis/review or prospectively via realist evaluation) and refuted, reinforced and subsequently refined accordingly. The ultimate objective being improvements in the theory. This process adheres, in the main, to the 'wheel of science' (Wallace, 1971) see figure 3.2.

Figure 3. 2: The wheel of science (after Wallace, 1971, in Pawson and Tilley, 1997: 84)



An issue for the realist researcher is what exactly is meant by 'theory' and beyond that at which level of theory the researcher should focus their lens. Therein lies a challenge in that theory has been reimagined and contested throughout the history of social science. Pawson and Tilley (1997) demonstrated this heterogeneity with an extensive list of what theory has been taken to mean, ranging from general orientations, concepts and paradigms to empirical uniformities and regularities via middle range theories. The realist researcher attaches primacy to middle range theory (Pawson and Tilley, 1997, Marchal et al., 2012) proposing that these middle range theories provide the link between abstract theory and data. Merton defines middle range theory as:

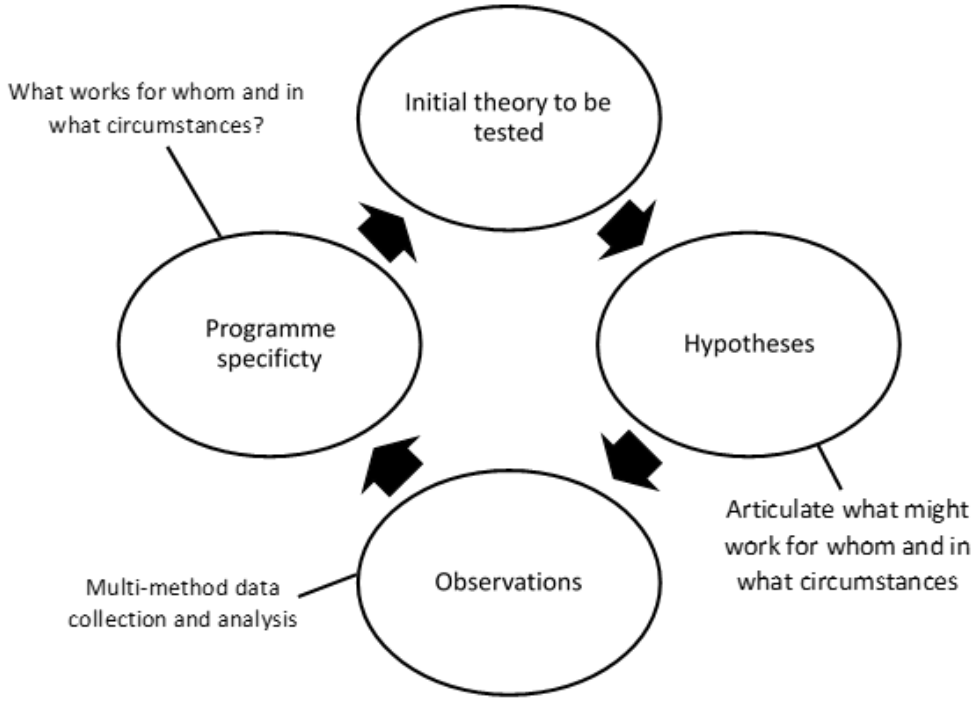
> *Theories that lie between the minor but necessary working hypotheses that evolve in abundance during day-to-day research and the all-inclusive systematic efforts to develop a unified theory that will explain all the observed uniformities of social behaviour, social organisation, and social change.*
>
> Merton, 1949, 448

The challenge in the presence of this heterogeneity, with respect to the concept and definition of 'theory', is exaggerated by the inconsistency in terminology that is found in realist literature. Indeed, Pawson himself appeared to use the terms programme theory and middle range theory interchangeably (Shearn et al., 2017) whereas other authors make a clear distinction between the two (Davidoff et al., 2015) or indeed talk of theory in general terms (Rycroft-Malone, 2012). The issue arising from this inconsistency is that it can become unclear, for the realist researcher, both what terminology to use and indeed the characteristics thereof (Marchal et al., 2012). Despite the apparent inconsistency, and the subsequent confusion it appears to elicit in the literature (Marchal et al., 2012), there is general agreement with respect to two features of theory and theory building – theory can sit at various levels of abstraction and stratification (Pawson and Tilley, 1997, Pawson 2006, Shearn at al., 2017, Marchal et al., 2012).

It is perhaps unsurprising considering the complexity inherent in social systems that there should be some confusion, inconsistency and contradiction in the analysis thereof. Nevertheless, there does appear to be an inclination towards consistency with respect to the application of the realist methodological approach; the theory expressed is tested and refined through the application of realist research approaches. This refined theory is articulated at the level that is sufficiently generalised to be transferable to other settings. For Pawson that is the beauty of Merton's middle range theory- *"[t]he prize here is that we have a tool that permits generalisation"* (Pawson, 2008: 2).

The proposition was that there exists some common thread, or threads, between social programs. These common threads or patterns are described as demi-regularities (Lawson, 1997) and may be extrapolated from empirical work. The final step for the researcher is to abstract these plausible explanations to the level of transferable theory (Marchal et al., 2012). It is not the objective of realist research to produce universal generalisations, more so accumulations of insights that can help inform decision-making. In summary, the theory development process deals in generative causal explanations, the cornerstone of realist explanation, providing an account of the underlying mechanisms that give rise to demi-regularities (Pawson, 2008). For example, an evolving theory might demonstrate the effectiveness of an internet appointment booking system as a method for patients to access an advanced nurse practitioner clinic in general practice. It might be hypothesised that this theory be readily transferred to other, novel initiatives in primary care. As a consequence of this model we have a somewhat modified wheel of science according to the principles of realist methodology (Figure 3.3).

Figure 3. 3: The realist cycle of science (adapted from Pawson and Tilley, 1997)



Pawson and Tillley (1997) outlined the differences, and distinctiveness, of the realist cycle of science. These differences being: the explicit realist framing of the initial theories and the method by which these theories are articulated, the transparent advocacy of methodological plurality and the way that the outcomes are specific to the programme of investigation. The objective is the expression of what works for whom in those specific circumstances, rather than some universal generalisation. That is not to say that the regularities identified are useless. Indeed, the contrary with lessons from one investigation feeding back into theory development which help explain success and failure elsewhere (Pawson and Tilley, 1997: 86).

To expand on the example from above – the effectiveness of the internet appointment booking scheme relies on the GP practice having the specific capacity to establish the system as well as patients having access to the internet. Where these features might have been present in the original evaluation, an alternative rural context with poor internet access might result in dissimilar outcomes. The learning itself is clearly useful but the outcome can be seen to be context specific.

The process of theory building represents no small challenge (Astbury and Leeuw, 2010) but is essential as it provides the starting point for realist research (Wong et al., 2013; Greenhalgh, et al., 2015; Wong et al., 2016). In their attempt to 'unpack the black box' of theory building Astbury and Leeuw (2010) found considerable variation, in terms of complexity, detail, method of representation and terminology used. These findings were replicated in an exploratory review of the literature undertaken by Shearn et al. (2017) who found that on occasions the theory building process was not reported at all and where the process of theory building was reported several different approaches were employed (Shearn et al., 2017).

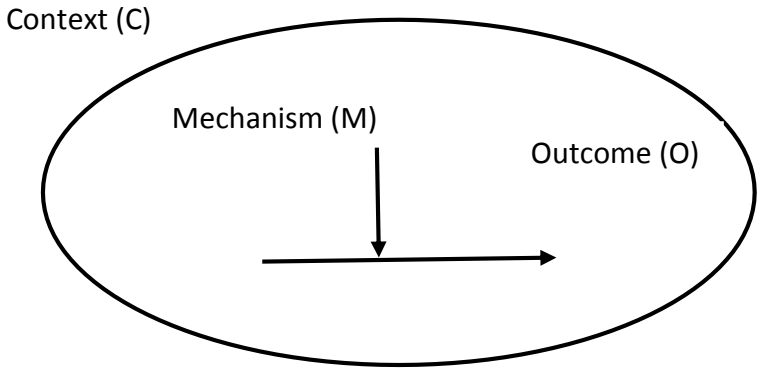
The RAMESES group have produced a number of guidance documents (Wong et al., 2013; Greenhalgh, et al., 2015; Wong et al., 2016) within which there are suggestions for the development of the programme theories– frequently described as initial rough programme theories (Shearn et al., 2017). According to the RAMESES group training materials *"[t]he term 'initial rough theory' refers to the initial sketch of a theory that is used to guide a realist synthesis"* (Wong et al., 2013: 11). They go on to describe processes for the development of initial rough programme theory including the use of published literature and conversations with key stakeholders. Additionally, initial rough programme theories can be drawn from more abstract theories both where these theories are explicit in the programme and/or where these theories have not been referenced by the programme itself (Shearn et al., 2017).

Shearn et al. (2017) outlined a number of issues associated with the development of initial rough programme theories using just previously published literature alone. These included the straightforward and uninformative recycling of what is already known, the generation of an overabundance of potential theories and the unstructured nature of the theories. The RAMESES group suggested that, in response to these challenges, any research should be clearly focused (Wong et al., 2013).

Punton, Vogel and Lloyd (2016) described the application of the realist approach as providing *"a systematic (although certainly not easy) way to examine… programs in a complex environment"* (2016: 9). These challenges have been reported elsewhere (Dalkin et al., 2015, Adams et al., 2015). The challenges inherent in theory development and articulation, combined with the complexity inherent in social programs, inevitably lead to necessary choices. Most realist research could be described as taking a 'pragmatic' (but not pragmatist) orientation to theory development and methods (Wiltshire, 2018).It would appear important that theory development clarity, transparency, alongside this pragmatic approach are essential. Clarity in theory building is often lacking (Shearn et al., 2017, Marchal et al., 2012, Astbury and Leeuw, 2010). The following empirical work attempted to provide clear and transparent explanation of the theory building process.

If the programme theory is the *"unit of analysis"* (Pawson, 2006:36) in realist research then a method of articulating these theories is required. The realist account of causality intends to develop understanding through explanation and according to Pawson (2006) these explanations are configurational. Despite Pawson (2013: 21) describing them as the "most unlovely term in realist terminology" these descriptions take the arrangement of context, mechanism, outcome configurations – CMO configurations. Principally, a CMO is a proposition that a "*program works (O) because of the action of some underlying mechanisms (M), in particular contexts (C)"* (Pawson 2013: 22), (Figure 3.4).

Figure 3. 4: Basic components of realist causal explanation, from Pawson, 2006: 22



If the objective is the production of refined theories through the application of realist methodologies this is achieved by exploring the relationships between contexts, mechanisms and outcomes (Rycroft-Malone et al., 2012). These three fundamental components of the realist methodological approach are now considered.

3.5 – Context

Each and every intervention, or programme, sits within its own unique context. The characteristics of these contexts cannot be understated with respect to their potential influence on the programme. The relationship between causal powers and their effects is contingent (Sayer, 1997) and context provides that contingency. All social programs are introduced into a set of pre-existing conditions (Pawson, 2013, Coles, 2017). However, as Coles (2017: 2) goes on to state *"[c]ontext is not merely the backdrop to implementation: it interacts, influences, modifies, facilitates or constrains the intervention and its effectiveness"*.

A hypothetical example from the current study; posters used to disseminate information (the mechanism) to increase awareness of FPCP (the outcome) may not be realised when the posters are positioned out of patients' eye line (the context). Another common example given is that of the potential of a match to light but it does so only dependent on the right conditions. (Broadbent, 2008).

Definitions of context include *"all factors that are not part of a… Intervention itself"* (Ovretveit, 2011: i18) or *"the set of characteristics and circumstances or unique factors that surround a particular implementation effort"* (Damschroder et al., 2009: 52). Certainly, within the field of quality improvement the reporting of context is considered fundamental (Coles et al., 2017) and if the realist configuration is represented as an equation, C + M = O, it is clear why; any change in the context clearly influences the outcome.

It might be the active nature of the context that has led to some confusion. Certainly, in their review of published empirical studies in the field of health systems research Marchal et al. (2012: 204) reported *"[a]nother main source of diverging views is the difference between mechanism and… context"*, a finding echoed by Dalkin et al. (2015). Without a doubt the relationship between contextual features and causal mechanisms in any programme theory is highly interwoven (Coles, 2017). The two can become blurred but the interactions between them, and the consequences of these interactions, are fundamental to the programme.

Further complexity can be anticipated when one considers the fluidity of programme theory and the components thereof. To pick up the previous hypothesis; in a general practice that used posters to disseminate information (M), there was an increase in patient awareness of the FPCP (O), this increased patient awareness becomes the context (C^1) for an increased understanding (M^1) of the role of FPCP leading to greater utilisation (O^1). This process has been variously described as a cascading (Jolly and Jolly, 2014) or rippling (Jagosh et al. 2015) of contexts and mechanisms whereby what was a context at one point became a mechanism at a later stage.

Despite the growing interest in context (Coles, 2017) the evidence suggests that the field is still immature and inconsistent (Marchal, 2012, Lau et al., 2015). The task for the realist evaluator is to determine the influence of the pre-existing contexts on the causal mechanisms inherent in the programme.

3.6 – Mechanisms

The variability and inconsistency evident with respect to contexts extends to the conception and articulation of mechanisms. This may be surprising in that mechanisms are the most characteristic feature of realist causal research (Pawson, 2013). Indeed, for Bhaskar (1975: 6) the *"aim of science is the production of the knowledge of the mechanisms of the production of phenomena"*.

Alongside his publications on social theory, Robert Merton is attributed with foregrounding the importance of social mechanisms in understanding the social world (Hedström and Swedberg, 1998). Astbury and Leeuw (2010) described a large and growing body of literature on mechanisms. They attributed this interest to *"the notion that identifying the mechanisms that link cause and effect relations is crucial for the development of deeper and more fine-grained explanations of social phenomena"* (Astbury and Leeuw, 2010: 363). An unpleasant corollary of this interest is the confusion that surrounds what mechanisms are (Mayntz, 2004: 238). There is a vast amount of literature relating to mechanisms but in the context of this work the point of reference will be literature relating to the application of mechanisms via a realist approach.

Pawson and Tilley used a number of descriptions for mechanisms ranging from 'agents of change', 'the interconnections that explain the rhythms and associations of systems' and 'the engines of explanation' (Pawson and Tilley 1997, Pawson 2006, 2013). They also use terms consistent with those seen in CR, such as 'emergent' and generative'. In essence for Pawson, mechanisms *"describe how the resources embedded in the program influence the reasoning and ultimately the behaviour of the programme subjects"* (Pawson 2013: 115). This distinction between mechanism-resources and mechanism-reasoning is consistent with their original, seminal text (Pawson and Tilley, 1997) where reference was made to stakeholder choices (reasoning) in response to the programme capacity (resources). Despite this distinction the disaggregation of mechanism-resources and mechanism-reasonings has been little referred to (Dalkin et al., 2015). Dalkin et al. (2015) made the case for the explicit division of the two, arguing that any programme introduces resources (mechanism-resources) into a specific context (C) which impact participant reasoning (mechanism-reasoning) which subsequently lead to outcomes (O). This led to a revision in the original formula as such; M (Resources) + C + M (Reasoning) = O (Dalkin et al., 2015). Dalkin et al. (2015) remained consistent with Pawson and Tilley in that they reiterated the coexistence of resources and reasoning (Pawson and Tilley, 1997; Dalkin et al., 2015: 4). As

Pawson and Tilley state, *"they always work in a 'weaving process' which binds resources and reasoning together"* (Pawson and Tilley, 1997: 66).

A number of authors have attempted to synthesise the literature and clarify what is meant by a mechanism. Astbury and Leeuw (2010) identified three key characteristics found consistently amongst an initially confusing morass of descriptions (Astbury and Leeuw, 2010: 367). The three characteristics were; mechanisms were usually hidden, mechanisms were sensitive to variations in context and mechanisms generated outcomes.

Marchal et al. (2012) asked whether realist evaluation was keeping its promise in a review of published studies in health systems research. With specific reference to mechanisms they found that the definition and application thereof was *"another bone of contention"* (Marchal et al., 2012: 203). They found authors defined mechanism in many different ways, although some complied closely with the definition given by Pawson and Tilley others conflated mechanisms with the intervention itself or with context. Lacoutre et al. (2015) undertook a scoping review examining the concept of mechanism from literature using a realist approach. They found considerable variation in the terminology used to describe a mechanism, the idea of the necessary attributes of a mechanism and the referent from which the concept was drawn (Lacoutre et al. 2015). As a consequence of their review Lacoutre et al. (2015) suggested their own definition of a mechanism which they felt built on that of Astbury and Leeuw (2010). Firstly, a mechanism is hidden but real, secondly a mechanism is an element of reasoning and reactions of an agent, or agents, consequent to the resources made available to them and, finally, a mechanism *"evolves within an open space – time and social system of relationships"* (Lacoutre et al., 2015: 8). This final point demonstrates the dynamic nature of a mechanism, having the potential to interact with other mechanisms, with elements of the context or, indeed, with the outcomes it has influenced.

In conclusion there was confusion and inconsistency in the use of the concept of mechanism. However, all three reviews advocated an explicit focus on mechanism derived explanations (Astbury and Leeuw, 2010; Lacoutre et al., 2015;

Marchal et al., 2012). Some confusion was attributed to the relative immaturity of the application of the realist approach and, as such, should be no surprise (Lacoutre et al., 2015, Marchal et al., 2012). The focus on generative causal explanations may counter the trend towards oversimplified linear logic models and may avoid the problem of the non-generalisable, one-off evaluations (Astbury and Leeuw, 2010).

3.7 – Outcome

The final component, and the one often quoted as most easily understood (Dalkin et al., 2015), is that of outcome. Most researchers have an idea of what they hope the programme will achieve. Outcomes are the intended or, at times, unintended changes that arise from the intervention. For an outcome to be realised a mechanism needs to fire and this will be specific to the contextual circumstances. However, contrary to the traditional pre-test/post-test concept of causation these outcomes cannot be expected to be simply replicated (Punton, 2016). Contextual differences and specificities will cause a unique firing of mechanisms resulting in unique outcomes. Whether or not the desired outcome is realised is dependent on the interplay of positive and countervailing mechanisms (Byng, Norman and Redfern, 2005). The task for the realist investigator is to inspect the outcomes against the programme theory with the hope of eliciting some patterns. As Pawson states *"[i]t is the totality of outcomes – successful, unsuccessful, bit of both – that may act as an initial empirical guide for future optimal locations"* (2013: 22).

3.8 – Theoretical and practical limitations in the application of realist approaches

The application of realist approaches has been described as challenging. Indeed, Pawson, in his introduction to realist synthesis, states *"[r]ealist reviews are not for novices"* (Pawson et al. 2004: 38). Punton, Vogel and Lloyd (2016) concurred, describing the application of the realist approach as *"a systematic (although certainly not easy) way to examine… programs in a complex environment"* (2016: 9).

These challenges have been reported elsewhere (Dalkin et al., 2015, Adams et al., 2015).

The challenges of theory development have been described. Another source of challenge has been conception and articulation of CMO configurations (Punton, Vogel and Lloyd, 2016; Dalkin et al. 2015; Adams et al. 2015). A repeated difficulty has been the differentiation of context and mechanism. This is not helped by the ambiguity, and contention, concerning the definitions of mechanism (Astbury, and Leeuw, 2010) and context (Marchal et al., 2012). It is unsurprising, therefore, that researchers may conflate the two and find themselves asking *"is this really a mechanism, or is it a feature of the context affecting the mechanism, or a feature of the intervention itself?"* (Punton, Vogel and Lloyd, 2016: 5).

The application of the theoretical frameworks, make realist's reviews and evaluations a substantial undertaking (Hewitt, Sims and Harris, 2014). Authors advocated allowing sufficient time early in any project to get to grips with the theoretical framework and configure initial programme theories (Hewitt, Sims and Harris, 2014). Adams et al. (2015) suggest researchers choose carefully when to use realist evaluation and select more routine approaches in complex programme areas. The suggestion appears to be that the application of a degree of prudence and indeed, Pawson et al. (2004: 39) state, *"realist review is fundamentally pragmatic, and much can be achieved through the drip, drip, drip of enlightenment"*.

Pawson et al. (2005) returned to this pragmatism, suggesting the researcher be transparent with regards to the limits they impose with respect to the 'territory' they cover, the 'nature and quality' of the information they retrieve and their 'expectations' with regards to findings and recommendations. The necessity for this transparency is reinforced by Wong (2018b). The reflexive anchors, of pragmatism and transparency, were adhered to throughout the research that follows.

3.9 – Summary

The use of realist research methods has increased (Marchal et al., 2012, Pawson, 2013) and Pawson described himself as confident in the continued relevance and sustainability of realist approaches (Emmel et al. 2018). This chapter has outlined the antecedents of realist approaches and the main concepts therein. In doing so the applicability of realist approaches to the intended research has been justified. The next chapter describes important practical considerations related to the application of realist methods to this research project.

Chapter 4- Methods II

4.1 – Introduction

The previous chapter described the philosophical underpinnings of realist approaches to the evaluation of complex social systems. In doing so it provided an introduction to realist reviews, or syntheses, terms which are synonymous and realist evaluations. The chapters that follow utilised these methods to explore the operationalisation of the FPCP initiative. This chapter bridges the gap between these two sections providing descriptions of important methodological decisions that were fundamental to the enactment and subsequent interpretation of the following research.

Chapter 3 outlined both the strengths and limitations of realist approaches. Within these descriptions the challenges of undertaking realist research were identified. Fundamental to these challenges was the complexity and consequent time required to complete both realist syntheses and evaluations. As Pawson, in his introduction to realist syntheses, suggested: *"[r]ealist reviews are not for novices"* (Pawson et al. 2004: 38). From a theoretical perspective a number of the challenges, inherent in realist research, were identified in the previous chapter and they will not be revisited. From a practical perspective the application of the realist theoretical frameworks make realists reviews and evaluations a substantial undertaking (Hewitt, Sims and Harris, 2014). As a consequence time appeared to be an issue in a considerable number of the published realist research with authors advocating the need for sufficient time from early in any project, to get to grips with the theoretical framework and configure initial programme theories (Hewitt, Sims and Harris, 2014). Equally, the analysis phase of any realist work is acknowledged as challenging and requiring *"considerable researcher reflection and creativity"* (Dalkin, 2015: 49).

Adams et al. (2015: 273) go on to state:

> *In cases where time and resources are constrained, it is advisable to apply realist evaluation selectively to amplify understanding of more complex programme areas, and rely on routine methods for less complex domains*

The following section describes the pragmatic process by which the initial programme theories that were taken forward into the empirical research were constructed. During this process important decisions were made with regards to the breadth of the research and it was felt important to make these decisions transparent to the reader.

4.2 – Initial programme theory development

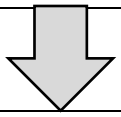
As has been identified 'theory' provides the starting point for realist enquiry, indeed any intervention is itself a theory, or a number of theories (Pawson and Tilley, 1997; Pawson et al., 2004). As such the starting point for any realist enquiry should be the articulation of the hypothesised theory/theories to be explored (Wong et al., 2013; Wong et al., 2016).

Consequently, the starting point for this realist research project involved the construction of theories pertaining to the actualisation of FPCP services within general practice, for patients experiencing MSDs. The first phase of this process was an individual task based on the researcher's expert knowledge of the FPCP initiative. An attempt was made to articulate a general theory for FPCP (Figure 4.1.). In doing so an attempt was made to demonstrate an awareness of the broad macro-level theories that could potentially be implicated in the FCP initiative (Pawson et al., 2005; Shearn et al., 2017). By way of a definition the varying layers of theory are: micro (relating to individual), meso (relating to interpersonal), and macro (relating to institutional, infrastructural, and cultural) (Shearn et al., 2017).

Figure 4. 1: Overriding theoretical statement and macro-level theory acknowledgement.

Overriding theoretical statement:

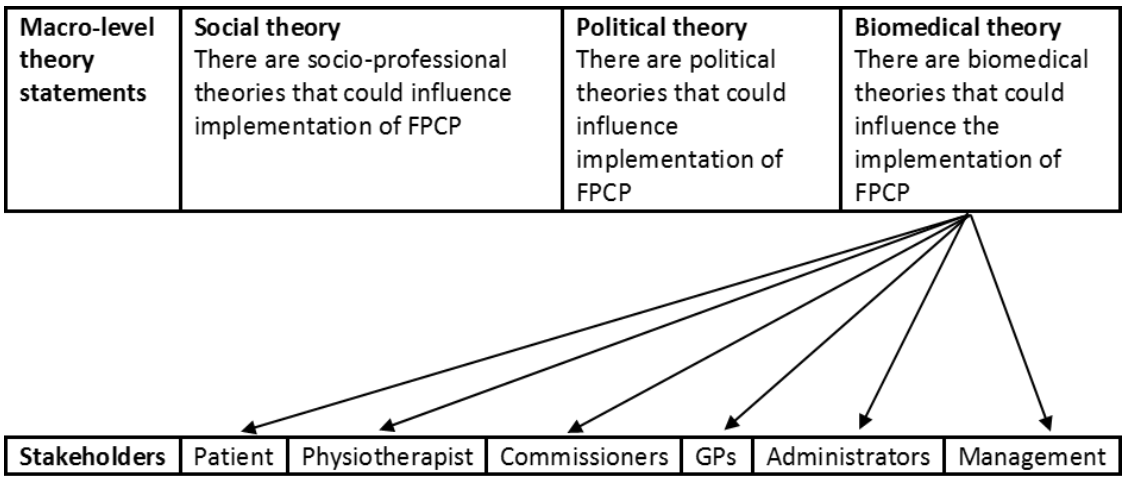
FPCP for patients with musculoskeletal (MSK) health complaints can provide a part solution to the current challenges faced by general practice, in primary care



Macro-level theory statements	**Social theory** There are socio-professional theories that could influence implementation of FPCP	**Political theory** There are political theories that could influence implementation of FPCP	**Biomedical theory** There are biomedical theories that could influence the implementation of FPCP

Consideration was then paid to the multiple stakeholders implicit within the FPCP initiative (Figure 4.2). This step-wise process is shown to demonstrate the rigour that the researcher applied in constructing the initial programme theories and to exhibit the researcher's awareness of the complexity inherent to the FPCP initiative.

Figure 4. 2: Relationship of macro-level theories to stakeholders



As is evident in figure 4.2, the intricacy of the social system, inherent to FPCP, was apparent and acknowledged. It is reasonable to imagine that each and every stakeholder was involved in each higher level theory. The example of this (Figure 4.2), which is given for illustrative purposes, describes that the application of the traditional medical model of healthcare provision is likely to have implications for all stakeholders; patients, GPs, commissioners etc.

At this point a number of potential theories were hypothesised. This process was iterative, combining expert knowledge with a limited, purposive, non-systematic literature review using the broad search terms of 'implementation' and 'healthcare'. The intention of this brief review of the literature was to further corroborate and 'flesh-out' the theories. The result of this process was the development of five broad theoretical headings. These are shown in table 4.1 with themes drawn from the literature identified in the scoping literature search.

Table 4 1: Meso-level themes from the literature

	Meso-level theories and associated themes				
Publication	**Patient related issues**	**Professional interprofessional issues**	**Practical/ resource issues**	**Managerial/ operational issues**	**Workforce/ staffing issues**
(De Allegri et al., 2011)		Scepticism Feared loss of autonomy Professionalisation of junior doctors and nurses		'Orders from above'	Communication processes
(Hoare et al., 2012)	Patient satisfaction with practice nurse role	Practice nurse professionalisation Practice nurse education-collegiate system		Government policy explored	Practice nurse expanded roles Practice nurse-clinical role Efficacy
(Grutters et al., 2007)	Explored patient issues specifically	Explored professional issues			
(Hunter and Segrott, 2014)		Inter-professional boundaries Professional project	Method of documentation Documentation protocols		
(Vassilev et al., 2015)	Patient peer support Patient motivation Unwanted 'visibility'	Relationship between professionals	Type of technology Accessibility to technology		

The research team were satisfied that the five theory headings would be represented in the literature and were likely to be fundamental to the FPCP initiative. The next step involved the articulation of these programme theories using examples from the literature expressed using the typical realist heuristic of the context-mechanism-outcome (CMO) configuration (Pawson and Tilley, 1997).

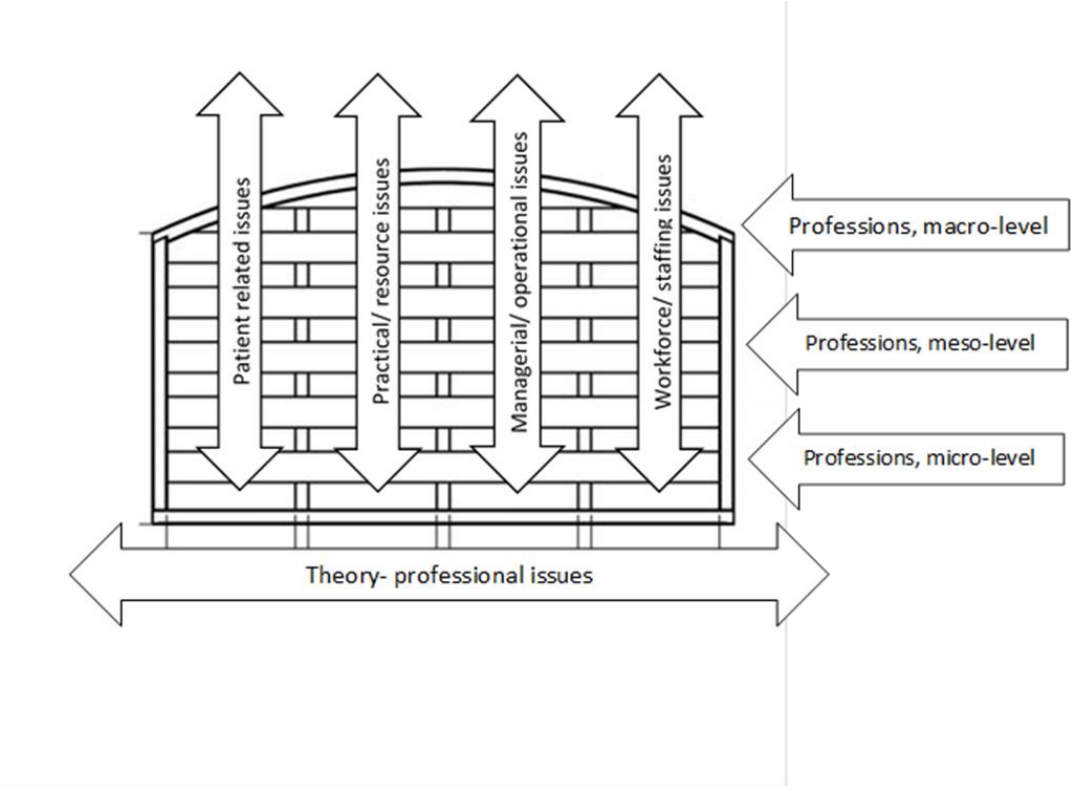
This provided the opportunity for the research team to understand, and develop confidence in this method of theory expression. What became apparent to the research team, and as a consequence became a focus for the evolving project, was the wide-ranging nature of the theory pertaining to 'professional/interprofessional issues' which appeared to span across, if not underpin, the other theories. For example Hoare et al. (2012: 964) aimed to "*illustrate the breadth of nurse-led services in general practice*" and in doing so they identified issues relating to professionalism that could be ascribed to patients understanding of the nurse role, boundary definitions within the workforce and how national policy influenced operationalisation.

Furthermore, it appeared that issues related to the interprofessional/professional theory not only influenced each of the other theories but furthermore influenced them at each strata of society (micro, meso and macro). For example the implementation of telehealth interventions (Vassilev et al., 2015) had professional/interprofessional implications at an individual level (communication between staff and between staff and patients), at a meso-level (how well telehealth as a professional initiative can be "*integrated into everyday life and health care routines*" (Vassilev et al., 2015: 59)) and at a macro-level (as a professional initiative with the intentionality of improving knowledge or, even, as a tool for surveillance).

As such, the developing theory configuration was represented as having the interwoven nature of a fence panel (Figure 4.3). The theories of 'patient related issues', 'practical/resource issues', 'Managerial/operational issues', 'workforce/staffing issues' are envisaged as running parallel to one another while

the theory of 'professional/interprofessional issues' bridges between them, while at the same time impacting them at a micro, meso and macro-level.

Figure 4. 3: Interwoven nature of programme theories



The process of initial programme theory construction continued with the researcher constructing twelve potential initial programme theories. Once again these proposed theories were constructed as a consequence of expert knowledge in the field and knowledge of the literature pertaining to FPCP. These twelve potential initial programme theories were circulated to stakeholders for refinement and consensus agreement on the final 'initial rough programme theories' (Wong et al., 2013).

These two stages are represented in Figures 4.4 and 4.5. Figure 4.4 describes examples that reinforced the five theories supported by the limited, purposive search of the literature and figure 4.5 describes the twelve potential rough programme theories that were circulated to stakeholders.

Figure 4.4: Articulation of five initial draft theories

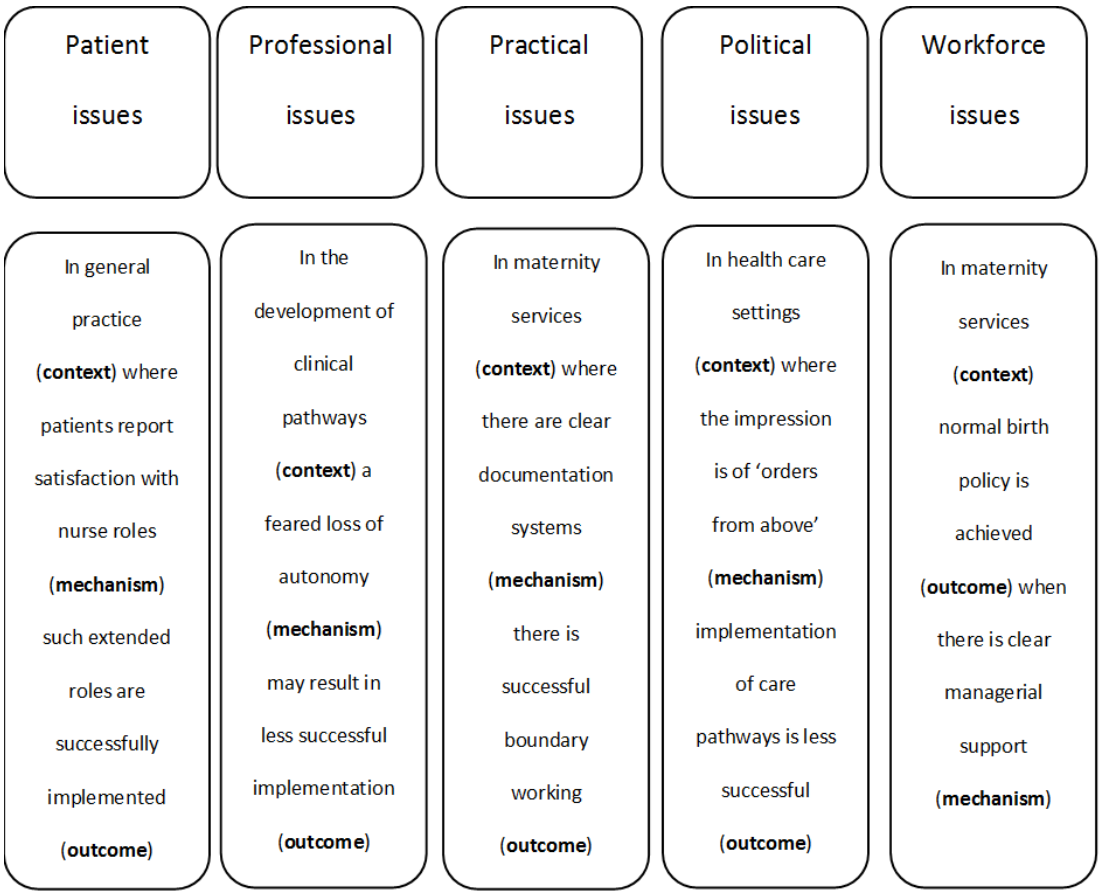
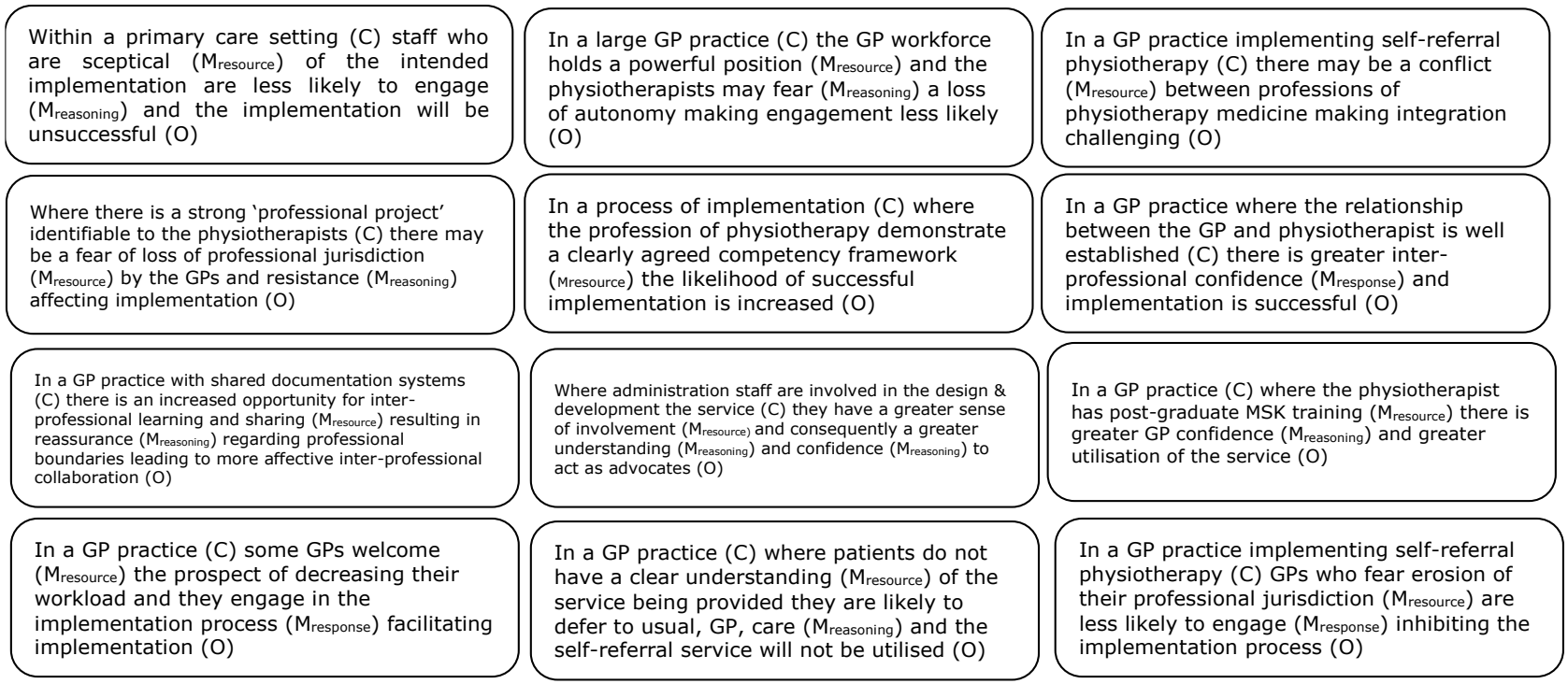


Figure 4. 5: Articulation of twelve potential rough programme theories



These twelve potential theories were distributed to all stakeholder groups to gain a consensus as to which of them should be taken forward in to the planned research. Stakeholders included the research project group, clinical physiotherapists with experience of delivering FPCP, a physiotherapy service manager, a clinical commissioner and a patient and public involvement representative. Views and opinions with regards to the programme theories were communicated either in meetings or via email until four 'initial rough programme theories' were agreed as appropriate to take forwards in to the next stage of the research. These final four programmes are shown in table 4.2.

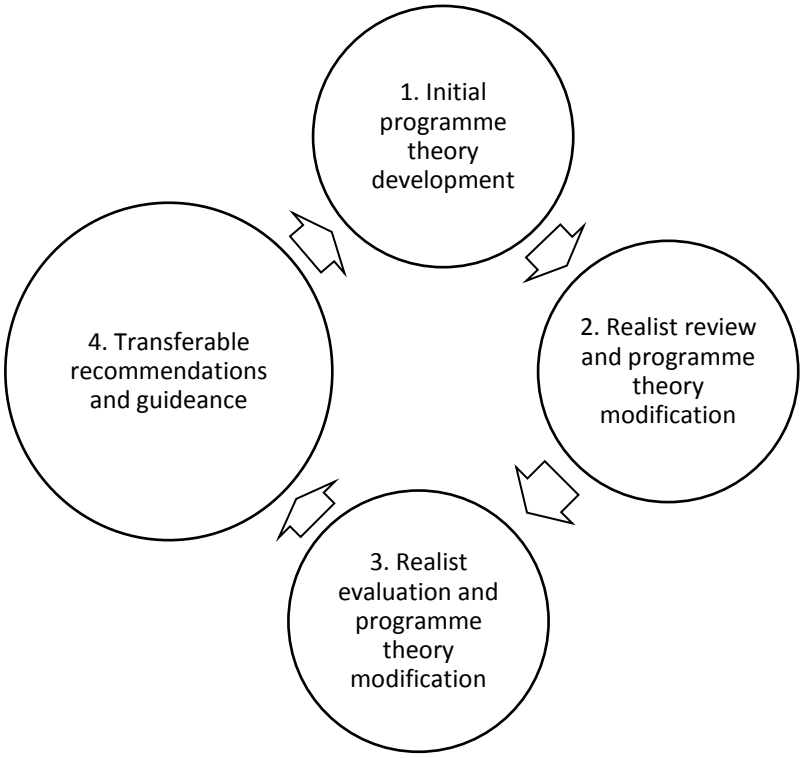
Table 4 2: Initial rough programme theories

Programme theory 1 – Patient understanding of FPCP
Patients need to have a knowledge (Context) of FPCP, as a resource but they also need to have an understanding of how FPCP could be of benefit (Mechanism-Resource) without this they are likely to defer to usual care (Mechanism-Reasoning) and FPCP will not be utilised (Outcome)
Programme theory 2 – Roles and boundary definitions in the FPCP initiative
Where GPs have a knowledge (Mechanism- Resource) of the professional project initiative of physiotherapists (Context) the GPs will react (either -ve or +ve) (Mechanism- Reasoning) and FPCP utilisation will be affected accordingly (Outcome)
Programme theory 3 – GP knowledge of FPCP
GPs have a greater knowledge of physiotherapists role in the management of MSDs (Mechanism-Resource) when there are systems that support the clarification and communication of professional roles, responsibilities and divisions of labour (Context) and subsequently GPs will have greater confidence (Mechanism-Reasoning) resulting in greater interprofessional collaboration (Outcome)
Programme theory 4 – Operationalisation of FPCP
Non-medical staff (Practice managers/administrators/commissioners) have greater knowledge (Mechanism-Resource) of FPCP when they have greater involvement in the implementation process (Context) and they are more likely to be confident (Mechanism-Reasoning) to advocate the service, resulting in better utilisation (Outcome)

The objective of this explanation has been to make transparent the process by which the initial rough programme theories were reached. Hopefully, it also demonstrates the *"abundance of ideas"* (Pawson et al., 2005: 27) available to the team and the complex task involved in deciding *"upon which combinations and which subset of theories are going to feature on the short list"* (Pawson et al., 2005: 27).

It was quite evident that all of the ideas could not be included and some pragmatism was required in the selection process. However, as demonstrated via this explanation this process was methodologically systematic and rigorous. Nevertheless, it became evident to the research group that further challenging decisions were necessary regarding the capacity of the research. The overall research project hoped to complete a whole realist cycle of investigation (Figure 4.6).

Figure 4. 6: Proposed research project cycle



This chapter was written after completion of the research and in terms of execution, the project cycle was completed comprehensively. The successful realist review and realist evaluation are reported in chapters 5 and 7 and 8 respectively. However, it became apparent that the initial breadth of the intended investigation was likely to result in a compromise to the depth of the results subsequently reported. The richness and depth of the results arising from realist methods was a fundamental reason for the selection of this approach and central to realism and realist approaches (Bhaskar, 1975; Pawson and Tilley, 1997).

The precautions articulated by previous authors, in terms of research expectations (Pawson et al., 2005) have already been highlighted. In order to do justice to the research project and to ensure meaningful, new knowledge a decision was made to focus attention on just two of the initial rough programme theories. This disclosure is made in a commitment to the reflexivity and transparency made at the start of this thesis.

Justification for this decision came from three fundamental perspectives. Firstly, a commitment to the realist approach and the unearthing of new, knowledge within complex social systems which, in-and-of-itself, relates to the second justification. That to honour this commitment, as a consequence of practical restrictions in terms of resources, time and thesis parameters realistic decisions had to be made. Finally, as demonstrated the programme theory pertaining to issues relating to the professions bridged across, and interlaced with, all of the other programme theories. As such, and with the benefit of hindsight, it is evident that new knowledge relating to the omitted theories was generated within the programme theory 'Roles and boundary definitions in the FPCP initiative'.

4.3 – Summary

This chapter has made explicit the process of programme theory development which constitutes the stepping off point for the practical enactment of any realist investigation. This was a systematic and thorough process which resulted in four initial rough programme theories. This chapter has also made clear the pragmatic

methodological decisions made by the research project team in terms of justifying the selection of which, and how many, of these programme theories were to be investigated. It is from this standpoint that the selection of the programme theories relating to 'patient understanding of FPCP' and 'roles and boundary definitions in the FPCP initiative' were taken forwards in the research that follows in chapters 5 and 6.

Chapter 5 – First point of contact physiotherapy as a professional project; a realist review

5.1 – Introduction

This realist review was registered with PROSPERO Centre for Reviews and Dissemination

- Project number: CRD42016043963

The previous chapters foregrounded the empirical realist research that follows in the coming four chapters. This chapter describes a realist review of existing published literature with a lens applied to FPCP and an interpretation of this initiative as a professional project (Larson, 1977).In assuming the FPCP role and extending their jurisdiction (Abbott, 1988), physiotherapists could be perceived to be challenging the a priori dominance of general practitioners in treating these patients.

The rationale underpinning the FPCP initiative was evident and there was empirical evidence that supported efficacy thereof. However, there appeared to be a seemingly poor take-up of self-referral services by patients. This suggested the issue was more complex and this review explored these two associated issues. Specifically, this review explored potential mechanisms related to:

- Patient understanding of FPCP as positioned against the predisposition for patients to default to their GP as a FPC.
- FPCP as a professional project looking to expose the mechanisms pertaining to professional boundary definition and professional jurisdiction inherent in such a project.

The hope was that by exposing these mechanisms the initial theories would be refined leading to the development of transferable theory that could inform future implementation of services that stand against the historically situated, traditional model of care delivery in primary care. In doing so this review would contribute to

improvements in patient care. This is the first such review of FPCP and originality was provided through the use of realist review methodology. The realist review is an increasingly popular approach to analysis of complex interventions and programmes (Wong et al., 2013).

Realist review, as a method, extends beyond the scope of traditional systematic reviews. This review allowed for the exploration of the complex concepts and interactions, inherent in FPCP, and explored what works for whom, how and why? The intention of this realist review was to expose any issues pertaining to the programme theories that might remain hidden to traditional empirical study but exhibit evidence of impact on implementation and subsequent utilisation of FPCP.

5.1.1 – The realist review method

There were a number of reasons for choosing a realist review method over a more traditional systematic review. Systematic reviews are primarily interested in exploring the effectiveness of the intervention. This realist review and, more broadly the overall project, was less concerned about the clinical efficacy of the FPCP initiative and, more so, how issues of the professions influenced the implementation and utilisation thereof. It was clear that the implementation of FPCP for MSDs in England was patchy and inconsistent (CSP, 2015). Furthermore, it was known that the process of implementation is complex and multifactorial (Ferlie et al., 2005). As such, any review of the process needed to be sensitive to these issues and the realist review method seemed ideally suited to this task.

Additionally, although there was little mention of specific approaches it is clear that recent guidelines, for the development and evaluation of complex interventions, acknowledged the need to recognise contextual features and causal mechanisms (Moore et al., 2015; Craig et al., 2008). The realist review *"acknowledges that within complex interventions there are many dimensions and layers of explanation that warrant exploration"* (Wong, Greenhalgh and Pawson, 2010: 2). Any realist review looks beyond the intervention and outcomes, exploring the inner workings of the programme. Accordingly, a realist review was likely to

include literature from much broader paradigms than straightforward empirical studies, including epidemiological studies, case studies, qualitative studies and grey literature (Pawson et al., 2005).

Despite the acknowledged complexity, the methodological process applied in a realist review should still endeavour to be rigorous and transparent (Pawson et al., 2004). Any would-be reader should be able to see clearly every step of the process and be satisfied as to methodological rigour (Pawson et al., 2004: V). As a commitment to this transparency, the following review adhered to the RAMESES guidelines for quality and publication standards (Wong et al., 2013).

5.2 – Method

The following section outlines the method applied in this realist review. Pawson et al. (2005a), while emphasising the differences between systematic reviews and realist reviews, advocated the use of some of the conventional Cochrane headings as stepping off points for the key stages of a realist review (Table 5.1).

Table 5. 1: Five stages of realist review (From Pawson et al., 2005a)

Stage 1 – Clarify the scope of the review
Identifying the review question, defining the purpose of the review and articulating the key theories to be explored
Stage 2 – Search for evidence
Starts with exploratory background search leading to progressive focusing to identify the key programme theories leading to a final search strategy, with additional snowball sampling to explore new hypotheses as they emerge
Stage 3 – Appraise primary studies and extract data
Use of judgement to supplement formal critical appraisal checklists and the subsequent extraction of data into bespoke extraction forms and databases
Stage 4 – Synthesise evidence and draw conclusions
Synthesis of data to achieve refinement of initial programme theories. The initial review question continues to drive the synthesis process and the evidence helps generate insights about the influence of context
Stage 5 – Disseminate, implement and evaluate
Articulation of recommendations to key stakeholders and subsequent evaluation of applied recommendations

The following review reports each of these five phases. As described in chapter 4 pragmatic adaptations to the methods were necessary. To a certain extent, this was because of practicalities with respect to the time and resources available for the

project. However, these decisions also allowed a greater depth to the review and greater subsequent richness to the reporting thereof. These limitations were characteristic of the realist review process (Pawson, 2005).

5.3 – Phase 1 – Clarify scope of the review

5.3.1 – Identify the review questions

The process of identifying the review questions in a realist review is a complex process and one which the reviewer needs to, and should expect to return (Pawson et al., 2005). The question should contain some of the components of "What works, how, why, for whom, to what extent and in what circumstances, in what respect and over what duration?" (Wong et al., 2013). It should be anticipated that a significant number of alternative lines of enquiry would emerge during the process of the review. The RAMESES group advocated containment of the review suggesting this require discussion and negotiation with key stakeholders with this process continuing up to, and maybe even beyond, the mid-point of the process (Wong et al., 2013).

The overarching objective of this realist review, by conceptualising the FPCP initiative as a professional project, was to determine the relationship between the project and the successful, or otherwise, design, implementation and utilisation of FPCP physiotherapy for patients with MSDs, as an alternative to GP care, in a primary care setting.

As such, the research questions the realist review addresses were:

1. If FPCP for patients with MSDs, as an alternative to usual GP care, was a professional project, what were the implications of this project that needed considering in design, implementation and utilisation?

2. Were there any demi-regularities evident in the association between the professional project and the design, implementation and utilisation of FPCP that could provide transferable lessons for future practice?

5.3.2 – Articulate key theories to be explored

Chapter 4 described and justified the prioritisation of two theories. These two initial rough programme theories were taken forwards to be tested against the literature (Table 5.2).

Table 5. 2: Initial rough programme theories related to issues of the professions

Programme theory 1 – Patient understanding of FPCP
Patients need to have a knowledge (Context) of FPCP, as a resource but they also need to have an understanding of how FPCP could be of benefit (Mechanism-Resource) without this they are likely to defer to usual care (Mechanism-Reasoning) and FPCP will not be utilised (Outcome)
Programme theory 2 – Roles and boundary definitions in the FPCP initiative
Where GPs have a knowledge (Mechanism-Resource) of the pro-professionalisation initiative of physiotherapists (Context) the GPs will react (either -ve or +ve) (Mechanism-Reasoning) and FPCP utilisation will be affected accordingly (Outcome)

5.4 – Phase 2 – searching for relevant evidence

The search strategy applied was purposive and iterative (Pawson et al., 2005, Wong et al., 2013). Furthermore, as the literature itself can inform and refine the programme theories the process was not expected to be uni-linear. The RAMESES group described the principle of saturation as a guide for when to cease the iterative search process (Pawson et al., 2004, Wong et al., 2013). The project group were aware that achieving saturation was unlikely due to the resource constraints inherent in the project. They were also aware that literature pertaining to issues of the professions was likely to extend beyond medical databases.However, due to the resource limitations a pragmatic decision was made to restrict the search to medical databases as the primary question related to the implementation of FPCP (Table 5.3).

Table 5. 3: Search strategy

Search strategy
Strategy for searches in MEDLINE, CINAHL, EMBASE, PsychINFO via OVID and Web of Science Free text terms and operators • 'primary care' OR 'general practice' OR 'primary health care' • 'physiotherap$' OR 'physical therap$' OR 'therap$' • 'Profession' OR 'professionalisation' OR' professionalisation' OR 'professional identit$' OR 'professional project$' OR 'professional jurisdiction$' OR 'professional boundar$' • 'Self-refer$' or 'direct access$' (Limiters: English language only, 20-year publication limitation)

Further attempts to ensure comprehensiveness were made via snowballing (Greenhalgh and Peacock, 2005) and checking the retrieved list of literature against the personal database of the researcher.

5.5 – Phase 3 – Appraise primary studies and extract data

5.5.1 – Appraise literature

Unlike other methodologies, the realist review methodology does not exclude any literature based on traditional systematic review criteria or evidence-based medicine hierarchies (Rycroft-Malone et al., 2012). Nevertheless, it is pertinent to ask the question; is this literature good enough to be included (Rycroft-Malone et al., 2012, Pawson et al., 2004). Pawson suggested, when considering the inclusion of literature, that factors such as sample size, data collection methods, data analysis methods and the claims made are taken into account (Pawson et al., 2004).

A series of screening prompts/questions were applied to the literature. Having undertaken the searches, the following questions were applied to the titles and abstract of the retrieved literature:

1. Did the publication appear to be about FPCP or self-referral physiotherapy?
2. Was the publication in primary care?
3. Was it likely from reading the title and the abstract, that issues related to the initial rough programme theories were discussed?

A dearth of literature specifically related to physiotherapy and fulfilling the above criteria was anticipated. As such, a second tier of literature selection was used:

1. If the article was not specifically related to FPCP or self-referral physiotherapy was it related to other non-doctor healthcare professionals providing care, as an alternative to GP care, in a primary care situation?
2. Was it likely from reading the title and the abstract, that issues related to the initial rough programme theories were discussed?

The first screening process was undertaken independently by the researcher. As a result of this initial process a reduced list of potential literature was circulated to the project team for assessment. Two members of the team reviewed each title and abstract. Where there was disagreement between the two the title and abstract was reviewed by a third person. Where it remained unclear, consensus was sought through discussion with the project team. From this second round of selection, the researcher snowballed articles from the reference lists (Greenhalgh and Peacock, 2005). The remaining articles underwent a third screening process, involving two reviewers, with disagreements resolved as previously described.

5.5.2 – Extracting the data

Data were extracted from those articles passing through the screening process. The included literature was mined for data extracts by the researcher. There were no definite descriptions of what should or should not be extracted in a realist review, as each piece of work is clearly individual and specific. Once again, RAMESES group guidelines were applied (Wong et al., 2013). It was important that the data

extracted was relevant to the original programme theories and research questions, refining, refuting or substantiating them. To support the process the extracted data was recorded using a number of methods. A Data Analysis and Synthesis Process form (Wong et al., 2015; Booth, 2017) was written for each piece of literature. This quality appraisal was different to a systematic review and asked questions of the literature with respect to relevance and rigour (Pawson et al., 2005).

To assist in the synthesis process extracts of data were coded using QSR International's NVivo 11 Software. The researcher developed a coding system whereby primary nodes were generated using the initial rough programme theories and sub-nodes were created for each element of the CMO configurations. This hierarchy provided a coding manual for the project team (Syed and Nelson, 2015, Morse, 2015).

To ensure rigour in the review method 10 per cent of the literature was randomly selected and coded jointly by three members of the project team, a method used elsewhere (Maidment et al., 2017). For an approach that was novel and unfamiliar to several members of the project team a reasonable degree of agreement was achieved and any disagreements were resolved through discussion. The researcher took on the role of "gold standard/master coder" coding all of the data with members of the project team acting as 'reliability coders' (Syed and Nelson, 2015). Both this approach and the reconciliation of this agreement through consensus had been shown to be effective in establishing reliability when coding narrative data (Syed and Nelson, 2015, Morse, 2015).

5.6 – Phase 4 – Synthesising the evidence

The realist concept adhered to the generative explanation for causation. That is, within a specific context (C) certain generative mechanisms act (M) which result in particular outcomes (O). It was within this fundamental underpinning philosophy that the data was synthesised. The review sought to elucidate what mechanisms relating to the two rough programme theories were evident in the literature and influenced the operationalisation of FPCP. Moreover, in what circumstances did

these mechanisms manifest how this influenced outcomes? The synthesis process was an iterative one beginning during the data extraction phase and continuing by testing said data, against the original rough programme theories (Wong et al., 2013). Often the process by which authors synthesise their data is unclear. In this realist review, the steps taken by Rycroft-Malone et al. (2012) and Brennan et al. (2014) were adopted. The coded exerts were copied to Microsoft Excel 2013 to facilitate manipulation of the data.

Synthesis of the data resulted in a number of new, refined programme theories. Frequently, the final programme theories evolved through the identification of a number of sub theories. To maximise methodological transparency the sub theories are reported in the findings.

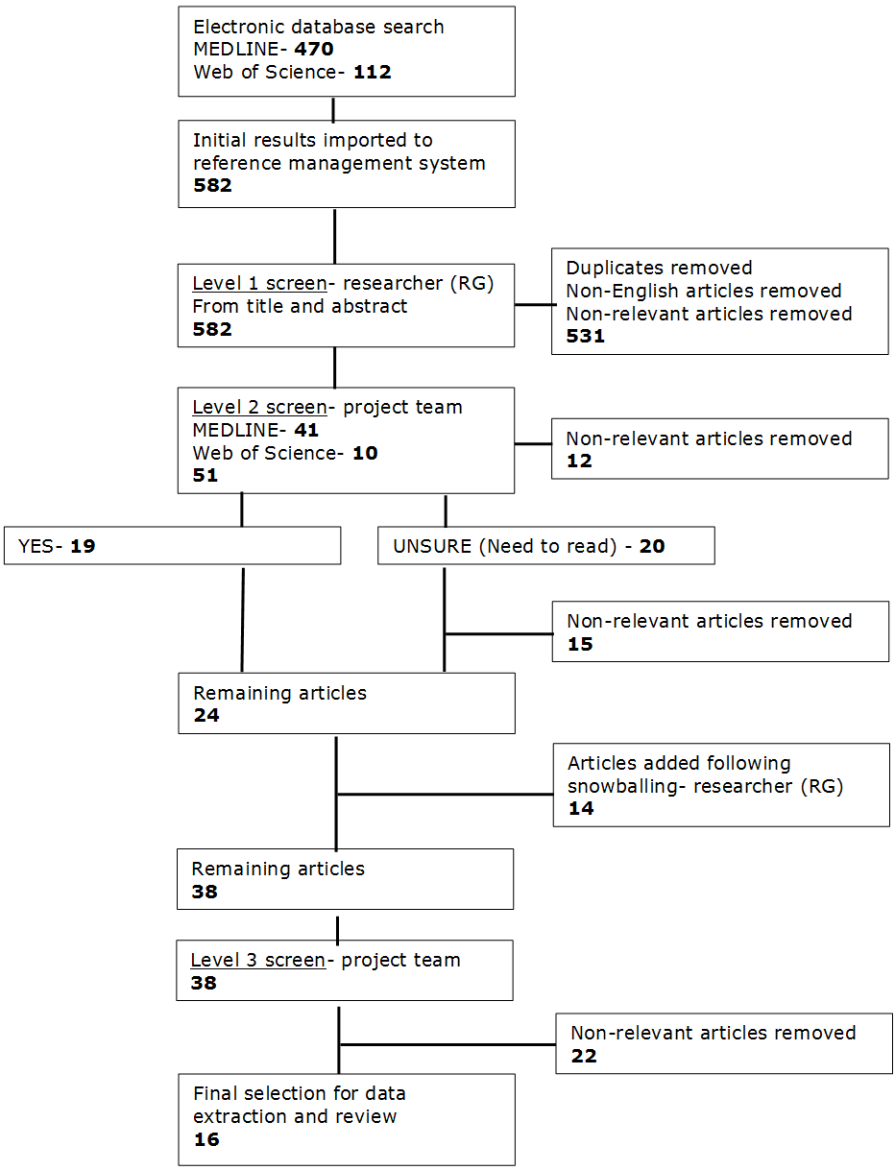
5.7 – Results

5.7.1 – Search approach

The initial search identified 582 pieces of literature. An initial screen by the researcher resulted in the removal of 531 pieces of literature. These were either not relevant, not English language or duplicates. The remaining fifty-one items were screened by the project team as previously described. This resulted in the removal of twelve articles that were assessed as not relevant. Of the remaining thirty-nine items, it remained unclear as to the relevance of twenty. After reading the full text, fifteen of these twenty were excluded. This resulted in twenty-four pieces of literature progressing to the next stage of data selection. The researcher snowballed the reference lists of these twenty-four and identified a further fourteen pieces of literature that had potential relevance.

This resulted in thirty-eight items progressing to the next level of screening which the project team undertook. The outcome of this screening was the removal of twenty-two items resulting in a final body of sixteen pieces of literature progressing through to the review. This process is represented diagrammatically below, Figure 5.1.

Figure 5. 1: Source selection process



5.7.2 – Document characteristics

Sixteen documents were included in the review (Holdsworth et al., 2008, Webster et al. 2008, Swinkels et al. 2014, Ferguson et al. 1999, Holdsworth and Webster, 2004, Ludvigsson and Enthoven, 2012, Goodwin and Hendrick, 2016, Foster et al. 2012, Xyrichis and Lowton, 2008, Bélanger and Rodríguez, 2008, Shoemaker, 2012, Bury and Stokes, 2013, Bury and Stokes, 2013a, Dufour et al., 2014, Pullon et al., 2011, Soklaridis et al., 2007) and they provided an eclectic mix of approaches.

Interestingly, none of these pieces of literature would have passed inclusion criteria for a traditional systematic review, further justifying the application of a realist review approach. The contextual characteristics of the literature included in the review are summarised in appendix 1. This includes a description of the methods, setting and the population under investigation, where applicable. In addition, assessment of the relevance and rigour is made and a description of the position of the literature, related to the programme theories and any contribution it makes to theory refinement.

In addition, each piece of literature was classified according to its 'contextual richness' (Pearson et al., 2013, Pearson et al., 2015, Booth, V., 2017). This approach had been used elsewhere in realist reviews (Pearson et al., 2013, Pearson et al., 2015, Booth, V., 2017). The literature was classified as either conceptually rich, having a thick description but not being conceptually rich or as having a thin description. It might be assumed that literature classified as thin would add little to the review. However Pearson et al. (2015) found that literature they classified as thin, and which commonly included commentaries, editorials and reports from the grey literature, often revealed novel contributions. This classification system revealed a relatively even spread from the sixteen pieces of literature. Seven were identified as having thin description, five were identified as being thick but not contextually rich and four articles were identified as having conceptual richness (Appendix 1).

5.8 – Findings

During the synthesis process, the original rough programme theories evolved and the outputs of this realist review are a number of new, evidence-based CMO configurations. A number of partial CMO configurations underpinned the final CMO configurations, acting as building blocks, and contributing to the final configurations. In reporting the findings of this realist review, the evidence is presented narratively. Each of the new programme theories has a number of CMO configurations and these are presented under their programme theory.

It is important to highlight that within the narrative descriptions the terms FPCP, self-referral physiotherapy and direct access physiotherapy are synonymous. Historically, most literature has referred to self-referral physiotherapy (Ferguson et al., 1999, Webster et al., 2008 Holdsworth et al. 2008, Swinkels et al., 2014, Holdsworth and Webster, 2004). Some authors have referred to direct access alone (Shoemaker, 2012), some authors have referred to direct access and self-referral simultaneously (Bury and Stokes 2013, 2013a) and some authors refer to physiotherapists providing a FPCP (Ludvigsson and Enthoven, 2012, Goodwin and Hendrick, 2016).

The two programme theories are reported consecutively and to assist the reader a description of how they are presented follows:

1. The programme theory title is given
2. The theory is introduced
3. The initial rough programme theory is presented
4. The CMO configurations are described with a narrative description of the supporting evidence
5. The process of moving from the partial CMO configurations to the final CMO configurations is described narratively
6. The refined CMO configurations are presented

To further assist the reader Appendix 2 reports the CMO configuration components with their associated references.

5.9 – Programme theory 1: Patient understanding of FPCP for musculoskeletal conditions.

5.9.1 – Introduction

In constructing programme theory 1, the project team recognised the potential importance of patient understanding of FPCP for successful implementation and subsequent utilisation. Furthermore, the project team acknowledged that information dissemination would likely be important for increasing patient awareness and understanding of FPCP.

5.9.2 – Initial rough programme theory

Patients need to have an awareness **(Context)** of FPCP, as a resource, but they also need to have an understanding of how FPCP could be of benefit **(M-Resource)** as, without this, they are likely to defer to usual care **(M-Reasoning)** and FPCP will not be utilised **(Outcome).**

The partial CMO configurations are described and following each configuration there is a narrative description of the evidence that supports the CMO.

5.9.3 – Evidence base CMO configurations

5.9.4- CMO representation 1: Public support for FPCP

In the context of FPCP **(Context^{1})** physiotherapists and physiotherapy governing bodies perceived that there was support from the public **(M-Resource^{2})** and demonstrated public support empirically. Physiotherapists and physiotherapy governing bodies recognised that advocacy strategies **(M-Resource^{1})** regarding FPCP should target patients using a variety of media **(M-Resource^{3})** and tailored specifically **(M-Resource^{4})** to raise public awareness **(M-Reasoning^{1})**. As a consequence of the perception of pre-existing public support **(Context^{2})** physiotherapists and physiotherapy governing bodies determined that canvasing the public **(M-Resource^{1})** was less important than the need to secure political support, support of medical and other health professionals and strategies directed at the public were not prioritised **(M-Reasoning^{2})**.

Evidence to substantiate this partial CMO configuration came from five of the sixteen articles (Bury and Stokes, 2013, 2013a; Webster et al., 2008; Ferguson et al., 1999; Ludvigsson and Enthoven, 2012; Goodwin and Hendrick, 2016).

Within their survey exploring the global view of FPCP, Bury and Stokes (2013), asked member organisations of the WCPT what resources would facilitate them moving the direct access initiative forwards. Six main themes emerged

(evidence, knowledge translation, education, legislation, advocacy **(M-Resource^{1}),** and professional leadership). More specifically, within the theme of advocacy the issue of *"raising awareness* **(M-Reasoning^{1})***…among the public"* (Bury and Stokes, 2013: 454) was identified. However, this was regarded as less important than the need to secure political support and the support of medical and other healthcare professionals. As in their parallel study, exploring the views of European members of the WCPT (Bury and Stokes, 2013a), the worldwide members of the WCPT identified service user support **(M-Resource^{2})** as a main enabler of the direct access initiative.

Evidence from these two papers suggested that member organisations assumed a pre-existing level of public support for FPCP **(Context^{2})** (Bury and Stokes, 2013, 2013a). Webster et al. (2008) also reported evidence of public support **(Context^{2})** for self-referral. It appeared that, because of this assumed support, **(Context^{2})** physiotherapists did not prioritise (**M-Reasoning^{2}**) advocacy strategies **(M-Resource1)** directed at the public (Bury and Stokes, 2013, 3013a).

Nevertheless, the review provided evidence of the perception, of a proportion of members of the WCPT, for the need to apply advocacy strategies to members of the public **(M-Resource^{1})**. More so, these strategies should utilise a *"variety of media* **(M-Resource^{3})** *[and be] tailored to different stakeholder groups* **(M-Resource^{4})***"* (Bury and Stokes, 2013: 455).

5.9.5 – CMO representation 2: Use of advocacy strategies to improve public awareness and understanding of FPCP

Physiotherapists perceived a low level of public awareness **(Context^{3})** and understanding **(Context^{4})** of FPCP and recognised the importance of advocacy strategies targeted locally **(M-Resource^{5})** and nationally **(M-Resource^{6})** to improve patient awareness **(Reasoning^{1})** and understanding **(Reasoning^{3})** and increase utilisation of FPCP **(Outcome^{1})**.

Evidence to substantiate this partial CMO configuration came from five articles (Holdsworth et al., 2008; Webster et al., 2008; Bury and Stokes, 2013, 2013a; Pullon et al., 2011).

Holdsworth et al. (2008), in their appraisal of GP and physiotherapists opinions about FPCP, reported the majority of physiotherapists perceived a low level of awareness **(Context^{3})** and a low level of understanding (**Context^{4})** amongst the public. Consequently, they identified mechanisms by which public awareness **(Reasoning^{1})** and understanding **(Reasoning^{3}**) could be improved, although no differentiation between the two was made. Suggested strategies ranged from local campaigns **(M-Resource^{5}**) (media campaigns, targeting specific population groups and improving ease of access) to national campaigns **(M-Resource^{6})** (media campaigns and physiotherapy profession input into governmental policies). Bury and Stokes (2013, 2013a) also identified strategies, suggesting the use of a variety of media **(M-Resource^{3})** which should be tailored specifically **(M-Resource^{4})** to raise public awareness **(Reasoning^{1})**. It was evident that the authors felt that this lack of awareness **(Context^{3})** and understanding (**Context^{4})** was a major concern for the profession in terms of FPCP utilisation.

> *If the general public are unaware* **(Context^{3})** *of what physiotherapists can offer, how can they be expected to refer* **(Outcome^{1})** *themselves to a service they know little about* **(Context^{4})***? It would seem that awareness-raising strategies* **(M-Resource^{1})** *are required to address this issue*
>
> Holdsworth et al., 2008: 242

The assertion was that utilisation of FPCP would not be realised **(Outcome^{1})** if these issues were not addressed. Certainly Pullon et al. (2011) reinforced this impression suggesting that the lack of understanding **(Reasoning^{3}**) of roles had *"the potential to consistently undermine otherwise well-intentioned efforts to achieve the best possible health for patients"* (Pullon et al., 2011: 128).

Webster et al. (2008) provided further evidence of poor patient understanding of FPCP **(Context[4]).** They explored patients' knowledge and attitudes to self-referral physiotherapy across twenty-six locations throughout Scotland. In this survey, less than 23 per cent of patients describe themselves as being knowledgeable or very knowledgeable about self-referral physiotherapy with less than 5 per cent of the patients being very knowledgeable (Webster et al., 2008). Similarly, the authors expressed their concern concerning this apparent lack of knowledge **(Context[4])**. They state:

> *[I]t is essential that the physiotherapy profession uses effective modern marketing strategies* **(M-Resource[1])** *to enhance the public's awareness* **(M-Reasoning[1])** *and confidence* **(M-Reasoning[5])** *in physiotherapy-led services, and to publicise how access to these services can be achieved* **(Outcome[1])**
>
> Webster et al., 2008: 148

5.9.6 – CMO representation 3: Assessment of advocacy strategies

Where patient advocacy strategies had been implemented **(Context[5])** a number of approaches **(M-Resource[1])** had been used to disseminate information (publicised in the local paper **(M-Resource[7])**, posters displayed in the health centre **(M-Resource[8]),** patient newsletters **(M-Resource[9])** and verbal dissemination by primary care team **(M-Resource[10])**. There was no evidence of any systematic pre-planning or assessment **(M-Reasoning[4])** of the influence of these strategies on patient awareness **(M-Reasoning[1])**, confidence **(M-Reasoning[5])**, or understanding **(M-Reasoning[3])**.

Evidence to substantiate this partial CMO configuration came from four articles (Ferguson et al., 1999, Webster et al., 2008, Holdsworth et al., 2008, Holdsworth and Webster, 2004).

In one of the very first evaluations of self-referral physiotherapy (Ferguson et al., 1999), the marketing of the service, based within one GP practice, was briefly described. However, this description was limited to the single statement that the

service was *"publicised in the local paper* **(M-Resource[7])** *…and a poster was displayed in the health centre* **(M-Resource[8])***"* (Ferguson et al., 1999: 14). There were no details of the content of this material, how it was developed and there was no assessment **(M-Reasoning[4])** of the effectiveness of this publicity campaign.

Equally, in their series of articles related to the implementation of FPCP services throughout Scotland **(Context[1])** (Webster et al., 2008, Holdsworth et al., 2008, Holdsworth and Webster, 2004) the authors described the new service being publicised **(M-Resource[1])** for three months prior to implementation. This information was supported by associated data from literature in the series of articles related to the implementation of FPCP services throughout Scotland but not included in the review (Holdsworth et al., 2006, 2006a). The advertising campaign, for this national project, made use of patient newsletters **(M-Resource[9])**, posters within the GP practices **(M-Resource[8])** and through verbal dissemination **(M-Resource[10])** by the primary care team. Once again, there was no explanation of the planning involved in the conception of this strategy or the subsequent assessment **(M-Reasoning[4])** of the effectiveness of these approaches.

5.9.7 – CMO representation 4: Embedding of FPCP

In the context of FPCP **(Context[1]),** services became 'embedded' **(Context[6])** in general practice over time, becoming more visible **(M-Resource[8])** to the public. The visibility of embedded FPCP services **(M-Resource[8])** resulted in patients becoming more familiar **(M-Reasoning[6])** with the service resulting in an increased utilisation **(Outcome[1])**. Concurrently, patients who had accessed FPCP services were more likely to be supportive **(M-Reasoning[7])** and to describe satisfaction **(M-Reasoning[8])** with FPCP.

Interestingly, and warranting further investigation, there was no evidence to suggest embeddedness **(Context[6])**, (Visibility **(M-Resource[11])** + familiarity **(M-Reasoning[6])** + support **(M-Reasoning[7])** + satisfaction **(M-Reasoning[8])**) which resulted in increased utilisation **(Outcome[1])** was accompanied by increased understanding **(M-Reasoning[3])**.

Evidence to substantiate this partial CMO configuration came from thirteen articles (Bury and Stokes, 2013, 2013a; Holdsworth et al., 2008; Webster et al., 2008; Ferguson et al., 1999; Holdsworth and Webster, 2004; Swinkels et al., 2014; Ludvigsson and Enthoven, 2012; Goodwin and Hendrick, 2016; Dufour et al., 2014; Foster et al., 2012; Shoemaker, 2012; Bélanger & Rodríguez, 2008).

A consistent theme that emerged from the evidence was one that the project team entitled 'embeddedness' **(Context[6])**. Evidence suggested that a greater percentage of people utilised the FPCP services (**Outcome[1])** the longer it was in existence. Certainly, evidence from the Netherlands showed that from 2006 to 2010, the proportion of patients self-referring to physiotherapists rose from 22 per cent to 43 per cent (Swinkels et al., 2014). The authors apportioned this increase **(Outcome[1])** in access to a rise in patient awareness **(M-Reasoning[1])** although no clear justification for how this rise in awareness had come about is given. However, politically, in 2006 there was a change in government policy with a view to increasing access and choice for patients and it was on these grounds that self-referral physiotherapy was introduced in 2006. This reinforced the views of the member organisations of the importance of political support for the FPCP programme (Bury and Stokes, 2013, 2013a) with the hypothesis being that this political support influenced public opinion.

The theme of 'embeddedness' **(Context[6])** was further reinforced in the primary evaluation undertaken by Ferguson et al. (1999). They demonstrated a steady increase in the proportion of patients self-referring to the physiotherapy service **(Outcome[1])** over a three-year period. Supporting this was evidence in the evaluation by Ludwigsson and Enthoven (2012), who attributed the utilisation **(Outcome[1])** of their FPCP service, to the familiarity **(M-Reasoning[6])** that was inherent in the 'embeddedness' **(Context[6])** of the established physiotherapy service which existed prior to the FPCP service. The implication is that there was an already established 'visibility' **(M-Resource[11])**, of the FPCP service to the practice patient population.

Bélanger and Rodríguez (2008) undertook a qualitative synthesis of multidisciplinary primary care teams that corroborates this embeddedness theme, while at the same time augmenting it. An extract from one of their included papers spoke of *"the lengthy process of regularising new roles"* (Bélanger & Rodríguez, 2008: 591) implying the importance of the necessary, and significant, time required for embeddedness to be achieved **(Context[6]).** In their overview of five years of patient self-referral in the Netherlands Swinkels et al. (2014) stated that patients opinions for accessing FPCP **(Outcome[1])** *"mostly related to their familiarity* **(M-Reasoning[6])** *with the (health) complaint or the health care professional"* (Swinkels et al., 2014: 1791). Beyond the sphere of physiotherapy, Pullon et al. (2011) reported a paper by Rothman and Wagner (2003) who explored the characteristics of team working associated with better care delivery. They identified the need for services to *"be visible"* **(M-Resource[11])** (Pullon, 2011: 129) to be valued by patients.

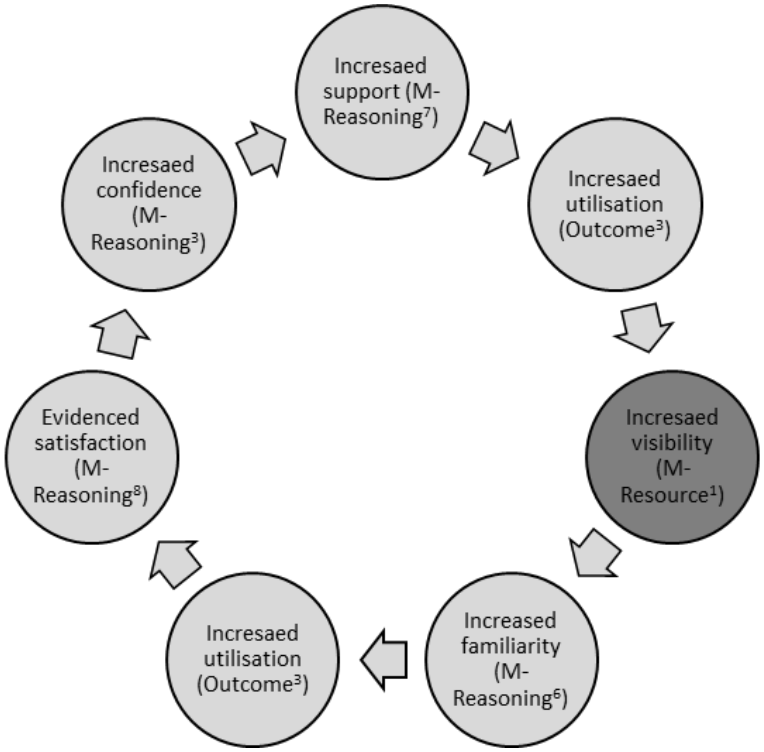
There was evidence to suggest that advocacy strategies **(M-Resource[1])** and/or the 'embeddedness' **(Context[6])** of a service could increase the visibility **(M-Resource[11])** of services to the public. Neither of these postulated mechanisms had been explored empirically within FPCP. Nevertheless, it was hypothesised that this visibility **(M-Resource[11])** could lead to a public familiarity **(M-Reasoning[6])** with FPCP and lead to a subsequent increase in patient access **(Outcome[1])** (Swinkels et al., 2014).

Evidence from Webster et al., (2008: 145) suggested a cyclic process whereby *"[s]elf-referred patients were more likely to be strongly supportive* **(M-Reasoning[7])** *of being able to self-refer"*. Unquestionably, there was repeated evidence demonstrating patient satisfaction **(M-Reasoning[8])** with FPCP services (Goodwin and Hendrick, 2016, Ludvigsson and Enthoven, 2012, Holdsworth and Webster, 2004, Webster et al., 2008). Webster et al. (2008: 145) went on to say:

> *As well as being more satisfied* **(M-Reasoning[8])**, *self-referred patients had a greater overall confidence* **(M-Reasoning[5])** *in the effectiveness of physiotherapy, even with limited knowledge* **(Context[4])**

It would be reasonable to hypothesise based on the evidence generated within the theme of 'the embedding of FPCP' that a cycle of 'embedding' exists (Figure 5.2):

Figure 5.2: Embeddedness cycle



Despite this hypothesis, there was no evidence to demonstrate a correlation between support **(M-Reasoning^{7})** for, or satisfaction **(M-Reasoning^{8})** with, FPCP services and subsequent understanding **(M-Reasoning^{3})** thereof**.** In fact, any evidence available suggested no relationship (Pullon et al., 2014, Webster et al., 2008). As Webster et al. (2008: 145) state:

> *Whilst not decrying the use of patient satisfaction as an indicator, little evidence exists to provide any indication of what patients or the public actually know about physiotherapy.*

This applied even when patients had first-hand experience of FPCP (Webster et al., 2008). Furthermore, there was no empirical evidence of the visibility **(M-Resource^{11})** of FPCP services arising because of the advocacy strategies **(M-Resource^{1})** applied. In addition, the evidence was unclear as to which response(s)

were produced in patients, (Increased awareness **(M-Reasoning[1])**, confidence **(M-Reasoning[5])**, or understanding **(M-Reasoning[3])**) over time that led to a subsequent increase in utilisation **(Outcome[1])** of FPCP. As a result these features warrant further investigation.

5.9.8 – CMO representation 5: Patient demographics and FPCP

> Where FPCP physiotherapy services were available **(Context[1])** certain patient demographics (health complaint, duration of complaint, age, gender, educational status, work status, work-related absence, previous experience of physiotherapy) **(M-Resource[12])** influenced patient awareness **(M-Reasoning[1])** and/or patient understanding **(M-Reasoning[3])** of the role of physiotherapy and increased utilisation of FPCP **(Outcome[1])**.

Evidence to substantiate this partial CMO configuration came from six of the identified articles (Ferguson et al., 1999; Holdsworth and Webster, 2004; Ludvigsson and Enthoven, 2012; Swinkels et al., 2014; Holdsworth et al., 2008; Webster and Holdsworth, 2008).

Swinkels e al. (2014) referenced the initial evaluation examining the first year of direct access to physiotherapy in the Netherlands (Leemrijse et al., 2008). They found significant differences between patients accessing FPCP independently and those referred by their GP. The type of health problem **(M-Resource[12])** appeared to be the greatest predictor, with patients experiencing non-specific neck and back pain most likely to refer themselves **(Outcome[1])**. Furthermore, where the health problems was of an acute nature or a recurrence of a previous problem, self-referral was more likely **(M-Resource[12])**.

A number of intrinsic patient characteristics including younger age **(M-Resource[12])**, male gender **(M-Resource[12])** and being more highly educated **(M-Resource[12])** increased the likelihood to use FPCP **(Outcome[1])**. Previous experience of having attended physiotherapy **(M-Resource[12])** was also found to predict self-referral behaviour (Swinkels et al., 2014).

Holdsworth and Webster (2004) found similar differences in patient characteristics between those accessing physiotherapy as a FPC and those referred by their GP. The patients in their evaluation were once again, more likely to be younger men **(M-Resource[12])**, in paid employment **(M-Resource[12])** and with less work-related absence **(M-Resource[12])**. Their MSK health condition was also likely to be more acute **(M-Resource[12])**.

Evidence provided in the later stages of the Scottish national trial (Holdsworth et al., 2006, 2006a) which were accessed as secondary data, appeared to contradict some of these earlier findings (Holdsworth et al., 2008, Webster and Holdsworth, 2008). Interestingly, these later evaluations of patient characteristics highlighted no differences between gender and age patients accessing FPCP services **(M-Resource[12])**. Nevertheless, patients accessing FPCP **(Outcome[1])** continued to be more likely to be in paid employment **(M-Resource[12])** with less work-related absence **(M-Resource[12])** and, consistent with previous work, the health complaints of patients using FPCP were more acute **(M-Resource[12])** (Holdsworth et al., 2008, Webster and Holdsworth, 2008).

These findings are important when considering implementation of FPCP and equity of access. Swinkels (2014) reported an increase in the percentage of older patients seen in physiotherapy services in the Netherlands. They suggested this was related to the generalised ageing population and the increase of older people seen in FPCP purely reflected this. Nevertheless, this paralleled increase, seen in physiotherapy, was reassuring demonstrating, relative equity of access to all age groups. This finding was reinforced by Webster et al. (2008) and before that Ferguson et al. (1999) with no differences found in either age or gender.

5.9.9 – CMO representation 6: Autonomous health seeking behaviour and FPCP

Where FPCP physiotherapy services were available **(Context[1])** autonomous health seeking behaviours **(M-Resource[13])** increased patient awareness **(M-Reasoning[1])** and/or patient understanding **(M-Reasoning[3])** of the role of physiotherapy and increased utilisation of FPCP **(Outcome[1])**.

Evidence to substantiate this partial CMO configuration came from three of the papers (Webster et al., 2008; Holdsworth and Webster, 2004; Pullon et al. 2014).

A particular characteristic evidenced in the literature was that of autonomous health seeking behaviours **(M-Resource[13])** (Webster et al., 2008). In their evaluation of patients' knowledge and attitudes, they found that self-referred patients **(Outcome[1])** described attitudes consistent with autonomous behaviours **(M-Resource[13])**. This behavioural characteristic had been referred to previously by Holdsworth and Webster (2004) who made the association between treatment compliance and the characteristics of proactivity and autonomy. Concerning patient attitudes and beliefs Holdsworth and Webster (2004: 70) suggested self-referral patients had *"a greater belief in their own ability to influence their course of recovery, and therefore, the perceived severity of their symptoms"*. In contrast to this positive correlation, Pullon et al. (2014), in their interview based study of patient and staff perceptions of teamwork in primary care, found a lack of understanding **(M-Reasoning[3])** of interdisciplinary teamwork. The CarePlus programme under investigation necessitated goalsetting and the application of self-management techniques. Despite having been involved in the programme the participants showed little autonomy and *"[c]oncepts of patient self-management* **(M-Resource[13])** *were almost absent from the talk of patients"* (Pullon et al. 2014: 133). They concluded that these misunderstandings and, more specifically in this case, lack of autonomous behaviours **(M-Resource[13])**, had the potential to undermine the objectives of initiatives and programmes **(Outcome[1]).**

Webster et al. (2008) referenced previous evidence supporting the importance of autonomous health behaviours in a self-referral service for patients with inflammatory bowel disease. In this investigation, patients who demonstrated autonomy **(M-Resource[13])** and a desire to take control of their health expressed support for self-referral **(M-Reasoning[7]).**

Of interest, Webster et al. (2008) commented that there were still patients who preferred to see a doctor. While this may be expected, Webster et al. (2008) suggest this position needed to be acknowledged and considered. However, they do not explore this issue any further. This apparent evidence of a preference for medical intervention led to the development of another theme related to patient understanding **(M-Reasoning[3])** and subsequent utilisation **(Outcome[1])** of FPCP.

As Webster et al. (2008: 142) state *"[i]t has to be accepted, therefore, that a proportion of patients, irrespective of their level of knowledge, may still prefer healthcare professionals to make decisions on their behalf".* More specifically, some patient's beliefs and behaviours appeared to lead them to consistently default to their GP as the legitimate FPC health provider. This potentiality would clearly represent an obstacle to novel interventions like FPCP.

5.9.10 – CMO representation 7: The GP as the default first contact practitioner

In many health systems patients see their GP as the FPC for MSK complaints **(Context[7])** this means they identified **(M-Resource[14])** with, and had historically situated trust **(M-Resource[15])** in, the GP as the legitimate first choice for their healthcare, having most certainty **(M-Reasoning[9])** in the GP role and confidence in the clinical competence of their GP **(M-Reasoning[10])**. FPCP challenges this established hierarchy and patients may not have confidence **(M-Reasoning[5])** in FPCP and do not access it **(Outcome[1])**, defaulting to their GP. Where patients do access FPCP **(Outcome[1])** it is for health concerns they perceive as less medically serious **(M-Resource[16])**.

Evidence to substantiate this partial CMO configuration came from six of the articles (Pullon et al., 2014; Shoemaker 2012; Webster et al., 2008; Foster et al., 2012; Ferguson et al., 1999; Ludvigsson and Enthoven, 2012). Evidence appeared to support the proposition that there is a propensity to regard the GP as the legitimate FPCP health care professional.

As Foster et al. (2012) stated in their review and critical analysis, in the majority of healthcare systems, and certainly in the UK, the first health professional a patient is likely to see with MSK problem is their GP **(Context[7])**. This has been the case since the turn of the twentieth century and is therefore historically, deep-rooted. The authors suggested this can change and pointed to a trend for patients to utilise **(Outcome[1])** alternative professions as evidence of this. However, they also described a number of assumed characteristics, of GP care, that accounted for the development of the 'gatekeeper' role of the GP. These include *"comprehensiveness of care, focus on the person with the disease and their psychosocial context, continuity of care, and the doctor-patient relationship"* (Foster et al. 2012: 207). The authors referenced an editorial in the British Journal of General Practice that examined the National Programme for Information Technology (NPfIT). The suggestion was that the NPfIT was a political programme aimed at increasing patient choice in primary care. The associated concern was that patients do not necessarily have the experience or confidence **(M-Reasoning[5])** to be able to select the right service to access.

The work of Pullon et al. (2014) provided an important contribution when exploring the issue of the GP as the default legitimate FPC **(M-Resource[14])**. As has been previously stated, Pullon et al. (2014) described evidence from previous studies, as well as their own work, demonstrating patient lack of understanding of health professional roles **(M-Reasoning[3])**. Patients were vague about the roles of the clinicians **(Context[4])**, particularly the non-doctor staff. Indeed, it was with respect to the GP's role that patients had most certainty **(M-Reasoning[9])**. Patients saw the GP as the leader of the service and the one to *"have a certain overall knowledge and expertise"* (Pullon et al., 2014: 132). Despite seeing the nurse

practitioner more frequently, none of the patients saw them as the leader and indeed, they lacked understanding of nurse roles, capabilities and clinical autonomy **(M-Reasoning[3]).**

Further indication of the patients' attachment to the GP as the legitimate FPC was provided in the evaluation of Ludvigsson and Enthoven (2012). In this successful FPCP service, they identified no difference in the characteristics of those patients self-referring to physiotherapy and those who saw the GP, as the FPC, other than their presenting health status. Patients assessed by the GP reported worse general health as measured by the EQ–5D. The fact that those patients with worse self-reported general health selected to see a GP could be indicative of one of a number of features. It would be reasonable to hypothesise a number of explanations to account for these findings. It may have indicated a general lack of understanding of the role of physiotherapy **(M-Reasoning[3])**, it may have indicated a degree of caution on behalf of the nurses undertaking the signposting role, or it may have indicated that patients with worse self-reported health felt more confident in the traditional, established care and competence of their GP **(M-Reasoning[10]).** Furthermore, it may also represent a perceived correlation between GP competence and ability to deal with health concerns that are more complex **(M-Resource[16])**.

This proposition resonates with the early evaluation of Ferguson et al. (1999). One of the reasons they reported that patients preferred the opportunity to self-refer is that they *"did not like to take up the GPs time unnecessarily"* (Ferguson et al., 1999: 17). This seemed to reinforce a hierarchical correlation, in patients' minds, between severity of symptoms and the roles and responsibilities of GPs and physiotherapists respectively **(M-Resource[16])**.

The primacy of the GP was seen as historically situated and deeply entrenched (Foster et al., 2012, Webster et al. 2008, Shoemaker 2012). As Shoemaker states (2012: 243) *"A general societal perception exists of the physician as the health care provider who oversees and directs health care and nearly all*

members of society associate the physician with diagnosis and treatment of disease, illness, and injury" **(M-Resource[14])**.

These sentiments were echoed in respondents' comments to the survey undertaken by Webster et al. (2008). Patients who had attended a FPCP service were asked for their opinions. Amongst the comments were concerns such as: *"Want to be able to see my general practitioner", "General practitioner should refer", "A physiotherapist might not have experience on your condition that your general practitioner does", "Any opinion on 'fitness for work' would have to be in liaison with a doctor", "There might be other medical problems"* **(M-Resource[14])** (Webster et al., 2008: 147). These comments were balanced by a number of positive remarks with respect to FPCP but they are again indicative of a perceived hierarchy of competence, roles and responsibilities in the decision-making process of patients' **(M-Resource[16])**. It appeared that patients had concerns about accessing alternative practitioners that were directly proportional to their self-assessment of the severity of their health complaint **(M-Resource[16])**.

It appeared that a significant feature of the privileged position held by medicine, within society, was trust (Pullon et al., 2014). Not only had medicine attained this privileged trust **(M-Resource[15])** but patients' sought reassurance that, where teams work in an interdisciplinary manner, the non-medical members of the team would defer to the doctor: *"should anything serious come up…they will go through the right channels"* (Pullon et al., 2014: 132). In the same research there was a concern expressed by the patient participants that the team working threatened their trust **(M-Resource[15])** and, implicit in this concern, their health. As one participant said, *"you can have quite a personal relationship with your doctor. So to be kind of palmed off to someone else feels like being palmed off"* (Pullon et al., 2014 132).

The gatekeeping role held by GPs for over a century provided patients with "*one point of initial contact with a health professional they know and trust* **(M-Resource[15])** *when experiencing significant health concerns"* (Foster et al., 2012: 207). Closely associated with the privileged trust accredited to GPs was the

associated confidence therein. As Foster et al. (2012: 207) stated, where patients have a choice they *"often do not go to the right specialist, because they do not have the ability or confidence to select appropriate care"*. This confidence was, according to Webster et al. (2008: 142), both a potential reason for low self-referral rates **(Outcome[1])** whereby *"some patients were not confident* **(Reasoning[5])** *with this approach"* and an imperative, *"[i]f self-referral systems are to be accessed appropriately, patients have to have knowledge* **(M-Reasoning[3])** *of physiotherapy, confidence* **(Reasoning[5])** *in its potential effectiveness"* (ibid: 142).

In summary, the trust and confidence, patients have in their GP, is long-held and appears, from statements in the evidence, resistance to challenge and change. Furthermore, it has the potential to influence patients' use of FPCP. Nevertheless, and indicative of the hidden, interwoven complexities inherent in complex interventions there is evidence to suggest this persistent feature can change: even if this is through the more passive feature of embeddedness **(Context[6])**.

5.10 – Moving from partial CMOs to refined CMOs

The programme theory 'patient understanding of FPCP for MSK conditions' contained a broad mixture of topics. The data selection process revealed a predominance of literature with both thin and thick descriptions, but lacking contextual richness, particularly in the physiotherapy specific literature, most of which contributed evidence to this programme theory. Synthesising the literature using a realist review approach produced greater detail than would otherwise have been achieved using conventional synthesis techniques.

For example, the project team identified an interest in 'advocacy strategies' to disseminate information with the rough programme theory acknowledging their presence in the need for the public to have an 'awareness of FPCP'. The review process provided depth to this rough theory identifying an abundance of mechanism-resources under the broad theme of 'advocacy strategies' **(M-Resource[1]).** These included using a variety of media **(M-Resource[3])**, tailoring strategies specifically **(M-Resource[4]),** tailoring strategies locally **(M-Resource[5])**,

tailoring strategies nationally **(M-Resource^{6})**, using publicity in the local paper **(M-Resource^{7})**, using posters displayed in the health centre **(M-Resource^{8})**, using patient newsletters **(M-Resource^{9})**, using verbal dissemination by primary care team **(M-Resource^{10})**. While the refined CMO configurations do not report these advocacy mechanisms individually, the subsequent realist evaluation will explore them in more depth utilising the detailed new knowledge from the realist review in the interviews and focus groups. A degree of judgemental rationality was applied in the process of moving from the partial to the refined and reported CMO configurations.

While the data reported one outcome (Utilisation of FPCP **(Outcome^{1})**) several other outcomes could have been reported. For example, where advocacy strategies were directed at patients, conceivable outcomes could have been an 'increase in patient awareness' or an 'increase in patient understanding' of FPCP. However, these have been represented as mechanisms, (Public awareness **(M-Reasoning^{1})** of FPCP, Public understanding **(M-Reasoning^{3})** of FPCP) as they appear causally related to an individual utilising FPCP services.

Equally, a number of contextual lenses could be applied to the analysis of FPCP (Pawson and Tilley, 1997). Jagosh et al., (2012) described the context as the backdrop to the programme and this backdrop can have multiple layers (Lacouture et al., 2015). For example, this contextual layering is evident in the statement; in the context of FPCP **(Context^{1})** where normal practice is for patients to consult their GP for MSDs **(Context^{7})**.

As such, the synthesis process revealed cascades of contexts and mechanisms (Jolly and Jolly, 2014), whereby what was a context at one point became a mechanism at a later stage. For example, the use of advocacy strategies was a contextual feature **(Context5)** within some general practices but equally the information disseminated within these strategies became a mechanism **(M-Resource^{1})**. Likewise, a pre-existing lack of awareness **(Context3)** in a population was a contextual feature into which the FPCP was introduced but this awareness

evolved into a mechanism **(M-Reasoning[1])** as the population responded to the resources provided by the programme.

5.11 – Refined CMO configurations- patient Understanding of FPCP

5.11.1 – Patient understanding and advocacy strategies (CMO 1)

In the context of FPCP **(Context[1])** there was poor public awareness **(Context[3])** and understanding **(Context[4])** of FPCP and physiotherapists used advocacy strategies **(M-Resource[1])** to disseminate information, targeting the public to improve public awareness **(Reasoning[1])** and understanding **(Reasoning[3])** of FPCP and increase utilisation of FPCP **(Outcome[1])**.

5.11.2 – Embedding of FPCP (CMO 2)

In the context of FPCP **(Context[1]),** embedded services **(Context[6])** were more visible **(M-Resource[14])** and became more familiar **(M-Reasoning[6])** to the public who therefore accessed the service **(Outcome[1])**, reported satisfaction **(Reasoning[8])** with and support **(Reasoning[7])** for the service and utilisation consequently increased further **(Outcome[1])**.

5.11.3 – Patient demographics and FPCP (CMO 3)

Where FPCP services were available **(Context[1])** certain patient demographics **(M-Resource[12])** and autonomous health seeking behaviours **(M-Resource[13])** increased patient awareness **(M-Reasoning[1])** and/or patient understanding **(M-Reasoning[3])** of the role of physiotherapy and increased utilisation of FPCP **(Outcome[1])**.

5.11.4 – The GP as the default first contact practitioner (CMO 4)

Patients usually saw their GP as the FPC practitioner for MSK complaints **(Context[7])**, they identified **(M-Resource[14])** with and had a historically situated trust **(M-Resource[15])** in the GP as the legitimate first choice for their healthcare and had certainty **(M-Reasoning[9])** in the GP role and confidence in the clinical competence of their GP **(M-Reasoning[10]).** In the absence of confidence **(M-Reasoning[4])** in FPCP, patients defaulted to the GP as the FPCP **(Outcome[1])**.

5.12 – Programme theory 2 – Roles and boundary definitions in the FPCP initiative

5.12.1 – Introduction

The second rough programme theory committed itself to the configuration of FPCP as a professional project by the profession of physiotherapy and hypothesised that within this project there would be some boundary negotiations. Consequently, it was theorised that GPs would react to the potential perceived boundary incursion, inherent in FPCP, and this would influence the implementation and/or the utilisation of FPCP.

5.12.2 – Initial rough programme theory

Where GPs have a knowledge **(M-Resource)** of the professional project initiative of physiotherapists **(Context)** they will react to that initiative **(Mechanism-Reasoning)** and FPCP utilisation will be affected accordingly **(Outcome)**

5.12.3 – Evidence base CMO configurations

5.12.4 – CMO representation 1: FPCP as a professional project

FPCP **(Context[1])** constituted a professional project **(Context[8])** with the objective of increasing professional jurisdiction **(Outome[2]).** The physiotherapy profession made use of political policy at the time **(Context[9])** and developed arguments **(M-Resource[17])** appealing to a number of stakeholders. A number of strategies were utilised within this initiative (political arguments **(M-Resource[18])**, use of evidence base **(M-Resource[19])**, development of a continuing education curriculum **(M-Resource[20])**) to justify the project while at the same time providing reassurance **(M-Reasoning[11])** to stakeholders (politicians and policy makers, GPs, nonclinical healthcare professionals, physiotherapists) regarding the highlighted risks of FPCP, most notably patient safety, increase costs and the overburdening of physiotherapy services.

There was strong evidence from the review that physiotherapists were looking to increase their professional jurisdiction (Timmons, 2011) and as such, FPCP was considered a professional project **(Context[8])**. If, as Foster et al. (2012) stated in their review and critical analysis, the first health professional patients are likely to see with MSDs was their GP then the proposal that physiotherapists assume this role for MSDs constituted a widening of professional jurisdiction **(Outcome[2]).**

Similarly, the evaluation by Goodwin and Hendrick (2016) demonstrated an extended scope of practice and role substitution with FPCP. In this evaluation physiotherapists were able to refer for diagnostic examinations, secondary care and were moving to replicate GP working. Indeed, the role had been extended further elsewhere to include injection therapy and independent prescribing as *"[p]hysiotherapists continue to push back their traditional boundaries"* **(Outcome[2])** (Goodwin and Hendrick, 2016: 12).

It appeared that the profession of physiotherapy had used a number of arguments, strategies and levers **(M-Resource[17])** to influence stakeholders as to the benefits of this project **(Context[8])** (Bury an Stokes, 2013, 2013a; CSP, 2004, in Holdsworth et al., 2008: 236). With respect to facilitators, the alignment of the FPCP initiative and existing government policy **(Context[9])**, in the late 1990s was timely. The pro-FPCP arguments that were articulated supported the political policy **(Context[9])** at the time (Holdsworth and Webster, 2004, Webster et al., 2008). Holdsworth and Webster (2004: 64) stated there was a:

> *[g]rowing interest in the concept of patient direct access (self-referral) to services in primary care, introduced during the 1990s can be demonstrated by the proliferation of nurse-led initiatives, primary care clinics, walk-in centres and NHS Direct*

However, they go on to say that at the time that the *"level of interest…has not extended to physiotherapy services…despite the fact that the profession was recognised as being fully autonomous in 1978"* (ibid: 65).

The pressures experienced in the late 1990s did not abate and Goodwin and Hendrick (2016) referenced the ageing population, the prevalence of MSDs, and workforce issues amongst GPs as contextual sociopolitical levers **(Context[9])** for a central governmental drive to a modernise primary care. This aligned with the FPCP initiative. Additionally, Shoemaker (2012) cited the challenges facing the GP workforce as justification for the programme of FPCP **(Context[9])**. If the sociopolitical context **(Context[9])** provided leverage for the profession, this leverage had to be actualised through gaining stakeholder support. The main stakeholder groups were identified as patients, politicians and policy makers, physiotherapists, other non-medical healthcare professionals and doctors. A principle target of the professional rhetoric were politicians and policy makers **(M-Resource[18])**. Seven papers referenced strategies targeted at policy makers (Bury and Stokes, 2013, 2013a; Holdsworth et al., 2008; Webster et al., 2008; Holdsworth and Webster, 2004; Shoemaker, 2012; Bélanger and Rodríguez, 2008).

Although the autonomy of physiotherapy had grown over the last three decades (Bury and Stokes, 2013) FPCP was acknowledged as a broadening physiotherapy's professional jurisdiction **(Outcome[2])** and an encroachment into the role traditionally held by GPs. As such, members of the WCPT saw the significance of influencing legislation **(M-Resource[18])**. A resource identified to achieve this objective was that of policy statements from professional bodies, and the adoption of *"proper legislation"* and the inclusion of *"direct access in the law"* (Bury and Stokes, 2013: 454). Concern with respect to legislation **(M-Resource[18])** seemed judicious given historical precedent. For example, in their qualitative synthesis Bélanger and Rodríguez (2008) found concerns from doctors *"regarding the legal accountability of new nursing roles"* (Bélanger and Rodríguez, 2008: 593).

If politicians and policymakers were identified as a primary group to target then the use of the 'growing body of supporting research' was recognised as a principal resource within the professional project **(M-Resource[19])**. The strategy was realised via the accumulation and dissemination of an evidence base to support the assertion that FPCP could play a role in alleviating the pressures faced by general practice **(M-Resource[19])**. Twelve articles referred to evidence supporting FPCP (Dufour et al., 2014; Bury and Stokes, 2013, 2013a; Foster et al., 2012; Holdsworth et al., 2008; Shoemaker, 2012; Ferguson et al., 1999; Holdsworth and Webster, 2004; Webster et al., 2008; Ludvigsson and Enthoven, 2012; Goodwin and Hendrik, 2016; Swinkels, 2014). Within a global perspective, the need for evidence to support FPCP **(M-Resource[19])** was the facilitative strategy most frequently cited by member organisations (Bury and Stokes, 2013). This alignment with the EBM paradigm, that was so persuasive at the time, was professionally shrewd. For example, in their opening line, Holdsworth et al. (2008) make the statement *"self-referral to physiotherapy is feasible, appropriate, cost-effective and well supported by patients and the public"* (Holdsworth et al., 2008: 236).

Certainly, as Foster et al. (2012) state, physiotherapy's commitment to the academic accumulation and dissemination of evidence supporting the FPCP practitioner role means:

> *[M]uch of the knowledge being generated about the assessment and management of musculoskeletal pain is seen as core business by those within physiotherapy and other musculoskeletal professional groups but rather less by the professional group (GPs) that most often provides front-line care for these patients*
>
> Foster et al., 2012: 210

The commitment of physiotherapists to the EBM agenda, as both a method of demonstrating the efficacy of FPCP, and the subsequent dissemination of said evidence, is clearly seen in the policy analysis undertaken by Shoemaker (2012) **(M-Resource[19])**. Shoemaker (2012) evidences a steady but noticeable increase in the published literature demonstrating the efficacy of direct access to physiotherapy, between the years 2001/2002 and 2005/2006.

A further, and related, strategy was the process of securing a body of collegiate knowledge **(M-Resource[20])** with eight articles citing this mechanism (Bury and Stokes, 2013; Ferguson et al., 1999; Foster et al., 2012; Dufour et al., 2014; Holdsworth at al., 2008; Bélanger and Rodríguez, 2008; Shoemaker, 2012; Swinkels et al., 2014). Once again, this was seen as important by member organisations of the WCPT. Improvements in the educational standards concerning physiotherapy training, at both undergraduate and postgraduate level, were recommended **(M-Resource[20])** (Bury and Stokes, 2013). This feeling was echoed in the earlier work of Ferguson et al. (1999) and was reinforced in the synthesis of Foster et al. (2012). The wider evidence suggested it was pertinent to use the rhetoric of educational competence as one of the validation strategies for FPCP.

Bélanger and Rodríguez (2008: 593) described the roles of practice nurses being limited to:

> *administrative and educational work…(with)...both general practitioners and practice nurses blam[ing] insufficient training as an impediment to a more active role in diagnosis and treatment*

The American Physical Therapy Association (APTA) began an initiative in the late 1970s to increase direct access without the need of referral from a physician. Fundamental to this programme were the:

> *[p]rogressive changes in professional education standards to better prepare entry-level clinicians to be able to screen for the presence of medical disease and to function in a direct access environment as a point of entry into the health care system.*

Shoemaker, 2012: 237

Both legislative **(M-Resource[18])** and educational considerations **(M-Resource[20])** were tools utilised by the physiotherapy profession to justify the increase in professional jurisdiction, inherent in FPCP **(Outome[2])**. This strategy is clear in the following quote from Bury and Stokes:

> *The WCPT has developed guidelines for physical therapist entry-level education and for professional regulation and legislation, all of which underpin the autonomous practice of physical therapists and the right to accept patients via direct access, so long as they have the competencies to do so*

Bury and Stokes, 2013: 457

It appeared that the objective of these strategies (Professional legislation **(M-Resource[18]);** the accumulation and dissemination of evidence-based physiotherapy **(M-Resource[19])** and raising of educational standards **(M-Resource[20])**) was to provide reassurance **(M-Reasoning[11])** to stakeholders with respect to the concerns

expressed – most notably patient safety, increased costs and the overburdening of physiotherapy services (Shoemaker, 2012). Clearly, the objective was to provide stakeholders with both reassurance about these risks, and confidence in the efficacy of FPCP.

5.12.5 – CMO representation 2: First point of contact physiotherapy challenges medical dominance

FPCP **(Context[1])** challenged the traditional hierarchical medical model of healthcare delivery (**M-Resource[21]),** where GPs were the usual FPC **(Conext[7])** and GPs felt threatened **(M-Reasoning[12])** by this model as it challenged their perception of the doctor: patient relationship, the primacy of their role, their power, eroded their role and encroached into their professional jurisdiction **(M-Resource[21])**. GPs, and particularly older GPs **(Context[10])**, were resistant **(M-Reasoning[13])** to FPCP and this influenced collaborative working **(Outcome[3])**.

There was little direct reference of advocacy strategies being directly targeted at the medical profession. Holdsworth et al. (2008) referenced the RCGP support for the initiative, in a CSP briefing paper (CSP, 2004). Indeed, prior to their study, Holdsworth et al. (2008) reported that the views of GPs, regarding physiotherapists assuming greater autonomy, were unknown. Their own evaluation revealed the majority of GPs were comfortable with the physiotherapist in this role although one quarter were uncomfortable. However, balancing this apparent support were the findings that the GPs in the study were more frequently resistant or ambivalent about physiotherapists taking on extended roles (Holdsworth et al., 2008).

The lack of explicit evidence relating to the views of doctors was interesting when set alongside the perceived importance of doctors' influence on the FPCP initiative. Worldwide members of the WCPT (Bury and Stokes, 2013) reported the views of the medical profession as the greatest perceived barrier to direct access. The European members reinforced this opinion with 75 per cent reporting the medical profession as the primary obstacle (Bury and Stokes, 2013a). Both European, and global, members of the WCPT acknowledged the contrasting,

potentially facilitative impact of support from the medical profession. However, only 16 per cent of member organisations felt there was support from the medical profession. Consequently, the need to influence the medical community was acknowledged (Bury and Stokes, 2013a). With this in mind, it was interesting that evidence of advocacy strategies being directly targeted at the medical profession was so limited.

That FPCP challenged the established status quo **(Resource[21])**, led to an acknowledgement of perceived interprofessional tensions, inhibiting collaborative working **(Outcome[3])**, Foster et al. (2012: 11) proposed that it was time to "*have this debate (about first point of contact practitioner) with openness, dialogue, and curiosity and to set aside professional tensions and traditional hierarchies"*. The influence of the traditional hierarchies in general practice, were evident in the policy analysis of Shoemaker (2012). It appeared that the hierarchies inherent in the political system made it hard for the Michigan Physical Therapy Association (MPTA) to exert influence on the legislative process in their attempt to increase direct access to physical therapy. Furthermore, this lack of access contrasted sharply with both access to the legislative process and subsequent influence of physicians on the legislature. These traditional hierarchies were acknowledged and they were repeatedly identified as barriers to equitable team working **(Outcome[3])** (Bélanger and Rodríguez, 2008).

It appeared, from the evidence, that physiotherapists had addressed the traditional hierarchical structure in a subservient, oblique, and persuasive manner. For example, in an early evaluation by Ferguson et al. (1999) prevention and misdiagnosis protocols were written to provide the GPs with reassurance **(M-Reasoning[11])** regarding the diagnosis of non-MSK conditions. The reassurance being physiotherapists would not work beyond the boundaries defined. Furthermore, Shoemaker (2012: 246) suggested that it was made clear physiotherapists would not *"diagnose and manage medical conditions that fall outside of their scope of practice"*. However, he acknowledged a dichotomy in that such compromises

needed to be considered carefully as they undermined the original programme objective and therefore perpetuated the established hierarchy.

The devolution of roles within general practice, inherent in FPCP, *"stands against a well-established tradition of all-encompassing solitary care"* **(Resource[21])** traditionally held by GPs (Bélanger and Rodríguez, 2008: 594). In their synthesis of qualitative research, the authors found this to be an issue for team working. The review identified that GPs made their own assessment of the competence of other clinicians and oversaw the development of roles *"only insofar as physicians do not feel threatened* **(M-Reasoning[12])** *by these changes"* (Bélanger and Rodríguez, 2008: 593). Bélanger and Rodríguez, (2008: 593) described the:

> *contradiction in general practitioners' experiences, whereby they may appreciate sharing responsibility and adopting the role of the expert, while also fearing* **(M-Reasoning[12])** *the loss of contact with the patient and of the 'complete picture'*

Despite the proposal that FPCP could lessen GP burden, there was evidence of GP resistance **(M-Reasoning[13])** to FPCP. From a legislative perspective, the Michigan State Medical Society (MSMS) and individual members aggressively opposed the bill to increase direct access to physiotherapy (Shoemaker, 2012). The rhetoric from the MSMS was three-pronged: a deterioration in the doctor: physiotherapist relationship, an increase in costs incurred and concerns about patient safety.

Soklaridis et al. (2007: 1203) in their study of primary care team reported the College of Physicians and Surgeons of British Columbia advising members to be mindful:

> *If medical acts become incorporated into the accepted scope of practice of other disciplines, the boundaries of medical practice may change.*

Dufour et al. (2014: 461) found in one study the absence of rehabilitation professionals was attributable to the fact that *"physicians would not agree to work with rehabilitation professionals"* **(M-Reasoning[13])** and this negatively influenced

collaborative working **(Outcome[3]).** It appeared that the traditional hierarchy in general practice led to the potential for GP resistance **(M-Reasoning[13])** because of the incursion into their professional jurisdiction and the potential erosion of the primacy of the doctor: patient relationship and the absolution of power. Xyrichis and Lowton (2008) in their literature review of interprofessional team working quote a GP (from an evaluation by Cook et al. (2001: 148)):

> *It's sometimes difficult for us to let go of our power base and as they (nurses) take on more responsibility for developing the service, we can feel that our role is being eroded.*

The feeling from staff was that this power imbalance was resistant to change **(M-Reasoning[13])** due to its historical longevity (Soklaridis et al. 2007). Indeed, there was evidence to suggest that older GPs **(Context[10])**, more entrenched within the traditional system, were more resistant to change **(M-Reasoning[13])** (Pullon et al., 2011).

5.12.6 – CMO representation 3: Developing professional relationships

GPs who had worked alongside physiotherapists **(Context[11])** were comfortable with **(M-Reasoning[14])** and supportive of **(M-Reasoning[15])** the principle and potential benefits of FPCP suggestive of a maturation of relationships over time FPCP suggestive of a maturation of relationships over time **(M-Resource[22])** and a subsequent effective collaboration **(Outcome[3])**.

The evaluations by Ferguson et al. (1999), Holdsworth et al. (2008) and Ludvigsson and Enthoven (2012) all demonstrated that where GPs had experience of working alongside physiotherapists **(Context[11])** they were comfortable with **(M-Reasoning[14])**, and supportive of **(M-Reasoning[15])** the principle of FPCP and collaborated **(Outcome[3])**. This was attributed, in some part, to the mature nature of the relationships between GPs and physiotherapists **(M-Resource[22])**. This sentiment was further reinforced by Dufour et al. (2014) with GP participants describing their comfort **(M-Reasoning[14])** and support **(M-Reasoning[15])** for integrating

physiotherapists within primary health care teams, when working alongside physiotherapists **(Context[11])**. Pullon (2011: 132) quotes a GP who described the benefits of multidisciplinary team working from their qualitative study:

> *A team is many different people, and with many different qualifications and backgrounds, and contributions to make… it gives you… a pool of skills for any one problem… no individual can provide a complete service…*

5.12.7 – CMO representation 4: Negotiating roles

In the context of a FPCP service **(Context[1])** it was essential to negotiate roles and role boundaries **(M-Resource[23])** as contested role boundaries negatively affect team working **(Outcome[3])** and, conversely, clarity enhances collaborative working **(Outcome[3]).**

A central issue that came from the evidence was the one of role definitions and boundaries **(M-Resource[23])**. Several studies, in the synthesis by Bélanger and Rodríguez, (2008) cited confusion and contested role boundaries as negatively affecting team working **(Outcome[3])** and subsequently patient care. These findings were replicated in the qualitative study of family health teams in Ontario undertaken by Soklaridis et al. (2007) and the literature review of Xyrichis and Lowton (2008). Soklaridis et al. (2007: e4) reported that in general, roles and responsibilities in primary health care teams remained vague leading to professional tensions, adding, *"[d]efining roles and responsibilities* **(M-Resource[23])** *will enhance the positive elements of collaborative interprofessional care* **(Outcome[3])**".

5.12.8 – CMO representation 5: Redistribution of power

In the context of negotiating team roles **(Context[12])** GPs often assumed the lead role **(M-Resource[24])** and found it difficult to accept the redistribution of power **(M-Reasoning[16])**. Nevertheless, GP input should be sought **(M-Resource[25])** in the process of role definition and this involvement should be sought as early as possible to maximise team congruence **(Outcome[3]).** Physiotherapists needed to assert themselves to influence the process **(M-Resource[26])**.

In the context of negotiating team roles and responsibilities **(Context[12])** three articles talked about the involvement of the medical profession (Bélanger and Rodríguez, 2008; Soklaridis et al., 2007; Xyrichis and Lowton, 2008). It was clear that the position of power, underpinned by the long standing medical dominance, privileged GPs and evidence suggested that physicians often took the lead role **(M-Resource[24])** dominating the role negotiation processes (Xyrichis and Lowton, 2008). Furthermore, there was evidence describing medical dominance and concerns from within the medical profession with respect to the dissolution of their position (**M-Reasoning[16])** (Xyrichis and Lowton, 2008, Soklaridis et al., 2007). This appeared to present a challenge as, in parallel, the input of the medical profession was acknowledged as vital in the process of identifying team roles **(M-Resource[25]**) (Soklaridis et al., 2007) with recommendations that this involvement should be sought as early as possible in the development of a primary care team to maximise team congruence **(Outcome[3])** (Bélanger and Rodríguez, 2008; Soklaridis et al., 2007; Xyrichis and Lowton, 2008). All three authors identified clear role definitions **(M-Resource[23]**) as facilitative of good interdisciplinary team working **(Outcome[3])** (Bélanger and Rodríguez, 2008; Soklaridis et al., 2007; Xyrichis and Lowton, 2008).

The synthesis of Bélanger and Rodríguez (2008) reported hierarchical structures as being *"repeatedly identified as a barrier to achieving equal roles for members"* (Bélanger and Rodríguez, 2008: 592). Quite clearly, physiotherapists had a body of evidence to support the case for FPCP roles. However, beyond services that had verified effectiveness through established services that led to mature

mutual relationships between physiotherapists and GPs **(M-Resource[22])** (Ferguson et al., 1999, Holdsworth et al., 2008, Ludvigsson and Enthoven, 2012, Dufour et al., 2014), there was a dearth of evidence demonstrating the impact of physiotherapy negotiation strategies. Furthermore, the only example of a direct investigation of physiotherapy influence within a negotiation process was the policy analysis undertaken by Shoemaker (2012). In this analysis, the resistance of the medical profession **(M-Reasoning[13])** to FPCP was identified and the neutralising effect this had on physiotherapy discourse was demonstrated. This had a clear negative impact on collaborative working **(Outcome[3])**. Nevertheless, the literature review undertaken by Xyrichis and Lowton (2008: 151) suggested non-medical staff (in their case nursing staff) should assert themselves and *"place themselves in a position where their professional input* **(M-Resource[26])** *is acknowledged"*.

5.13 – Moving from partial CMOs to refined CMOs

The programme theory 'Roles and boundary definitions in the FPCP initiative' contained a broad mixture of topics. The inclusion of qualitative studies, not immediately associated with FPCP, which explored the dynamics of primary care teams more generally, enhanced the contextual richness of the review process. This was acknowledged as a positive contribution of the realist review method.

As described for programme theory 1, contextual layering (Lacouture et al., 2015) and a multiplicity of mechanisms was evident in the partial CMO configurations. FPCP **(Context[1])** provided a context where normal practice was for patients to consult their GP as the FPC for MSK complaints **(Context[7])** and furthermore FPCP represented a professional project **(Context[8])**, supported by, and existing within, the sociopolitical context **(Context[9])** of the time**.** Further cascading of contexts and mechanisms were evident. For example in the context of negotiating clear team roles and responsibilities **(Context[12])**, GP input was seen as important **(M-Resource[25])** to ensure the development of clear roles and responsibilities **(M-Resource[23])** which resulted in subsequent GP comfort with **(M-Reasoning[14])** and support for **(M-Reasoning[15])** FPCP and resulted in effective collaborative working **(Outcome[3]).**

Furthermore, it would be equally reasonable to attribute an 'outcome' to the attainment of clear roles and responsibilities through this process of negotiation whereby 'clear roles and responsibilities' provides context, resource (mechanism) and outcome through various configurative manifestations. In alignment with realist principles, judgemental rationality was applied to the multiple partial CMO configurations to synthesise and construct the final, refined configurations below.

5.14 – Refined CMO configurations – Roles and boundary definitions in the FPCP initiative

5.14.1 – First point of contact physiotherapy as a professional project (CMO1)

In the context of FPCP **(Context[1])** physiotherapy governing bodies and physiotherapists were engaged in a professional project **(Context[8])** and utilised a number of influencing strategies **(M-Resource[17])**, directed at multiple stakeholders, with the intention of providing them with reassurance **(M-Reasoning[11])** regarding the efficacy of FPCP and widening physiotherapists' professional jurisdiction **(Outcome[2])**.

5.14.2 – First point of contact physiotherapy challenges medical dominance (CMO2)

FPCP **(Context[1])** challenged the traditional hierarchical medical model of healthcare delivery **(M-Resource[21])** and some GPs felt threatened **(M-Reasoning[12])** by this innovation and were resistant **(M-Reasoning[13])** to FPCP and this negatively influenced collaborative working **(Outcome[3])**.

5.14.3 – Developing professional relationships (CMO 3)

GPs who had worked alongside physiotherapists **(Context[11])** were comfortable with **(M-Reasoning[14])** and supportive of **(M-Reasoning[15])** the principle and

potential benefits of FPCP suggestive of a maturation of relationships over time **(M-Resource[22])** and a subsequent improved collaboration **(Outcome[3])**.

5.14.4 – Negotiating roles (CMO 4)

In the context of FPCP services **(Context[1])**, and in the context of negotiating team roles **(Context[12])**, a number of features were important including the involvement of GPs, early in the process **(M-Resource[25])**, and the assertive influence of physiotherapists **(M-Resource[26])** in the process to ensure clear roles and role boundaries **(M-Resource[23])** and support GPs acceptance of a redistribution of power **(M-Reasoning[16])** as this role clarity enhanced collaborative working **(Outcome[3])**.

5.15 – Strengths and limitations

The principle strength of this realist review was the generation of new knowledge pertaining to patient understanding and roles and boundary definitions in the FPCP initiative. This new knowledge has the potential to inform clinical practice. A further significant strength of this review is the application of realist methods. The application of realist methodology to a systematic process of literature review revealed a rich and meaningful evaluation of the literature.

There was undoubtedly a paucity of literature relating directly to FPCP. It was interesting to reflect that none of the included literature was likely to have passed inclusion criteria for a traditional systematic review, further justifying the application of a realist review approach. It also became apparent that the literature relating specifically to FPCP, or self-referral physiotherapy, provided either thin or thick descriptions but none were identified as contextually rich. Snowballing reference lists resulted in the inclusion of four pieces of literature qualitatively exploring primary care team working more generally. All provided a richness which was absent in the physiotherapy literature. It was almost certain that further

widening the search would have revealed a greater body of literature that could have been added to the review. However, this was beyond the scope of the review.

Limitations of the review were the practical constraints, and subsequent methodological decisions that had to be made. This realist review formed a single component of a doctoral project and as such, time and resources were limited. The main consequences of these restraining features were described in chapter 4 with a reduction from four to two programme theories. Quite clearly, this influenced this review and the evaluation that followed. This decision was justified by the depth of the data generated in the two included programme theories. This decision was fundamental to the depth realism inherent in the realist research approach.

It was evident that given additional time and resources the literature search could have extended into several other bodies of literature; including business, sociological, and organisational literature. Although these domains would be unlikely to talk about FPCP specifically they may well have spoken to issues such as teamwork, marketing and communication. This does not detract from the contribution of this realist review and the generation of new knowledge. As realists, we espouse all knowledge as partial and by being explicit about the boundaries of this review, and the pragmatic approach taken; a transparency was provided to the reader.

Despite these limitations, this realist review adds to the body of literature relating to FPCP. This review moved beyond the traditional systematic review and considered contexts and mechanisms for the first time, in relation to FPCP. The theories were refined from the initial rough theories and the refined hypotheses will assist stakeholders in the future. In particular, this realist review exposed a number of, otherwise, hidden mechanisms that were important for projects where new models of service delivery, which cross traditional role boundaries, are considered.

5.16 – Conclusion and recommendations

FPCP is a modern iteration of the existing principle of self-referral physiotherapy. Despite evidence of clinical efficacy and stakeholder satisfaction the potential of self-referral physiotherapy, in its first iteration, does not appear to have been realised with a 'true' self-referral rate of 22 per cent being demonstrated (Holdsworth et al., 2006). This realist review cast light on why this low self-referral rate might be seen. It appeared that physiotherapists' assumed support for FPCP, from patients, physiotherapists and the medical profession. The perception, from within the physiotherapy profession, was that the main obstacle to the FPCP initiative would be the opinions of the medical profession. A consequence of this perception was that advocacy strategies directed at the public were not prioritised. As such, there was a persistent lack of understanding of the role of FPCP amongst the public. In addition to this intransigence is an equally stubborn dependence on the GP as the default FPC clinician for the majority of people. Mindful of the lack of public understanding it would have been encouraging to have discovered evidence of well-designed and implemented marketing strategies for FPCP. This was not the case with most evaluations giving no details of the process of designing, implementing or evaluating any advertising approaches. Clearly, this is any area that can be explored considerably, at both a professional level, and a local service level.

It was also evident from the review that FPCP formed a professional project for the profession of physiotherapy, encroaching in to the traditional jurisdiction of GPs. As such, there was potential for the GP workforce to react defensively. The review provided evidence of strategies to ameliorate this potentiality. These strategies would certainly be worthwhile considering in this ongoing initiative, both at a practice level and more broadly professionally.

A number of learning points and associated action points have been generated and these are presented for each programme theory (see table 5.4 and table 5.5).

5.17 – Learning and action points

5.17.1 – Programme theory 1: Patient understanding of FPCP for musculoskeletal conditions.

Learning point	**Action point**
There was assumed patient support for FPCP by physiotherapists. Because of this perception, it appears that advocacy strategies directed at the public were not prioritised. However, the evidence suggested that public awareness and understanding of FPCP was poor. The consequence of this dynamic was an unchallenged, persistent lack of understanding of the role of FPCP amongst the public.	Advocacy strategies should be targeted at the public to increase both their awareness of FPCP as a resource and their understanding of FPCP and the role it can play in the management of MSDs.
Evidence of marketing strategies directed at the public was vague. There was no evidence relating to the planning of marketing strategies and the evidence of the methods used was equivocal. There was no evidence of any evaluation of any marketing strategies employed.	There is considerable scope to explore methods of marketing of FPCP to the public. Furthermore, there would appear to be a necessity to evaluate the efficacy of any strategies utilised both at a local service level and more broadly, at a professional level.
It appears that FPCP services become embedded over time in general practice. The process by which this happens remains unexplored. A potential mechanism is that, over time, FPCP services become more visible and familiar to patients and access increases. However, it is unclear if this corresponds to greater understanding of the role of FPCP.	The principle of 'embedding', the associated increase in service utilisation and any corresponding increase in patient understanding of FPCP warrants further investigation. This may highlight advocacy strategies for future implementation.

The evidence concerning characteristics of patients more likely to access FPCP is mixed and contradictory.	It is important to examine the characteristics of people who access FPCP services further. Within this objective it would appear relevant to explore these characteristics with relationship to the differentiation between 'awareness of' and 'understanding of' FPCP. This knowledge may both expose those individuals and groups, who are currently excluded from FPCP services and, in doing so, help prioritise the targeting of advocacy strategies.
The evidence suggested a persistent dependence on the GP as the default FPC clinician for the majority of people**.**	This reiterates the importance of a combined approach to identify, systematically, existing public understanding and any potentially disenfranchised groups. Further, it draws together the evidence supporting the empirical design, implementation and evaluation of advocacy strategies targeting public awareness and understanding of FPCP with the intention of challenging the existing public default position.

Table 5. 4: Learning and action points; Patient understanding of FPCP

5.17.2- Programme theory 2 – Roles and boundary definitions in the FPCP initiative

Learning point	**Action point**
Physiotherapy professional bodies recognised the importance of influencing relevant stakeholders in the FPCP initiative. In doing so, a number of strategies were employed such as political arguments, research evidence of efficacy, and development of a continuing education curriculum. While all of these methods are consistent and efficacious with the wider sociology of the professions there was no empirical evidence of their influence.	Physiotherapists, at all levels, should persist in utilising validated methods to support the FPCP initiative. Stakeholder impact and understanding of FPCP, as a consequence of these methods, should be evaluated. This process could provide further reassurance to stakeholders about the articulated concerns attributed to the FPCP role and subsequently facilitate the initiative.
The FPCP role encroaches on traditional GP jurisdiction and GPs were acknowledged as potential obstacles to the initiative and this appeared to be more so in older GPs. There were indications outside the physiotherapy literature acknowledging evidence of GP resistance to the devolution of roles to others within general practice. GPs responded to this initiative through outright resistance, the insistence of their own criteria of professional jurisdiction and their own assessment thereof and a tendency to lead in the implementation process. There appeared to be a dichotomy whereby Physiotherapists recognised the	Physiotherapists should prospectively evaluate the opinions of GPs with regards to the FPCP initiative. This may provide further insight in to the contextual variations in opinions and allow for a more targeted approach to advocacy strategies.

importance of influencing the medical profession but the methods of doing so were not explicitly mobilised or appraised. There appeared to be a reliance on the evidence of GP comfort and support for services that had matured over time.	
The importance of the definition of clear roles and role boundaries was fundamental in facilitating effective collaborative working. Evidence suggested that the position of power held by the medical profession privileged them and evidence suggested that physicians often took the lead in this process. However, despite GP input being seen as essential there should be an equal contribution in the design, implementation and operationalisation of FPCP services from physiotherapy staff. There was no explicit evidence of this happening in an active, predetermined way.	Physiotherapists and GPs should collaborate in a prospective evaluation of the process of role and boundary definition in the implementation of FPCP. In doing so, a critical perspective to the evidence pertaining to professional tensions and hierarchies should be applied, along with an evaluation of the effectiveness of any subsequent FPCP implementation.

Table 5. 5: Learning and action points; Roles and boundary definitions in the FPCP initiative

5.18 – Summary

It was the intention of this realist review to generate new knowledge from existing literature pertaining to FPCP. This has been achieved and it was clear from the evidence generated that further work to influence patient understanding of FPCP is required. In summary, patient awareness and understanding of FPCP appears poor. Furthermore, these two concepts were rarely differentiated. Strategies to influence patient awareness and understanding were rarely systematically planned, implemented or evaluated and this warrants further attention. The evidence suggested that the long established position of the GP as the FPC for patients is resistant to change. If the full potential of the FPCP role is to be realised and its impact achieved these issues need addressing.

With respect to roles and boundary definitions, this review generated a number of important lessons. It appeared that the physiotherapy profession recognised the influence of the medical profession and the importance of gaining their support. However, there was no evidence of the profession systematically attempting to do this. Furthermore, FPCP encroached into traditional GP jurisdiction and some GP resistance was anticipated. Despite this expected resistance, and the acknowledgement of the need to influence doctor opinion, there was no prospective, proactive evidence of physiotherapists' establishing GP opinion of FPCP or collaborating in the definition of roles and role boundaries. This was shown as important in successful team working and justifies further investigation.

This review used FPCP as a case study of a profession responding to the significant challenges it faces due to the changing vista of healthcare. However, the findings have much to say to other health professions who are experiencing similar reconfiguration and reconceptualisation of their professional work and occupational boundaries particularly where they seek to modify their jurisdiction into the work of others. The findings from this realist review were used to inform a second stage of this research project that involved a primary realist evaluation. This realist evaluation is reported in chapters 6, 7 and 8.

Chapter 6 – First point of contact physiotherapy as a professional project; a realist evaluation

6.1 – Introduction

The previous chapter reported a realist review which explored FPCP and presented programme theories through a series of CMO configurations. The realist review provided a number of refined theories that represented new knowledge and a number of action points were generated that could, in their own right, inform future clinical practice.

This chapter introduces the subsequent realist evaluation that empirically interrogated the theories developed in the review. In doing so this chapter describes, and justifies, the chosen methods. As has been stated, all programmes are theories (Pawson and Tilley, 1997) and the theories generated in the realist review were used as a priori themes that were explored with stakeholders in the realist evaluation.

Realist evaluation, is a theory driven approach to the assessment of primary data collected by the evaluator and research questions should contain elements of 'what works, how, why, for whom, to what extent and in what circumstances, in what respect?' (Wong et al., 2016). As such the question for this evaluation was as follows:

- If FPCP constituted a professional project what were the reactions and responses of the multiple stakeholders to this, why were their reactions constructed as such, how were they articulated, in what circumstances and how did they influence operationalisation?

The conceptual, theoretical framework of realist evaluation was suited to the complexity of the programme, the social system and the research question. The objective of any realist evaluation is to uncover the 'how and why' and go beyond a straightforward description of the outcome (Wong et al., 2016). In this evaluation the outcome of interest was the operationalisation of FPCP and this was examined

through the opinions, roles and influences of the multiple stakeholders (Weiss, 1998).

Pawson and Tilley (1997) provided a set of principles to be adhered to in a realist evaluation rather than definitive methodological rules. These principles described the journey from research design to data generation and have been interpreted as a general strategy, or framework (Pawson and Tilley, 1997; Pawson 2013). As such, realist researchers do not advocate any one particular research approach within a realist evaluation (Pawson and Tilley, 1997; Emmel et al., 2018). Pawson and Tilley spoke of the need for "versatility of research design" (1997: 114), with Wiltshire (2018: 525) describing a methodological "plurality".

FPCP was envisioned as a professional project with the potential to mitigate some of the pressures facing primary care at the time. It was important to understand the nuances and hidden mechanisms inherent in the operationalisation of FPCP to ensure any outcome potential was realised. To satisfy the research question data collection methods that addressed questions about participants' experience and interpretation were required. Qualitative research methods were selected as they address questions about experience, meaning and perspective (Hammarberg, Kirkman and de Lacey, 2016).

Outlining the research question and positioning this evaluation as an enquiry into a complex social phenomena justified the application of both a realist evaluative approach and qualitative data collection methods. Realist evaluations have been undertaken in a number of healthcare environments ranging from the evaluation of single practice level interventions (Byng, Norman and Redfern, 2005) to the evaluation of features of effective working in care home settings (Goodman et al. 2017) to large scale whole-service transformations (Greenhalgh et al., 2009; Best et al. 2012). Prior to outlining the study design attention will be paid to researcher reflexivity.

6.2 – Researcher reflexivity

The researcher was a physiotherapist and had been fundamental in the conception, design, commissioning and implementation of a FPCP service. In addition, the researcher had been involved in an evaluation of a FPCP service and the dissemination of the findings. Furthermore, the researcher constructed the interview schedules and led the data synthesis process. Therefore, as discussed in the introduction to this thesis, it was seen as essential to provide reassurance to the reader.

Findlay (2003) suggested that qualitative research findings are the result of a co-production between the researcher and participants. As such, they advocated the need for researcher reflexivity, acknowledging that the researcher's position may affect the research design, process and outcome (Berger, 2015). The researcher's personal and professional characteristics and experiences have the potential to influence the study findings (Berger, 2015) and the goal of reflexivity is to monitor this, through deliberate effort, and establish systems to ensure that the research findings are plausible and trustworthy. Reflexivity was applied throughout in project team meetings and through the use of a reflective diary (Excerpt in appendix 7). The involvement of the project team, and a Patient and Public Involvement representative, in the development of the methods provided a reflexive standpoint (Hadi and Closs, 2016).

Researcher positionality, and their specialist knowledge, and experience, was a potential advantage. Their experience is likely to have led to more iterative insights and a deeper exploration, and interrogation, of new topics as they emerged through the process (Berger, 2015). Throughout the data collection and analysis process the researcher kept a reflective diary which provided a medium for personal self-reflection, a resource to record iterative theory development and an active comparison of new observations to prior knowledge and insights. The existing literature also provided a platform to facilitate reflexive monitoring. For example, there were a number of theories in the sociology of the professions

literature that provided a scaffold, and reference points, throughout the process to preserve the orientation, and evidence-based focus, of the research.

The researcher was cognisant of their privileged position and was committed to reflexivity throughout, taking time to self-evaluate their motivations, emotions and interpretations. Supervision with the project team assisted this reflexive process. The researcher's in-depth knowledge of the topic may have enabled a *"better in-depth understanding of participants' perception and interpretation of their lived experience"* (Berger, 2015: 230).

6.3 – Methods

Throughout this realist evaluation reference was made to the RAMESES II reporting principles for realist evaluations (Wong et al., 2016). This provided a framework and benchmark for the maintenance of standards throughout. The methods section begins by considering ethical concerns, the context in which the research occurred is outlined, and methods of data collection and analysis are described. This is followed with a description of the evaluation design. A number of methodological processes ensured rigour and reliability. These included the use of an audit trail (Hadi and Closs, 2016), member checking (Syed and Nelson, 2015; Hadi and Closs, 2016) and the use of a coding manual for the project team (Syed and Nelson, 2015, Morse, 2015). The objective, through the application of reflexivity and rigour was to increase the trustworthiness of the research findings.

6.3.1 – Ethics

This research was sponsored by the University of Nottingham and the University's Code of Research Conduct and Research Ethics (University of Nottingham, 2013) provided a comprehensive framework for the research. In maintaining the principles of the University's framework this research sought to maintain ethical standards of practice in research, protect participants' from harm, preserve the participants' rights, welfare and dignity and provide reassurance that the above was being done. The inclusion of patient participants resulted in the need for Health Research Authority ethical approval in addition to University approval. Documents

pertaining to this approval can be found in appendix 3. To allow participants to provide informed consent participant information forms and consent forms (examples in appendix 4 and 5) were developed. The purpose of these forms was to allow study participants to make well-informed and voluntary decisions about whether to participate (Peled and Leichtentritt, 2002).

Participant information forms were designed in a manner to communicate with people who are not researchers, and as such they were concise and written in laypersons' language. The consent form was written in similar laypersons' language. The researcher worked through the consent form with each participant, or collectively with a focus group, and answered any questions concerning the study. Two copies of the consent form were signed and one was given to the participant. The other was securely retained by the researcher and these were stored in a locked cabinet according to the University of Nottingham policy. All data generated was managed according to the Data Protection Act, 1998. Computer stored data was held securely and password protected. Access was restricted to the researcher and the research supervisors.

6.3.2 – Context

The evaluation was undertaken in an English city with a population of over 320,000 that was ranked as the eighth most deprived district in England in the 2015 Indices of Multiple Deprivation. There were a total of fifty-seven GP member practices within the city with over 200 GP's delivering services. There were thirteen single handed practices with almost all the remaining practices delivered through partnership arrangements. Practice list sizes ranged from 1,100 to 12,000.

A FPCP service had been established and evaluated in two GP practices three years prior to this research (Goodwin and Hendrick, 2016). During this initial one-year evaluation over 500 patients were assessed. Subsequent to this evaluation a pilot FPCP service had been implemented in twenty GP practices (Martini and Kelly, 2017). Between December 2014 and March 2017 there were 10,788 initial assessments in this pilot service. Both initiatives had demonstrated clinical efficacy

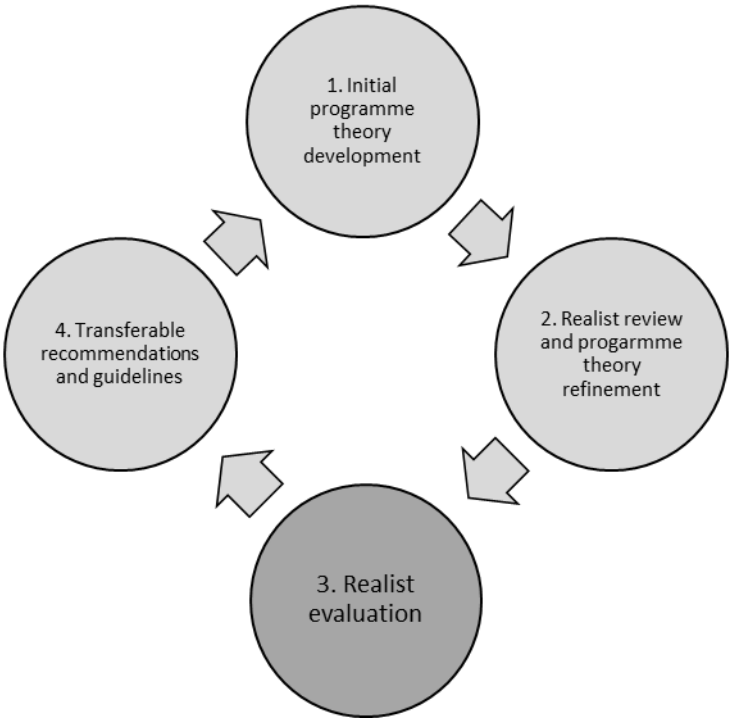
and high levels of patient satisfaction. However, at the end of the pilot period the service was not recommissioned. The pilot FPCP service was commissioned from non-recurrent CCG funds. At the end of the pilot period the GP practices were asked if they would like to continue funding the FPCP service from their own resources. None of the practices were able, or prepared, to fund the FPCP service. Funding from central reserves was common to most FPCP pilot services and this was the case in the 2018/19 NHSE FPCP pilot evaluation.

The physiotherapy team that provided the FPCP service consisted of twenty full-time equivalent staff of grades from band 5 to band 8a (NHS Employers, 2018) providing care for patients with MSDs. The initial evaluation had been provided by band 7 physiotherapists with extended scope of practice that included referrals for diagnostic investigations and secondary care. The subsequent pilot service had been provided at a non-extended scope of practice level (Band 6) and, as such, these advanced skills were not available. The team of Band 6 physiotherapists were clinically managed by an advanced practice physiotherapist (Band 7). All participants were recruited from patients and staff associated with either the initial evaluation or subsequent pilot FPCP services.

6.3.3 – Evaluation design

Qualitative data collection methods were judged most suited to the nature of the realist evaluation conceptual framework, purpose and research questions, as described above (Hammarberg, Kirkman and de Lacey, 2016; Teherani et al., 2015 Twinning, 2017; Denzin, and Lincoln, 1994). This evaluation formed stage 3 of the proposed research cycle (Figure 6.1). This evaluation utilised the theories developed in the realist review to drive the investigation.

Figure 6. 1: Proposed research project cycle



A number of qualitative approaches can be employed to understand participants' experiences and interpretations (Hammarberg, Kirkman and de Lacey, 2016). These approaches include surveys and questionnaires, interviews and/or focus groups, document analyses and observations (Hammarberg, Kirkman and de Lacey, 2016; Teherani et al., 2016; Twinning, 2017; Denzin, and Lincoln, 1994). For this evaluation individual interviews and focus groups were selected.

6.3.4 – Data collection methods

Interviews are a commonly used method of data collection (Manzano, 2016; Robson, 2016; Denzin, and Lincoln, 1994). Focus groups, on the surface, may appear similar to a semi-structured interview but with multiple participants. However, as a consequence of the number of participants the focus group has the potential to evolve into more of a discussion between participants. A possible advantage of this is the generation of deeper and richer expositions of the topics (O Nyumba et al., 2018). Conversely, it also requires considerable researcher skill and flexibility to manage the group.

The decision was made to interview the patient participants individually and the physiotherapists and administration staff in focus groups. Practicality dictated that the GPs were interviewed individually and due to the limited number of commissioner participants the intention was to interview them individually although two were interviewed as a pair.

An interview schedule, or topic guide, was devised for each participant group (appendix 6). Nevertheless, there is the possibility in both interviews and focus groups for the discussion to take on a "life of their own" (Gill et al., 2008: 294). As a consequence advanced moderation skills were required. The realist interview has developed a literature of its own (Pawson, 1996, Pawson and Tilley, 1997; Manzano, 2016). A fundamental difference is that, in the realist interview, the theories of interest are placed before the interviewee and they are invited to comment on with the intention of refining the theories (Manzano, 2016: 344). The subsequent conversation seeks to corroborate, refute and subsequently refine the theories and the conversation is described as taking place in a 'teacher–learner' cycle (Pawson, 1996).

With respect to sampling, this has traditionally been advocated based on the concepts of data completeness and saturation (Manzano, 2016). Suggestions for realist interviews included purposive sampling to maximise variability (Weiss, 1998: 164) and to aim for a substantial volume of data. A flexible, iterative approach was advocated – one which is led by the emerging data – relating to theories. This may require more interviews, and time, in the data collection process.

It was suggested that the interview process was phased (Manzano, 2016). However, the timescales inherent in a PhD project prohibited a phased approach. However, the reflexivity applied by the researcher, which included a process of reflection after each interview/focus group, allowed for iterative adaptations to the interview schedule to pick up on emerging theories.

6.3.5 – Recruitment and data collection process

The participants were recruited from a sample drawn from the original evaluation or subsequent pilot FPCP services. The objective was to recruit participants from all stakeholder groups to get a broad perspective. Participant groups were: patients, physiotherapists, GPs, administration staff, and commissioners. Recruitment was purposive (Palinkas et al. 2015) with individuals and focus groups identified and selected based on their involvement in the services, as described above. Recruitment of the administration staff, GP and commissioner participants was influenced by convenience, practicality and availability and previously established relationships with GP practices.

All of the physiotherapists involved in the delivery of the original, and subsequent pilot, FPCP services were invited to participate. Patient participants were recruited from a database of patients who had been given the study information sheet during their FPCP appointment during a two-month period between January and March 2017. If a patient preferred not to be involved this was recorded by their physiotherapist in their electronic records to ensure that patients not wanting to be involved in the study were not contacted. During the patient recruitment process the researcher contacted patients, who had received an information sheet, in chronological order. To achieve the required ten patient participants a total of twenty patients were scheduled to attend an interview. Four patients, when contacted the day before their interview, decided they no longer wanted to attend and a further six patients did not attend on their scheduled interview date. The patient participants were interviewed in a quiet, private room in one of two health centres.

The five GP interviews and three GP practice administration focus groups took place at the respective practices, for participant convenience. The three physiotherapist focus groups took place at one health centre with the focus group constituents derived via participant convenience.

The interviews and focus groups were recorded using digital voice recorders. A copy of the audio-file was saved in a secure study file. Each of the interviews and focus groups were transcribed verbatim. A university accredited third party was contracted to complete the transcription. There is an argument that transcribing the recordings allows the researcher to begin to familiarise themselves with the data (Robson, 2016). However, transcribing is extremely time-consuming (Hammersley and Atkinson, 2007) and to familiarise themselves the researcher listened to the audio-files several times. The transcriptions were uploaded into QSR International's qualitative data analysis NVivo 11 Software.

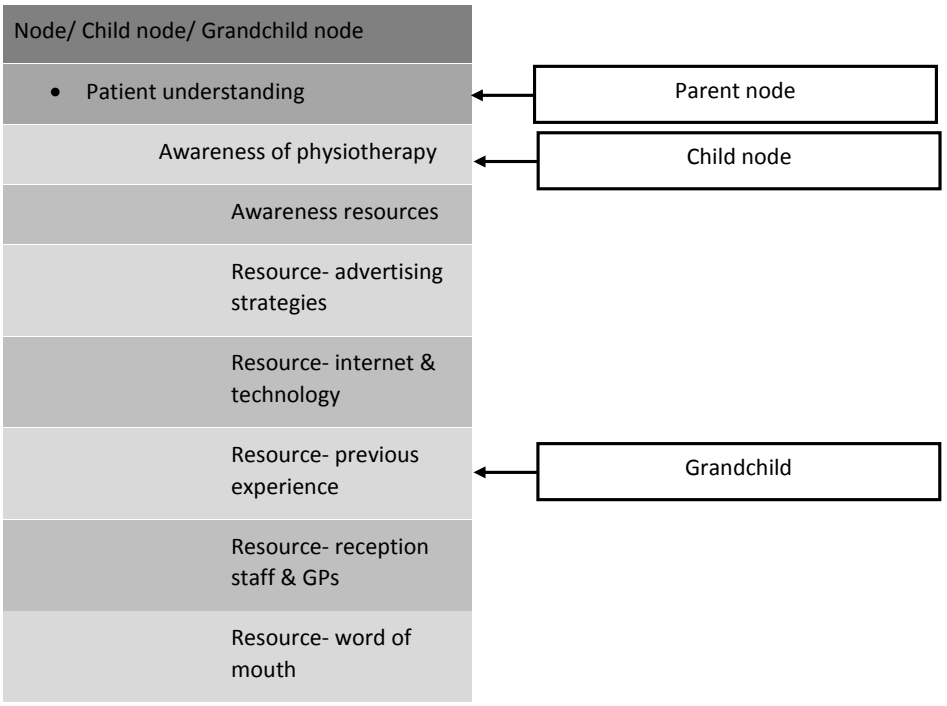
6.3.6 – Data analysis

Pawson and Tilley (1997) do not recommend any one particular approach to analysis but the principle is that it is theory driven. The previous realist review had confirmed the importance of two programme theories, articulated through a number of CMO configurations. This evaluation sought to interrogate these a priori theories and, as such, a deductive, theory driven, method was necessary. However, any method of analysis also needed to be flexible enough to allow for the inductive generation of new theories. As such a hybrid approach to thematic analysis was used (Fereday and Muir-Cochrane, 2006; Braun and Clarke, 2006). Braun and Clarke (2006) described the flexibility inherent in a hybrid thematic analysis as allowing for either 'bottom up' inductive analysis or 'top down' deductive analysis.

An a priori template of codes (Crabtree and Miller, 1999) was devised consisting of the components of the CMO configurations. This created a code book in NVivo, providing initial codes against which to interrogate the data. At the same time, evidence of new theories were coded via an inductive approach (Braun and Clarke, 2006). Meyer and Ward (2014), acknowledged that both deductive and inductive approaches have been the subject of wide criticism, but advocated this methodological plurality,

A hierarchical coding tree was developed with data collated into adult nodes, split into child nodes and further grandchild nodes. Figure 6.2 gives a small excerpt of this coding approach and shows 'patient awareness of FPCP' as a child node of 'patient understanding of FPCP'.

Figure 6. 2: Node/Child node/Grandchild node relationship



Brooks and King (2014) suggested coding is undertaken by more than one researcher as this demonstrates methodological rigour. Others have suggested trying to demonstrate interrater reliability in coding, within a relativist epistemological position is a redundant task (Boyatzis, 1998). In this study a pragmatic position was taken with approximately 10 per cent of the transcripts jointly coded by the research team (Maidment et al., 2017).

6.4 – Conclusion

This chapter outlined the methods of the realist evaluation of FPCP. Justification was made for the use of realist methods and more specifically qualitative data collection via interviews and focus groups. The complex method of data analysis has been described. The following two chapters describe the findings from the realist evaluation. Chapter 7 reports the findings relating to programme theory 1 and chapter 8 reports the findings relating to programme theory 2. Chapter 8 also reports the evaluation discussion, strengths and weaknesses and conclusion.

Chapter 7– Findings: Programme theory 1: Patient understanding of FPCP for musculoskeletal conditions

7.1 – Introduction

This chapter begins by outlining the details of the participants recruited to the study. Following that the findings pertaining to the programme theory patient understanding of FPCP are presented.

7.2 – Details of participants

Ten patient participants were recruited and the details of their characteristics are outlined in Table 7.1.

Table 7. 1: Patient participant characteristics

Patient id	Ethnicity	Age	Presenting condition	Duration of condition	Whether previously seen GP
1	White British	65	Knee	Less than 4 weeks	No
2	White British	35	Achilles tendon	3–6 months	No
3	White British	45	Knee	Less than 4 weeks	No
4	White British	74	Knee	6–12 months	No
5	White British	50	Elbow	3–6months	No
6	White British	47	Back	3–6 months	Yes
7	White British	52	Back	6–12 months	Yes
8	Indian	46	Back	6–12 months	Yes
9	White British	73	Knee	Over 1 year	Yes
10	White British	39	Back	Less than 4 weeks	No

Three physiotherapist focus groups were completed, with a total of ten physiotherapists (Table 7.2) and five GPs were recruited. Four commissioners were recruited one of whom was also a GP and, as such, they spoke to both participant groups. This presented a challenge, in terms of anonymity, and this participant is referred to interchangeably as a GP, or commissioner, in the findings. Two of the commissioners were interviewed individually and two were interviewed as a focus group of two. There were three administrator focus groups with three, four and five participants respectively.

Table 7. 2: Physiotherapist participant characteristics

Focus group	Participant clinical grade
Physio focus group 1	5 x Band 7 physiotherapists
Physio focus group 2	3 x Band 6 physiotherapists
Physio focus group 3	1 x Band 7 physiotherapist 1 x Band 6 physiotherapist

In total, forty-one participants recruited to the study with just under twenty hours of dictations recorded.

7.3 – Findings

The data synthesis was complex and time-consuming with several theoretical iterations developed and shared with stakeholders for sense-making. This process required repeated reference to the refined programme theories generated in the realist review with concurrent attentiveness to emerging, novel theories. The findings are presented sequentially with an initial narrative representation of the data synthesis followed by a diagrammatic representation of the CMO components. This approach has been used elsewhere (Goodman et al. 2017). When reporting direct quotes anonymity was ensured by a coding system as follows:

Table 7.3: Participant coding system

Participant	Descriptors	Coding example
Patient participants	Patient participant number	Patient_1
Administrator participants	Administrator participant number and practice affiliation	Admin1_practice1
Physiotherapist participants	Physiotherapist participant number, focus group number and professional grade	Physio1_FG1_B6
GP participants	GP participant number and practice affiliation	GP1_practice1
Commissioner participants	Commissioner participant number	Commissioner_1

7.3.1 – CMO representation 1: Awareness of FPCP

The realist literature review found poor patient awareness and understanding of FPCP and a lack of distinction between awareness and understanding of FPCP. The researcher was committed to differentiating between these two features. The findings from the interviews demonstrated that most participants had an awareness of physiotherapy and of the FPCP service but felt that the general population would only be aware of physiotherapy and not FPCP. Physiotherapy appeared to be a socio-historically established profession and the belief was that this would be the wider consensus. This was demonstrated by the following two quotes from an administrator and a patient.

1. **Admin4_practice1**

   I've never come across that [Lack of awareness]. *I think that patients here tend to know that they want to be referred to a physio, so I've never heard anybody saying well, what's a physiotherapist. So I've never come across that they don't know…*

2. **Patient_5**

   Yeah, it's just common knowledge. Yeah. I think, you know, I mean it's [physiotherapy] *been around ever since I've been alive, I'm about fifty, so you know….*

However, there was an equivalent lack of awareness of FPCP as this frank exclamation demonstrates:

INTERVIEWER

So what about the first point of contact service that they had in the GP practice, do you think if I went out into the street and said to people have you heard of first point of contact physiotherapy, what do you think the reaction would be?

Patient_7

I don't think they'd know what you was talking about.

This impression of a lack of awareness of FPCP was repeated frequently. The following two patient quotes demonstrated the complexity and overlapping nature of the theories that are exposed.

1. **Patient_4**

   I think the general population knows the word [physiotherapy], *what it entails? I would think generally people are not aware necessarily of what it entails. I'm not sure that they're aware that it's easily accessible.*

2. **Patient_5**

   I mean it's like with my frozen shoulder I'd never heard of first point, so obviously I went to the doctor and he referred me.

Although participants anticipated that the population would be aware of physiotherapy, in a general sense, in the context that it was an established profession, they predicted that the general population were unlikely to know what it entailed or the FPC characteristic of FPCP. As a result of this lack of awareness participants anticipated that patients would default to their GP as the FPC and there would be a non-utilisation of FPCP services. The mechanisms of patient

understanding of FPCP and the GP as the default FPC are explored later within this chapter. This synthesis provided the evidence for the first CMO configuration.

Table 7.4: Context-Mechanism-Outcome patient awareness of FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Physiotherapy as an established profession	Awareness of physiotherapy as a profession Lack of understanding of the role of physiotherapy Lack of awareness of FPCP	Patients default to the GP as the FPC	Non-utilisation of FPCP

7.3.2 – CMO representation 2: Sources of patient awareness of FPCP

The above theory had enriched the realist review findings providing evidence of a general awareness of physiotherapy, as a profession, but a parallel lack of awareness of FPCP. All of the patient participants interviewed had, by the nature of their inclusion in the evaluation, attended the FPCP service. As such, there was an interest in how these participants had become aware of the FPCP service. Interestingly, patients were able to articulate an understanding of the broader contextual motivations behind the FPCP initiative. The following two patients described their awareness of the pressures on the GP workforce and the associated burdens GPs faced and how FPCP might ameliorate them.

1. **Patient_2**

   If you go to any GP surgery, nine times out of ten it's someone in their late forties, fifties, they're getting on to retirement. And there's no one to backfill them jobs. I mean the doctor's surgery I go to, I would say the youngest

doctor there is probably in their forties. One, two doctors have retired, they haven't replaced them. So they might get locums in, but there's no, in five, ten years' time, there might be no permanent doctor there. So that's a concern.

2. **Patient_3**

   But I think it's the world we live in, we've got to find other ways round it, and there's not millions of GPs and they're always stretched, aren't they.

All participant groups described methods by which information relating to FPCP had been disseminated to the public. The main methods of information dissemination were; as a consequence of previous attendance, through word of mouth, via healthcare staff and via traditional advertising strategies. Examples included:

- **Physio1_FG2_B6 (word of mouth)**

  And that might have been passed down from relatives. So, you know, you've got patients coming in whose relative has had previous physiotherapy, and they might have had a specific treatment, and then they come with the expectation that they would get the same. But again, is that an age passing down thing

- **GP2_practice2 (previous attendance)**

  I suppose its awareness, you'll get some patients going back because they've got a new problem, [and] *it worked well for them before*

- **Commissioner_4 (previous attendance and word of mouth)**

  Yeah. I think when patients have gone through the process of actually seeing a pharmacist, or seeing a physio, you know, they're actually, if their experience is very positive they're totally won over, aren't they. And hopefully that then filters through

- **Physio2_FG1_B7 (healthcare staff)**

  The critical ingredient was the reception administration staff. If they were fully engaged, they understood what the service was about, what it was aiming to achieve, and they also had the ability or the confidence to ask the

patients what it was that they were coming to see the, coming to the practice for, they utilised the service a lot more effectively

The evidence suggested that information about FPCP was available through a number of routes. Where patients were exposed to this information it led to an increased patient awareness of FPCP. There was an impression of a correlation between an increase in awareness of FPCP and attendance. However, there was no evidence of any evaluation of the relative effectiveness of these methods of information dissemination. It seemed pertinent that the words 'might', 'suppose' and 'hopefully' were accorded to the methods of information dissemination via word of mouth and previous attendance. The implication appeared to be that essentially providers of services relied on good fortune for information to be disseminated. This is revisited later in the chapter as is the evidence pertaining to traditional methods of advertising. There appeared to be more certainty with regards to information provided by reception staff which was described above as 'critical'.

In summary, a number of processes by which information pertaining to FPCP was disseminated were described but these had not been evaluated. Furthermore, there was an assumed relationship between the receipt of information, an increase in awareness and subsequent attendance. This theory was important in that it detects the methods of information dissemination and in doing so it identifies how, by targeting these processes, patient awareness might be influenced.

Table 7.5: Context-Mechanism-Outcome sources of patient awareness of FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Physiotherapy as an established profession Existing pressures experienced by general practice	Dissemination of information via: -Word of mouth -Previous attendance -Signposting -Traditional methods of advertising	Increase in awareness of FPCP	Increased utilisation of FPCP

7.3.3 – CMO representation 3: Embeddedness of FPCP

The realist review had demonstrated a theory whereby, as FPCP became 'embedded' in a general practice there was a corresponding increase in patients accessing the service. This was attributed to mechanisms such as the 'visibility' leading to a 'familiarity' and subsequent increased access. This feature was explored and it was evident that new services within general practices did embed over time. This was discussed by administration staff through their parallel accounts of advanced nurse practitioners (ANP).

INTERVIEWER

Bearing in mind we're trying to implement services like this, and services like nurse practitioners, how do we change that perception then?

Admin1_practice1

By doing it.

Admin2_practice1

Yeah, providing a service.

Admin1_practice1

That's why we changed the physio bit, by doing it. We've got an ANP so that's just normal for us now. And we've had an ANP for five years, all our practice population are used to that.

Admin4_practice1

Yeah, and…also increased patient's awareness of the service being available.

The administration staff described the process whereby straightforwardly providing a service made it more visible to the practice population. Over time patients became more familiar with its presence and subsequently more aware that it was a resource that they could access. The administrators described the process by which the practice population had become increasingly familiar with the ANP service, which was a successful enterprise. New services became normalised in the practice community as they embedded over time. However, service delivery needed to be consistent as this process of normalisation could reverse. This administrator described what happened when the normalised pilot FPCP service was withdrawn, as a result of non-recommissioning. The message was clear, patient awareness could increase over time, as it becomes embedded…

Admin3_practice1

…But only when it's there.

INTERVIEWER

Okay, yeah.

Admin3_practice1

So obviously physio's not there anymore, so it's not normal.

There was disagreement in terms of the length of time it took for something to embed, with the administration staff proposing as little as two–three months whereas a GP participant suggested *"It's taken me decades as a GP to become embedded"* (GP1_practice2). In terms of embeddedness it was apparent that some services were more embedded, in the eyes of patients, than others. A patient

participant offered a perceptive observation with regards to this relative embeddedness:

Patient_5

People don't turn up and say they want to see the nurse, it's always the doctor. And I think it's embedded in people's mind now, over so many years, you go and see the doctor. If something's wrong with you, go to the doctors.

INTERVIEWER

So it's historical?

Patient_5

Yeah, definitely.

INTERVIEWER

And so these new things are sort of swimming against the tide of history really, aren't they?

Patient_5

I think they are, I think there's a brick wall they've got to go through, you know. And if they don't push hard enough, they ain't going to go through it. They've got to change people's mind-sets and I don't think it's going to be happening any time soon

This insightful extract links to theories that will be explored further which included the obduracy of the GP as the default FPC practitioner and the need to significantly invest in methods of increasing patient awareness of FPCP to challenge this positionality. This was even more important when the trust and confidence that was sought was positioned against that innately attributed to GPs.

Patient_5

Yeah, you know, you trust your doctor, your family doctor, you know. You've seen it in the olden times, any problems go and see your family doctor, he's there with a lollipop for the kids and things.

In summary, where FPCP was implemented there was the potential for it to embed over time. In this context the FPCP service became normalised within the offerings of the general practice. As this happened the practice population became more aware of the service. The suggestion was that there was a corresponding increase in the numbers of patients who accessed the service. However, it appeared that FPCP was evaluated relative to other services and in particular measured against the GP positionality. This embedding theory was important in that it provided evidence of the need for consistency and perseverance in the implementation of novel services that are set against the established primacy of the GP position. It also provided evidence supporting the need for effective methods of promoting FPCP in this context.

Table 7.6: Context-Mechanism-Outcome embeddedness of FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Embedded FPCP service	Increased visibility of FPCP	Increased familiarity with FPCP Increased awareness of FPCP	Increased utilisation of FPCP
Primacy of GP role	Trust in GP	Perception of GP as default FCP	Non-utilisation of FPCP

7.3.4 – CMO representation 4: Effectiveness of traditional advertising FPCP

The previous theory introduced the size of the task in challenging the primacy of the GP position in general practice in facilitating patient to access FPCP as a genuine FPC service. The primacy of the GP was described as a *"brick wall…and if they don't push hard enough, they ain't going to go through it"* (Patient_5). The realist review demonstrated an awareness, within the physiotherapy profession, of the need to

disseminate information about FPCP through a variety of advertising strategies. This evaluation reinforced this need by identifying a general lack of public awareness of FPCP.

Within this evaluation, participants reported a number of advertising strategies that had been used in the FPCP initiative. These were considered traditional advertising approaches and ranged from posters, pamphlets, life-sized mannequin adverts, to the use of TV screens in practice waiting areas. For one physiotherapy focus group there appeared to be a correlation between the energy put into advertising and the effectiveness thereof.

Physio3_FG2_B6

> *So some people put, like they put the posters up. I think one GP practice put notes on top of…*

Physio1_FG2_B6

> [A practice] *put a note at the bottom of patient's prescriptions saying if, you know, if you have any MSK problems there's a physio. They also, you know on the sign where it shows you the name…They also had a banner saying their service. So they were quite good, and their clinics always used to be quite full, so I agree with the advertising.*

However, there seemed to be a greater sense that these more traditional methods of advertising were not wholly successful as these administrators suggested:

Admin3_practice3

> *The problem with any waiting room is there's loads of information in it. And you're sitting there waiting for your appointment to be called, and you're kind of scanning round the room, but you're not really taking in what is actually on the posters, what information is there. It's just a mass of various services.*

Admin1_practice3

> *We had the big cut-out didn't we?*

Admin3_practice3

> *It was standing there and we still didn't get much comment from it. It's very hard to provide enough information so that people are aware of things, but also to be specific enough that they can actually pick up what you're trying to say to them.*

There was agreement that the most effective of these methods of advertising had been the life-sized, cardboard cut-out, physiotherapist advert. However, the impression was that it was more by chance that patients were made aware of FPCP by these traditional advertising approaches:

Admin4_practice2

> *We had posters up in reception, so occasionally if you got people queuing at the desk they might have seen it and then gone and booked their initial, they might have been booking a follow-up but then gone I've seen that so can I book.*

When the topic of adverts within practice waiting rooms was discussed with patient participants the majority had not been aware that there had been any advertising. This appeared to reinforce the impression of one of the administration focus groups:

INTERVIEWER

> *So if we just relied on the posters, do you think patients would have used the service?*

Admin3_practice3

> *No. Not if you weren't introducing it when they communicated with the practice. I wouldn't say so.*

The other new knowledge synthesised from the data within this theory was the need for specificity. Participants described a targeted approach to seeking out information in the plethora available to them in general practice waiting areas. From a patient perspective this meant they looked for what they required at that particular time, as these two patients described:

1. **Patient_9**

   Like I got my bad knee, that's the one I'm going to read.

2. **Patient_6**

   I often pick up brochures and things to look at, you know, regarding whatever, you know, like diabetes ones that affect me.

It was evident that there was a need for greater planning in the use of traditional advertisements and advertising strategies. Not only did the information need to be relevant to patients but it had to catch their eye. For this patient they had been unaware of the adverts because they *"weren't outstanding enough to look at, or to notice"* and they went on to advocate: *"I think you're going to need something that stands out from everything else. Like anything in life, if you want to be noticed you've got to stand out, and if you don't' stand out you don't get noticed"* (Patient_5).

Further specificity was discussed by staff participants and this meant that any advertising strategy had to be targeted to the local population demographic and economic profile. Essentially this provided an important contextual consideration in the theory development because, as this GP stated:

GP2_practice4

Very much so. Yeah, very much so. [Adverts need to be targeted] *Because they* [patients] *are very different from one mile down the road to here.*

There was no evidence that these socioeconomic contextual factors had been considered at all in the marketing of the FPCP service.

With regards to the content of any advertising material participants were clear that any adverts should include:

- **Admin1_practice1**

  …reasons for your self-referral. And perhaps a little bit on what they [physiotherapists] *actually do*

- **Patient_4**

  Certainly, if it's going on to self-referral, that would need to be well advertised, and how to do it, and how to go about it.

Furthermore, any literature needed to be in plain language and free from abbreviations;

Patient_4

> *I mean at one time it was all abbreviations weren't it, I used to put my hand up and say please can I have the full word. And its self-referral is something, we know what it means, I know what it means, my husband would know what it means. My mother wouldn't have known what it meant. And perhaps to a lot of the ordinary people in the street, they won't understand the word self-referral.*

This concern was echoed by the physiotherapists who expressed anxiety with regards to patient understanding of the nomenclature.

Physio2_FG1_B7

> *I think one of the problems is almost the name of the service. I know that we've talked about first contact physio and whether or not we change it, change it to something different. So, you know, a musculoskeletal assessment clinic*

In summary, this theory corroborated the realist review findings in that the perception of the participants was that the most commonly used advertising strategies were predominantly ineffective. On the whole the information, disseminated to patients, via these methods remained invisible to them. However, it appeared likely that these traditional methods of advertising will continue to be utilised, as they are seen as relatively easy to implement and cheap. Furthermore, this evaluation reinforced the lack of planning that went into the advertising strategies. This physiotherapist seemed unaware of how the decisions and adverts had been implemented.

Physio2_FG3_B7

> *Well I don't know in terms of what marketing they've done, I'm not acutely sure internally what [the provider organisation] have done, I don't know if they used the CCG or [the provider organisation] that did the advertising.*

This theory was important in that it demonstrated the need to both invest more time in planning traditional adverts in accordance with patient expectations and socioeconomic context. As such, patient opinions are imperative in the future design and implementation of these traditional advertising approaches. It was also clear that a robust evaluation of the effectiveness of any advertising approach had been absent, but was required. This theory demonstrated that there was no evidence to support the efficacy of traditional advertising strategies for FPCP and there was clearly a need for further research in this area.

Table 7.7: Context-Mechanism-Outcome the effectiveness of traditional advertising approaches

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Use of traditional advertising approaches No clear planning of advertising approaches used	Information on FPCP not visible to patients	No increase in awareness of FPCP	Ineffective advertising No increase in utilisation of FPCP
Specific sociocultural contexts	Patient knowledge to inform information dissemination Context and content specific information disseminated via traditional advertising approaches	Increased awareness of FPCP	Effective advertising Increased utilisation of FPCP

7.3.5 – CMO representation 5: Potential of innovative methods of advertising FPCP

The suggestion from the previous theory was that the traditional methods used to advertise the FPCP service were ineffective. There was no evidence of any of the advertising strategies being evaluated, in terms of their effectiveness. The physiotherapist participants appeared unclear of how the service had been advertised and who was involved in, and responsible for, the process;

Physio1_FG1_B7

> *I think it was more the GP practices than this organisation that promoted to patients. We would provide them with the tools to do that, so whether it was their cardboard cut-out, their poster, or later we did some screens that they could put up in their waiting areas. Yeah. And provided them with something they could put in their newsletter if they wished, or on their website. But then obviously it was up to the individual GP practices to then use that as they wished, and take that forward.*

There was a consensus that advertising the service had not been considered a priority. Mindful of the need to increase patient awareness of FPCP, there was an interest to develop this theory further and understand what lay behind this apparent indifference. This applied to the conception of the approaches used and the subsequent implementation and evaluation of their effectiveness. The apparent indifference appeared to be indicative of a general lack of prioritisation of advertising and an associated lack of the specific marketing skills alongside a deficiency in the necessary resources to fund advertising approaches.

This commissioner summed up the issues in the following two extracts:

1. **Commissioner_1**

   I don't know that internally we have the expertise a, to measure it, and b, to know what the options are. So if our original professional plan didn't work then how do we make it better, I don't know really that we have that in-house. It's not a set of skills that we have. I maybe talking about myself rather than the CCG in general, but I don't think we're very good at evaluating those methods.

2. **Commissioner_1**

   I think one of the problems is, is that when we start developing a budget for these services, that's probably one of the last things that we consider. And if we do consider it we never put enough money in the budget. And actually if we did put in a substantial amount of money for promotion in the budget, I don't know how that would be, how that would be considered…Yeah, I think so. And it's how then we would evaluate and justify that promotional spend if we don't have the tools to measure the effect of our advertising campaign

A further contextual restriction, on the advertising approach taken, was the piecemeal way in which the service had been implemented. The FPCP pilot had been instigated in a limited number of practices meaning it could not be advertised across the whole health community, clearly limiting the methods that could be utilised. As one of the physiotherapy focus groups pointed out:

Physio1_FG1_B7

I think if it was across the City, or across, if it was across an area as a whole, you could then use local media and have discussions, and those kinds of things which really reaches people. But when it's only in a few practices as a pilot, you can't do it. You're prevented from doing that. So if it's global across an area then definitely kind of going along those lines, just to raise awareness really.

Finance was also a restriction, as indicated by the commissioner above. For the physiotherapists this lack of financial commitment and subsequent lack of

promotion were frustrating, particularly when they were clear about the potential impact of FPCP. They saw this as both a local, and wider, professional issue.

Physio2_FG3_B7

> *As a profession I think we're quite confident in our abilities and our professional status, and we think we're well regarded amongst our healthcare colleagues and other peers. But I think we don't promote ourselves well, that's my general feeling.*

However, for this patient participant it was clear, if the initiative was seen as important enough, effective methods should be sought. Otherwise the success of any advertising scheme and subsequently, the initiative itself would be less likely.

Patient_5

> *I think it depends on how much you want to push this first point* [FPCP]*, you know. If you really want to push it then you'll go all out for it, but if it's just like a passing thought like, we'll see how it works and if it don't work then it hasn't hurt anybody, do you know what I mean? We won't really bother making much of an effort for it, you know.*

At a local level there was a sense that the responsibility of marketing FPCP should be collectively assumed by GP practices, physiotherapy services and commissioners, with them all providing a coherent message. In addition there were suggestions of innovative approaches to marketing which were available, if so prioritised.

Physio1_FG3_B6

> *I mean if we're clever, every time someone Googled Voltarol gel, we'd attach our little advertising banner about physiotherapy, and it would follow them around on the internet, wouldn't it. But I bet that costs an awful lot of money.*

Participants spoke of utilising other more innovative methods of advertising such as social media and television. While the restrictions described above were acknowledged participants felt that the FPCP initiative justified such innovations and commitment. The components synthesised in table 7.8 described two

concurrent theories; one outlining evidence generated from the participant experiences of the FPCP service and one hypothesised by participants as to how the potential of investment in innovative marketing strategies for FPCP could impact subsequent patient utilisation. In addition to this theory was a parallel professionalisation theory whereby physiotherapists demonstrated FPCP efficacy but were frustrated by the obstacles to their professional project.

Table 7.8: Context-Mechanism-Outcome the potential of innovative adverting approaches

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Advertising FPCP not prioritised Demonstrated efficacy of FPCP FPCP implemented in piecemeal fashion Use of traditional advertising approaches	Lack of marketing skills Lack of financial resources Lack of professional vision Limited information dissemination Information on FPCP not visible to patients	No increase in patient awareness of FPCP Physiotherapist frustration	Ineffective advertising No increase in utilisation of FPCP
Advertising FPCP prioritised	Adequate investment in marketing FPCP Information disseminated though innovative approaches	Increased awareness of FPCP	Effective advertising Increased utilisation of FPCP

7.3.6 – CMO representation 6: signposting as a method of information dissemination

The previous two theories in this evaluation demonstrated traditional methods of advertising were ineffective and that more innovative methods had the potential to be more effective. Alongside this participants felt that the most effective method of facilitating access to FPCP was signposting by practice administration staff. The realist review had identified 'verbal dissemination by the primary care team' as a method of advocating FPCP but this had not been explicitly outlined in the literature. Within this evaluation there was widespread agreement about the primacy of this role amongst all the staff stakeholders. Nevertheless, exploring this feature revealed complexity and new, related theories emerged.

There was a sense that signposting, as well as providing patients with a method of navigation, also conveyed information and thus constituted a form of patient education. This patient education was an expectation that the administration staff had of themselves, in their role. Furthermore, it appeared that the administration staff regarded signposting as a strategy that was supportive to patients. This intention to provide best patient care could be regarded as a further mechanism within this signposting theory. It may be that the administration staff brought this intention 'to' the programme (M-Resource) or interpreted their role as to provide best patient care and 'responded' accordingly (M-Reasoning). The following extracts provided evidence for the theories that were developed regarding education and the provision of best patient care.

- Education (M-Resource)

Admin4_practice1

> *I mean they bring their child to the doctors with a cough, so we're trying to urge them to go to pharmacists, to the Pharmacy First, isn't it?*

Admin5_practice1

> *Pharmacy First.*

Admin4_practice1

Pharmacy First. They've got a cold, they've got a cough. They still insist on seeing the doctor. But we try our hardest … you don't have to pay for your Calpol and your, this and that if you go to see Pharmacy First

Admin5_practice1

We're trying to educate people…

Admin4_practice1

It's just educating people more than anything.

- Provide best care (M-Resource)

Admin2_practice1

I think it was alright [signposting]*, because you're offering a better service aren't you, so you're like, you always want to try and get the person the best service that you can offer. And if it's better for them to see the physio straightaway, then that's what you try and do. But like I say, sometimes they don't listen do they.*

Admin4_practice1

It's like we're always signposting, aren't we.

Admin2_practice1

Yeah.

Admin4_practice1

To offer them another service that would benefit them more than just seeing the doctor.

Administration staff reported signposting could be met with some resistance. Despite the apparent stress that this might engender, the administration staff did not report this as a concern. More frequently, they conveyed relief at the additional capacity that the FPCP service created.

INTERVIEWER

Yeah, yeah. So although it was only two half days a week, there was a little bit of a feeling of relief?

Admin1_practice3

Yeah, because all of those patients that were booked into those two half days would have initially wanted a doctor. So they were happy to go to a physio, which took the relief off the demand on that day. Because we book a lot of same day booking appointments, so they were quite happy to go to the physio which took however many patients that was that week, that took away the demand for that many doctors' appointments.

The administration staff in this study ascribed their comfort with the signposting process as a consequence of a combination of personal experience (length of time in the role), the culture of signposting that existed in the practice and the signposting training that they received and as a result they felt confident in their signposting role. The impression was that without these constituent features the signposting experience might be different.

INTERVIEWER

Yeah. Okay. So and the other word that you said was sort of experience, it sounds like you've got a lot of experience?

Admin4_practice1

Twenty-three years.

INTERVIEWER

Yeah. Do you think that would be different from somebody who was a new recruit on reception?

Admin4_practice1

Yeah… they would be less confident?

Admin5_practice1

You just gain it don't you, you build on it.

Admin3_practice1

Well you ask anyway. Nobody's frightened to ask anybody.

INTERVIEWER

I was just going to say, how do you manage those new starters and that lack of confidence?

Admin4_practice1

They would probably come and ask somebody.

Another quote that discussed these related issues came from the same team:

INTERVIEWER

And finally on the topic of professionalism, there's some evidence about this sort of signposting role adding additional stress to reception and administration staff.

Admin1_practice1

No, not at all.

Admin4_practice1

No. We've been trained with it since we're here.

Admin1_practice1

We've just had this signposting health training from the GP Alliance.

INTERVIEWER

Okay, and was that good, was that helpful?

Admin4_practice1

Yeah.

Admin2_practice1

Well, it's what we've been doing anyway isn't it, for years. So for us it was a bit like well we already do that.

From a patient perspective there was evidence of some uncertainty with regards to the signposting role and this correlated with the resistance reported by administration staff. It appeared that the patient concerns related to the nonclinical nature of administration staff.

Admin1_practice2

> *But we're just receptionists, which you get said that a lot, so they don't want to listen to you because we're not the doctor. How can you say that, you're not a doctor?*

This patient substantiated the administrator's statement.

Patient_5

> *Yeah, because they do ask you what's wrong with you? I mean you haven't got to tell them, I just want to see the GP and basically then they have to make you an appointment.*

INTERVIEWER

> *And how do you think, how do you, or how do you think people feel, when they ask that question, you know, what's wrong with you?*

Patient_5

> *When they first asked me I was like are you medically trained? No, no, but it'll help the doctor. I'm not telling you nothing, you could be anybody.*

This sentiment was frequently reported and other obstacles to signposting were described. The lack of confidentiality in public waiting areas was an issue for patients.

Patient_1

> *Yeah, and the trouble with reception is in a way, the people to talk to the receptionist in an open area, with people behind them, it's a bit, people won't want to. Because of the personal complaints of whatever, with everybody behind you.*

This concern was described by one patient even when giving information over the telephone. There was certainly an impression of some occupational hierarchy influencing the signposting enterprise.

Patient_4

> *I don't think I have respect for receptionists making decisions about who you should see, and who you…* [shouldn't]

Contrastingly:

Admin1_practice1

> *And once the doctor tells them to self-refer somewhere, they'll happily do that.*

The confidence that administrators' reported in signposting, resulting from their training, their experience and the support of peers extended to a corresponding confidence in dealing with any patient resistance. However, there was also evidence to suggest patients adapted to the signposting role and came to accept it. According to one administration focus group:

Admin1_practice2

> *I've seen a change, because I've only been here eighteen months. So the surgery where I came from previously wouldn't do any signposting, it was just to the doctor. And then I started taking that on when I was here, and it was a real resistance with the patients. But in the space of like eighteen months more, they're happy to receive that a lot better.*

Admin2_practice2

> *I think we're getting some way with educating them and things like that. And as long as they think they're going to get treated, they're going to get a service, they're going to get what they need, most of them, aren't they, are quite happy.*

Admin1_practice2

> *Yeah, they are, yeah.*

Admin2_practice2

> *We do have the ones that do resist, and probably always will because you can't educate everyone. But aside from that, most people yeah, definitely.*

From a practical perspective the FPCP signposting training in the pilot service consisted of 1−2 hours where the objectives of the FPCP were explained alongside the practical processes. For the administrators this was important to ensure there were *"fairly clear guidelines of this person can see this type of condition, but will not see this type of condition. So we try not to put people with the wrong person"* (Admin1_practice2). As the staff who were based on reception, or on the telephone, it was the administration staff who generally had the first patient contact. As such, although it was *"important for the doctors to understand what it* [FPCP] *was and how it differed from what we already used, or the referral patterns that were already present…but probably even more important than that was for the front of house staff, the reception staff, to understand what was happening"* (GP1_practice3). It also appeared important to have an environment of peer support in what could otherwise be a stressful role. The practices in this study who described most confidence in signposting were also able to reference the training they had received (both with regards to FPCP specifically and signposting generally) and described clear and effective communication systems within their own practice.

This synthesised theory demonstrated the fundamental importance of the signposting role. Signposting was seen as essential in increasing patient awareness and was the main facilitator of access to FPCP. There was potential for the signposting role to introduce additional stress. Signposting was embedded in the practices recruited to this evaluation and the administrators were confident in the signposting role. Their confidence in the execution of the signposting role was facilitated by the training they received and peer support. Therefore it would appear important that the content and effectiveness of signposting training is evaluated if this can be demonstrated to facilitate the signposting role.

It appeared that, despite some initial concern, patients adapted to being signposted and this adaptation ran in parallel with the theory of FPCP embedding.

In the same way that services such as FPCP normalised over time, so too it would appear did signposting. In this evaluation it appeared that the pre-existing, embedded nature of the signposting system provided a context into which the FPCP was implemented.

The administration staff were motivated to signpost patients as they saw it as a mechanism to help to patients receive the most appropriate care and a mechanism of educating patients. This theory was important as it demonstrated the importance of the signposting role. Furthermore, it identified mechanisms that supported signposting which included FPCP signposting training and an environment of peer support with respect to the signposting role.

Beyond the identified intention of providing patient education, there was no actual evidence of a corresponding increase in patient understanding of FPCP as a consequence of signposting. Table 7.9 reported the components of this theory and, at the same time demonstrated the cascading (Jolly and Jolly, 2014) of components whereby what was a context becomes a mechanism.

Table 7.9: Context-Mechanism-Outcome signposting as a method of information dissemination

	Mechanism		
Context +	Resource	Reasoning	= Outcome
FPCP implemented into culture of embedded signposting	Administrators confident to signpost Administrators interpret signposting as providing patient education Administrators interpret signposting as method of providing best care	Increased patient awareness of FPCP Administrator relief at additional capacity	Effective patient navigation Increased access to FPCP
Provision of signposting training Administrator experience Peer support	Administrators confident to signpost	Decrease administrator stress Decrease patient resistance	
FPCP implemented into culture of embedded signposting	Provision of signposting training Experienced Administrator Peer support	Administrators confident to signpost	Decrease administrator stress Decrease patient resistance

7.3.7 – CMO representation 7: GP as the default first point of contact practitioner

Evidence for the effectiveness of signposting in terms of increasing patient awareness and subsequent utilisation of FPCP was articulated in the preceding theory. Any patient resistance to signposting was most commonly resultant of their preference to access a GP appointment. This aligned with the realist review that suggested patients defaulted to the GP as their FPC. Analysis of this theory revealed that it was more complex. Several cultural components influenced patients' perception of the GP as the default practitioner. Patient age was frequently remarked on as a contextual factor that influenced patient decision-making, as described by this GP:

GP1_practice4

> *Yeah. I think that some of the older generation, you know, they were brought up that the doctor is everything, the fountain of knowledge, and that's the person you go to. And, I mean I've been here forever, twenty-eight years or something like that, and I have people that tell all the other people that well I'm only going to Dr X, I'm not going to anybody else. And that's what they do, they wait for four, five weeks to get an appointment with you, and that's so stupid of them you know. Because there's loads and loads of really competent people out there they could see the same day.*

However, even this predominantly consistent feature had its contradictions:

Patient_3

> *I've got two children in their twenties, and I don't think they'd necessarily think of physio if there was an issue. I think maybe they'd just be GP like I was at first.*

It appeared that the perception of the GP as the default FPC practitioner spanned generations and appeared to be resistant to change. The following, lengthy extract demonstrated the complexity of the theories that this research developed.

GP1_practice3

With the elderly… they might want to see the doctor rather than physiotherapist, kind of to make sure that sort of thing is there.

INTERVIEWER

Something else, so something more sinister?

GP1_practice3

Yeah. And once the doctor, like old-fashioned thinking, doctor has seen and they have thought no, okay, it's okay to see physiotherapist.

INTERVIEWER

Okay. So they almost need that reassurance?

GP1_practice3

Yeah, reassurance. But I must say that in our practice I don't think that elderly will particularly just say no.

This quote reinforced the primacy of the GP position for the older population as a consequence of the trust inherent in the patient–GP relationship. It also highlighted some potential concern with regards to the perceived clinical competence of the physiotherapist, relative to the GP and the need for GP reassurance prior to attending FPCP. It was evident that FPCP challenged this established relationship and one physiotherapy focus group recognised the need for wider cultural change and described their frustration when it appeared that certain systems reinforced the status quo rather than challenged it.

Physio2_FG3_B7

It's a culture shift, isn't it, with people. Because I think, again, if you look at media, I know TVs probably not one of the most prominent media forms now, social media is, but often when they talk about any sort of health problems, musculoskeletal or otherwise, the first advice they give is you should really seek advice from your GP on this.

There was a consensus that the GP position, as the default FPC, provided an obstacle to the FPCP initiative.

Admin1_practice1

> *The doctor, a GP, knows everything. They know how to solve everything, or this is people's perception, they know how to solve everything, they'll make them better. So all you need to do is come and see a GP, because the GP is some sort of God.*

In summary, the participants repeatedly supported the findings of the realist review positioning the GP as the default FCP. Moreover, the position of the GP was reinforced by the wider cultural narrative, as evidenced on national media. Furthermore, this perception was so entrenched it spanned generations. As a consequence this positionality inevitably challenged the relative competence of other, non-GP, practitioners.

The trust intrinsic to the GP–patient relationship led patients to seek reassurance from their GP prior to changing their embedded, default behaviour (Admin1_practice1: *"And once the doctor tells them to self-refer somewhere, they'll happily do that"*). However, there was no evidence to demonstrate that the reassurance that patients got from their GP modified their fundamental beliefs, altered their interpretation of the primacy of the GP or changed their long-term behaviour. These theories were important and identified a number of other areas for future investigation. For example, what information did patient get from their GP when reassuring/signposting and did this alter their beliefs and importantly their future behaviours?

Table 7.10: Context-Mechanism-Outcome the GP as the default FPC practitioner

	Mechanism		
Context +	Resource	Reasoning	= Outcome
FPCP implemented into culture where the GP is seen as the default FPC practitioner	Patient trust in GP Media disseminate information emphasising primacy of GP	Lack of confidence in alternative practitioners to GP Patient perception of primacy of GP position reinforced	Non-utilisation of FPCP
	Reassurance of efficacy of FPCP provided by GP	Patient reassured about efficacy of FPCP	Utilisation of FPCP

7.3.8 – CMO representation 8: Patient understanding of FPCP

The evidence synthesised in this evaluation so far had explored patient awareness of FPCP and some of the features that exposed patients to resources that might increase awareness of FPCP. However, a differentiation between 'awareness of FPCP' and 'understanding of the role of FPCP' which was a commitment of this research, had not been illuminated to this point. It was clear that there was an established public understanding of the role of the GP and alongside this a deeply entrenched sense of trust, confidence and reassurance intrinsic to this relationship. Associated with this was a relative lack of confidence in the clinical competence of the FPCP physiotherapist. The following quote from an administration group emphasised these related issues.

INTERVIEWER

And what makes people worried about not seeing the doctor do you think, what might their concerns be if they don't get to see the doctor?

Admin3_practice3

That they're going to get some kind of second tier care.

INTERVIEWER

Right, okay. So they might be a bit worried about the skills of the physiotherapist?

Admin3_practice3

Yeah, yeah.

INTERVIEWER

And do you, you all sort of said yes to that, is that something that you feel confident about saying yes to because it's your own perception, or did you sort of get that feeling from patients?

Admin3_practice3

It's our experience of, as X mentioned, the advanced nurse practitioners. It's the same. If we try to persuade some patients to go and see them they will not, because they think that they don't know as much as the doctor

Central to the quote above, was a comparative lack of understanding of, and confidence in, the role of the non-doctor staff – in this case ANPs. The synthesis in this section explored this apparent lack of understanding. It was apparent that FPCP was implemented into a context, or number of contexts, that impeded it. For example, the GP was widely regarded as the default FPC practitioner and the media tended to reinforce this position. Counter current to this was evidence that physiotherapy was a well-established profession which most of the public are aware of.

When examining patient understanding of FPCP, an important associated issue that warranted consideration emerged from the data. This related to the healthcare paradigm in which FPCP was situated. From the physiotherapists' perspective it was clear that FPCP sat within a contemporary model of BPS healthcare *("I think there's been a shift away from sort of manual therapies within physiotherapy, and looking at more long-term measures to get people independent and recovering from musculoskeletal injury"* (Physio2_FG3_B7)). However, there was a sense that the FPCP initiative existed in a broader cultural context where the prevailing, traditional medical model of 'curative' healthcare still dominated.

INTERVIEWER

So they expect a fix almost.

Physio3_FG2_B6

Yeah.

Physio1_FG2_B6

I think that's a really good point, because sometimes I feel that patients come through physio because it's just like, they feel it's just the next stage to get what they want, such as like a scan. So potentially, like what you said before, if the patient has seen the GP and they've expected physio, it's just another step to basically get maybe to a specialist…

Physio3_FG2_B6

To tick the box really.

A further quote, this time from a GP, demonstrated the intransigence of this traditional medical model of healthcare that persisted in twenty-first century society:

GP2_practice2

I think it's probably just believing the doctor will fix them, and the plumber will fix the waterworks, and the person will fix the problem for them.

INTERVIEWER

Okay, so…

GP2_practice2

I don't think it's specific to physiotherapy.

INTERVIEWER

So you experience that with patients that come to see you that they're going to get fixed and that

GP2_practice2

I think that's generally right, twentieth century ideas, isn't it, or twenty-first century, that actually someone will sort the problem for you.

A particularly interesting insight with respect to this contextual characteristic was the apparent dichotomy, as summed up by this exchange with a GP.

INTERVIEWER

Yeah, it seems a bit of a contradiction in a way, isn't it, that they've got much more resources to have some self-guidance and some reassurance, but they're still almost, we've soften people to this dependency almost.

GP1_practice2

Yeah. But then there is also much more that we can do now than we could do then as well, and so I understand why it is a little bit more complicated.

INTERVIEWER

Okay, so you think we've almost raised patient's expectations about a fix being provided by us?

GP1_practice2

Yeah, absolutely. Absolutely, yeah

The FPCP initiative sat within these contexts and it was within these contexts that patients' generated their understanding of physiotherapy.

From a more general perspective the understanding of physiotherapy that some people have may bear no relationship to FPCP specifically. For example, an individual's understanding of physiotherapy may have arisen as a consequence of seeing an older relative mobilised by a physiotherapist during an inpatient hospital stay. As such, they have an awareness and understanding of physiotherapy in this context but maybe unaware, and have no understanding, of FPCP. However, there was a predominance of patient participant discourse that made an association between physiotherapy, as an intervention, and MSDs. The image most people had of physiotherapy practice related to its application in the assessment and treatment of MSDs.

It was clear that patient understanding of the clinical application of physiotherapy came from a number of sources and on the whole this aligned poorly with the model of FPCP. For example there was considerable talk of the media, and in particular television, providing an understanding of physiotherapy practice, as the following two patients demonstrated.

1. **Patient_5**
   I think the majority would [have an understanding]*. I think, you know, because it's all around, and I mean people know physio from watching TV, you know, football and things like that. They know you've got physios, and if a football damages themselves, you know, the muscles or things like that, the physio always comes on and sorts them out, you know.*

2. **Patient_9**
   I think [people have an understanding] *probably from TV. It's not that I've ever had a discussion with anybody, I think it's just mainly TV. No, I'd say something like medical programmes. Not 'Casualty', something like '24 hours in A&E', or things like that.*

There was widespread confusion between different MSK healthcare professionals. This resulted in confusion about who was, or wasn't, a physiotherapist and also appeared to reinforce the perception of 'hands-on', or manual, type therapies which clearly stood against the contemporary BPS, FPCP model. The following quotes from an administrator and a GP emphasised this.

1. **Admin3_practice3**

   I think a lot of people mix up a physiotherapist and chiropractor type services. A lot of them think they're automatically going to be manipulated, as opposed to perhaps given advice first.

1. **GP1_practice2**

   Some of them, when they're given information involving exercises and all of that, some of them think that physiotherapist is supposed to do something manually, for example the way the chiropractor and all those things do. So they'll say oh well, they did nothing, they only told me to do this, this, this exercise. So that is slightly wrong perception as well, that they expect that they will do some sort of manipulation or something like that.

One physiotherapist summed this dilemma up:

Physio1_FG2_B6

Yeah. And I also think if you then, personally I've asked a patient what, you know, what are your expectations of physiotherapy, and sometimes even, not even private physiotherapists get mentioned, it's sometime chiropractors. So people that, you know, don't really do fully or fully understand our role really.

INTERVIEWER

Okay, so sometimes they even get mixed up between the different professions?

Physio1_FG2_B6

Yes, definitely. And potentially a lot of patients, through my experience, just want to come and have a massage.

This confusion was further exaggerated by the coexistence of the parallel NHS and private health care systems. According to one GP:

GP1_practce3

> *I guess NHS physios and private physios have slightly differing agendas as well. And so, and so a private physio may be looking at doing something that feels nice so to get repeat custom, whereas an NHS physio might be looking to do something that the patient can then manage their condition longer term.*

These misunderstandings, about what it was that physiotherapists' did, how they did it and where they did it, resulted in patient confusion and this further lessened the likelihood of patients accessing FPCP.

Patient_3

> *Yeah. I imagine people that are just not too sure where to turn to. Or what's needed. I don't know really.*

INTERVIEWER

> *Okay, okay. So people having an understanding of what physiotherapy might be able to offer, sounds like that's probably quite important to help people, help people make* that… [decision to go]*?*

Patient_3

> *Yeah. I think you need to be informed of what it, what the service actually is, and what it's going to do for you, and how it's going to help you.*

The evidence suggested that patients obtained an understanding from a number of sources and in the main these were incongruent with the reality of FPCP. This corroborated evidence from the realist review that reported patient understanding of FPCP was poor.

An associated, if unexpected, feature that was discussed was the resultant anxiety arising from the misunderstanding of FPCP. When asked what they might expect if they visited the FPCP service one patient replied:

Patient_5

> *I think they know it's going to hurt.*

INTERVIEWER

Alright. And how might that make people feel?

Patient_5

Well, I mean, it's a lot of apprehension I think.

Another patient reinforced this opinion:

Patient_1

I think fear of the unknown.

Patient_1a

Fear of, alright, well to be very frank, they're going to be manipulating something and it's going to hurt.

This apprehension provided new, emerging evidence and was unexpected. However, the subsequent anxiety that arose as a consequence of this misunderstanding was not the only new mechanism to be generated. Patients' experiences of attending FPCP were explored and these experiences, when synthesised, did little to enhance the FPCP initiative and the wider objectives therein. As a commissioner reported:

INTERVIEWER

Okay. So do you think, I mean do you hear patients, you probably hear patients talking or reflecting more…

Commissioner_1

I hear them say the physio hasn't done anything. And I think of them as lazy physios who, like we have GPs that don't like examining people because it takes time to undress them, and examine them, and lay hands on them, and do some sort of manipulation. And I think your colleagues who aren't doing that, are actually missing the key component of being a clinician.

Or from one GP:

GP1_practice2

> *Yes, that is true. Some of them, when they're given information involving exercises and all of that, some of them think that physiotherapist is supposed to do something manually, for example the way the chiropractor and all those things do. So they'll say oh well, they did nothing, they only told me to do this, this, this exercise. So that is slightly wrong perception as well, that they expect that they will do some sort of manipulation or something like that. So in their mind they think oh, they did nothing.*

This sentiment was reiterated by a patient:

INTERVIEWER

> *No. Okay, yeah. So can I imagine that if your expectation is you're going to get one thing, and you go and you get something else, you know, how does that make you feel?*

Patient_6

> *Just usually cheesed off, and it's a waste of time as usual. Which is what, you know, is what I've found*

Patient disappointment was frequently reported sentiment and it would seem reasonable to imagine that this would adversely affect utilisation.

However, there were also signs of advocacy for the BPS model and FPCP, from outside the physiotherapy profession. These two excerpts come from GPs and demonstrated their efforts to align patient expectations more accurately.

1. **GP1_practice4**

> *To some people, to some people. I think that, you know, I've heard, people come to me and say I went to physio last time, that was a waste of time, they just gave me some exercises Or, you know, and then I would have the*

conversation well, what did you expect, you know, they… but then they're visiting doctors and nurses expecting the same thing.

2. **GP2_practice4**

Of course there are some who perhaps are a bit less confident, and probably the most common reason for that is they'll have had physio for something else years ago and it didn't particularly help. So they come in with a new problem and then when you recommend physio sometimes they'll say it didn't work, and they'll take a little bit of talking through. The fact that this a completely new problem, and it certainly isn't going to do any harm, and it may well benefit them.

These extracts somewhat addressed the question of the content of the reassurance provided by GPs about FPCP. It was evident that GPs also played an important role in signposting patients to FPCP services. Nevertheless, there remained no empirical evidence to suggest that signposting and reassurance altered patient beliefs or subsequent behaviour.

There was evidence to suggest that patients, who had already attended FPCP, adjusted their expectations and developed a more accurate understanding. The mismatch between expectations and reality that had been described adjusted following attendance, as the following patient articulated:

Patient_1

Well I'm okay with that [FPCP in a BPS model]*, but I've had experience with physios before.*

In support of this adjustment a physiotherapist recalled a patient's story:

Physio1_FG3_B6

I had a patient who came in and said, and I know it's a case study so it doesn't count, but came in and said oh yeah, I've been doing my exercises and it's been really good, but I've had loads of people tell me how rubbish physio is.

The realist review had provided evidence of a misunderstanding of physiotherapy generally and almost no understanding of FPCP specifically. This evaluation also demonstrated poor understanding of FPCP. Most patient participants were able to describe some form of understanding about what they expected in terms physiotherapy for MSDs. Their understanding, derived from varied sources with television and the media being frequently cited, was generally inaccurate. The evidence suggested that the misalignment in understanding of FPCP was compounded by confusion around other MSK health practitioners, such as osteopaths and chiropractors. It was further exaggerated by the parallel provision of MSK related health care services in the NHS and private healthcare sectors. Experience of physiotherapy, where participants described receiving 'hands-on' treatments, caused further misunderstanding. Where a patient had experienced physiotherapy, related to a MSDs in a BPS model their understanding of FPCP was more accurate.

This theory was important in that it provided the first empirical evidence of the lack of understanding of FPCP. If the potentiality of FPCP, as a part solution to the pressures on general practice, was to be realised patients need to not only be aware that the service exists but of what to expect when they attend. The current level of understanding means that, as things stand, FPCP will not match patient expectations.

The concurrent ineffectiveness of advertising approaches means FPCP relied on signposting, and embedding, to facilitate patient utilisation. It was evident that, with the extent of misunderstanding, signposting alone could lead to a dislocation of expectations and dissatisfaction.

It was clear during the evaluation process that the theory pertaining to patient understanding of FPCP was complex. Table 7.11 attempted to synthesise the data into CMO components but some of the complexity is likely to be missed. For example, theory two proposed that signposting resulted in successful FPCP utilisation. However, this may not be the case if a patient refused to attend. Furthermore, a patient who attended, as a result of signposting, may not have been

aligned in terms of their expectations. As a consequence, they may be disappointed and potentially unlikely to re-attend.

A bad experience of FPCP may lead to the resource of positive 'word of mouth' advocacy being reconstructed as a negative 'bad-mouthing'. Evidence had suggested that word of mouth was a powerful positive mechanism but in this case it could be an equally powerful, counterproductive negative mechanism in the FPCP initiative. Hence, if signposting is seen as a method of educating patients, the information given to patients in the signposting process needs to be clear, understandable and accurate. This interaction is complex and has not been investigated empirically, to date.

Table 7.11: Context-Mechanism-Outcome patient understanding of FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
FPCP implemented into culture where the GP is seen as the default FPC practitioner FPCP implemented into a culture where the traditional medical model is predominant	Information regarding FPCP obtained from a variety of sources: -Media -Word of mouth -Coexisting manual therapist professions -Coexisting NHS: private healthcare systems -Coexisting medical: BPS model healthcare	Patient anxiety and fear Inaccurate expectations Poor understanding of FPCP	Non-utilisation of FPCP Patient disappointment (For those signposted to FPCP)

Information regarding FPCP obtained from a variety of sources: -Media -Word of mouth -Coexisting manual therapist professions - Coexisting NHS: private healthcare systems - Coexisting medical: BPS model healthcare	Patient anxiety and fear Inaccurate expectations Poor understanding of FPCP	Lack of confidence in alternative practitioners to GP Patient perception of GP primacy maintained	

7.3.9 – CMO representation 9: Processes of realigning patient understanding of FPCP

The previous theory in this evaluation provided evidence describing a lack of understanding, or actual misunderstanding, of both physiotherapy for MSDs generally and FPCP specifically and the potential deleterious impact that this had on patients accessing FPCP. As a consequence the researcher was interested to highlight any strategies that improved patient understanding of FPCP. The data demonstrated a number of mechanisms by which more accurate information was disseminated to patients. Unsurprisingly, when considering the fundamental role that signposting was shown to play in helping patients navigate through the system and provide information it was also believed to facilitate an understanding of FPCP. This was acknowledged by a commissioner:

Commissioner_3

> *Where it worked well it tended to be the practices where the receptionists were really proactive in asking the patient what the issue was. And those practices that had a good established, already established that process, you know. Because some practices don't ask the patients, and if the receptionist asks the patients they're like I'm not talking to you, you're not a clinician. But some practices have already got that established so they just added that in, do you need, you know, do you think you want to see a GP, do you think you want to see a physio, do you think you want to see a nurse.*

This sentiment was echoed by the physiotherapists:

Physio3_FG2_B6

> *I think the directing that they did, potentially on the telephone, and the offering of kind of going well, we have a physio on site, would you like to see them, then that yeah, I felt that that was probably more important than a patient glimpsing a poster in the room.*

To be effective the administration staff had to be confident in signposting and, as had been demonstrated, a number of contexts influenced this confidence (Signposting training, a culture of signposting within GP practice, administration staff experience). In relation to the questions posed at the end of the previous theory there was an acknowledgement that administration staff had to have a good understanding of FPCP themselves to be able to pass this understanding on to patients. The following quotes highlighted the relationship between reception staff understanding and subsequent patient understanding.

Physio1_FG2_B6

> *I think their under, particularly the receptionist staff, their understanding had to be quite good, I felt, in order for them to direct it, because that what you've just said, in terms of having different receptionist staff, if they didn't have complete understanding of what it was all about, they potentially didn't then guide them.*

The GPs clearly saw that they had a role in this too:

GP1_practice3

Yeah, yeah. I guess I try and manage people's expectations. And I guess, I guess when I started out they were, people came and expected the physio to do their thing and then that would be it. Whereas now…

INTERVIEWER

So almost like curative?

GP1_practice3

Yeah, and the work to be done in the session. Whereas now I try and explain that actually a lot of the work is done by them at home, and the physio's role is education, and that maybe isn't something that they realise initially.

This extract provided clear evidence of the GP's own understanding and their intention to provide an accurate description of FPCP to patients. There were no corresponding reports from patients as to the accuracy of the information given to them and the influence this had on their understanding of FPCP.

Two further configurations were synthesised that demonstrated how patient understanding was realigned. The first mechanism demonstrated that understanding of FPCP improved experientially. Subsequently, patients were more likely to re-attend having done so before.

The second mechanism that improved patient understanding aligned with the feature of embeddedness which also had been shown to increase patient awareness of FPCP. Dissemination of information by word of mouth was a fundamental mechanism that ran alongside the process of embedding and this frequently featured in participant descriptions. There was an overwhelming sense of the importance of this mechanism despite the prevailing narrative of an increasingly disconnected society. The following extracts highlighted these two features of understanding coming from experience of attending FPCP and from the embedded nature of the service.

Commissioner_4

> *Yeah. I think when patients have gone through the process of actually seeing a pharmacists, or seeing a physio, you know, they're actually, if their experience is very positive they're totally won over, aren't they. And hopefully that then filters through*

This GP talks to both mechanisms and also that of advertising and signposting

GP2_practice3

> *I suppose its awareness, you'll get some patients going back because they've got a new problem, it worked well for them before. Word of mouth, and the advertising that we've just mentioned. And I think it just drops off the tongue for the reception staff as well*

The consequences of this improved patient understanding of FPCP was an increased utilisation of FPCP services and a corollary high level of patient reported satisfaction. This extract from an administration group summarised this dynamic.

INTERVIEWER

> *So one of the practices has said that patients were surprised when they went to see the physio because, as we said right at the beginning, they have a perception of they're going to get manipulated on a couch, and they didn't. Because they are, the physiotherapists were expecting them to take on some responsibility. Did you find any issues with that?*

Admin1_practice2

> *Not any issues. The ones that I had the experience with were really impressed with the service. Positive. Yeah, it was really, really positive.*

Admin3_practice2

> *Yeah. And continued to have follow-up. And they were quite disappointed when the service was stopped.*

Admin1_practice2

> *We had a lot of disappointed patients.*

From this statement it appeared that, despite a general misunderstanding of FPCP, the process of attending did not necessarily lead to patient disappointment. Certainly the physiotherapists were keen to demonstrate patient satisfaction with FPCP.

1. **Physio2_FG1_B7**
   I think in the main most patients appreciated what service that they got. Clearly, one of the practices did a friends and family test and got a really, you know, really good result from that so patients were obviously happy with the service they received.

2. **Physio1_FG1_B7**
   I think the comments on the patient satisfaction surveys were very much that they, that patients actually once they've been to the service really appreciated having a little bit longer with someone who would, who could fully explain their issues to them, and they felt that they'd had a, you know, they felt that they'd had a really good assessment at the end of that session. Because there was a little bit more time allowed.

In summary, this theory provided evidence that a number of mechanisms increased patient understanding of FPCP. These strategies included signposting, advertising, word of mouth as a corollary consequence of FPCP services becoming embedded and previous experience of attending FPCP. Despite the acknowledged potentiality this evaluation demonstrated traditional advertising had been ineffective. On the whole the efficacy of information dissemination by word of mouth, signposting and previous attendance on improving understanding remains speculative. Despite the evidence to suggest these strategies could improve understanding they warrant further investigation.

Table 7.12: Context-Mechanism-Outcome processes to realign patient understanding of FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Poor understanding of FPCP	Accurate information dissemination -signposting -word of mouth/embedding -previous attendance	Improved patient understanding of FPCP	Utilisation of FPCP
Provision of signposting training Administrator peer support Administrator experience	Good administrator understanding of FPCP Provision of accurate information Confidence in signposting		
Patient previously attended FPCP Embedded FPCP service	Patient satisfaction with FPCP Good understanding of FPCP	Increased awareness of FPCP as a resource option	

7.3.10 – CMO representation 10: Characteristics of patients attending FPCP

The data had revealed that although there was widespread awareness of physiotherapy, as a profession, there was poor awareness of FPCP. Furthermore, patients had a generally poor understanding of FPCP, in terms of how it might help manage MSDs and there was a tendency for patients to view the GP as the default first point of access for their health concerns. Nevertheless, patients did attend FPCP and it appeared that the most effective method of facilitating access and providing them with information was signposting by administration staff.

The realist review had provided mixed evidence with respect to the characteristics of patients who attended FPCP. The patient population recruited to this evaluation had a mean age of fifty-three (range 35–73). This was representative of a typical MSK physiotherapy caseload (Akpala, Curran and Simpson, 1988; Dennis et al. 2018). There were seven female and three male patient participants. Back pain and knee pain were the most common health complaints. Similarly, these characteristics were representative of a typical MSK physiotherapy department caseload. Certainly there was no evidence to support the previous assertions that the typical patient attending FPCP was a young, male patient (Swinkels et al., 2014; Holdsworth and Webster, 2004). The literature suggested patients accessing FPCP did so with more acute health complaints. This group of patients did not have a propensity to acute problems. With respect to age some other interesting, qualitative data was synthesised. There was an initial sense that age did not appear to influence those who attended:

Admin2_practice1

> *I wouldn't have picked a certain type of person, or group of person to be honest.*

Admin4_practice1

> *There was old ladies, older men, young people.*

Contradicting this, it was acknowledged that the older population might experience certain barriers to accessing FPCP.

GP1_practice2

> *With the elderly…they might want to see the doctor rather than physiotherapist, kind of to make sure that sort of thing is there.*

INTERVIEWER

> *What, that it's not something different?*

GP1_practice2

> *Something else going on.*

This finding related to the pre-eminence of the GP, in the general practice, for the older population and particularly those with multi-morbidities. This perception was repeated frequently. It also highlighted the challenge in disentangling the proportion of patients with MSDs from the wider caseload. A further issue identified was that the methods of communicating with older people might be a barrier for how they accessed FPCP.

Patient_4

> [The elderly would not understand] *What self-referral is? I mean if I think back to my mother, she'd say well what does that mean, what do you have to do? You know, what do you have to do for that? Even the words are quite hard for people to think well, you know, what does it mean, self-referral. You know, we're back to the basics of the vocabulary which is every day to perhaps you and me…*

There was also the perception that the isolation and lack of advocacy that frequently accompanied ageing might add a barrier. However, it was clear that this could extend to other socially isolated groups.

Patient_4

Well I think an elderly person who is alone, very much alone, hasn't got an adult, an adult supporter. I think somebody who isn't able to speak about what they feel, and what they want isn't very capable of talking about it, and expressing themselves. I think that sort of person [might not access FPCP]

So, although the descriptive data did not demonstrate a predominance of younger people attending FPCP there was qualitative data indicating the older population would experience barriers. Furthermore, the impression from participants was that the older patients would be more likely to adhere to their belief in the primacy of the GP and be less likely to autonomously attend FPCP. Consequently, what emerged was the fundamental role of signposting in terms of ensuring inequity of access to FPCP.

Patient_4

But I also think older people would need it explaining more.

INTERVIEWER

Okay, okay.

Patient_4

You know, how to go about it. And probably a repetition of what to do.

However, alongside this requirement for older patients to be more actively signposted to FPCP was an acknowledgement of their ability to adapt to new systems, with time.

1. **Physio1_FG3_B6**

…the majority of them came from the front-line staff. And then, actually you get quite a lot of older people because they are quite okay about it. Well if you think about it, they are the ones that go in and see practice nurses on a really regular basis; they've usually got comorbidities that they're managing so they're used to that method of working. You know…

2. **Physio1_FG3_B6**

It's almost integrated because they wouldn't expect to see a GP about their diabetes; they'd expect to see the diabetic nurse. They wouldn't expect to see the GP about their COPD, but they'd see their COPD team, or whatever.

The above quotes resonated with the wider political agenda of introducing multidisciplinarity in to general practice and how this had the potential to be embraced by the older population.

It was clearly not as straight forward as the older population did not access FPCP, unless signposted, and the younger population did. It was apparent that there were a number of cultural, demographic and economic determinants. For example, it was apparent that some of the younger, working age population had associated motivations. The following two examples suggest how this might influence a positive uptake for FPCP.

GP1_practice2

Possibly younger men will see physio, because they probably do understand more. And they would probably think that okay, there's probably not something serious going on. With the elderly there is one, there could be one barrier there, because they have quite a few other comorbidities, so they might want to see the doctor rather than physiotherapist, kind of to make sure that sort of thing is there.

Patient_2

Because men just want to get it sorted. They just want to crack on with life. It's like most men do football, so they want to be able to go and play football, go to the pub after. Myself, I've got a little-un, so for me running upstairs at night when he's crying in bed, you know, and you're struggling to just walk on a step. It's really infuriating, so you just want to get it sorted. So in the event of having to race up one night, you can just do it.

Equally, for women patients:

Patient_3

So it might be the work they do, or it might be just being a mother, you feel like you've got to look after yourself for your children. To keep active and, did I say for your job?

However, what also became apparent was that even in the younger population there could be cultural disincentives. For example access to drugs was spoken about:

Admin2_practice1

Some people just want the doctor because they want their tablets.

Admin5_practice1

They want medication rather than the physio.

Admin2_practice1

They want the painkillers rather than anything else. So there was a minority of people that wouldn't budge and no, they were going to see the doctor.

In one practice, situated in a particularly deprived area, the lower socioeconomic demographic of their patient population prompted the administration staff to suggest that the younger people would, in fact, be those least likely to attend.

INTERVIEWER

What about the ones that you said who were sort of, you know, absolutely no, I want to see a GP. Are they easy to sort of categorise in terms of their age or description?

Admin2_practice1

I'd say a younger person.

Admin1_practice1

But I think that a lot of it did boil down to medication.

Admin2_practice1

It was medication. They knew that, like I say, sometimes yeah, they might have back pain, you can say they've got back pain, you can't…

INTERVIEWER

Right, okay. So medication as in terms of sort of almost like addiction medication, or..?

Admin4_practice1

Yeah.

A GP reinforced this sentiment:

GP1_practice2

I mean we, our practice is in such, it is an area with lots of deprivation so probably that does contribute; the psychosocial factors contribute to it as well. There's lots of dependence really on the medical services. Even the younger people are like this, there's lots of dependence I think, on the medical services.

INTERVIEWER

And that's an obstacle to people using these services do you think?

GP1_practice2

Yes.

It was evident that socioeconomic determinants influenced access to FPCP. Contrasting the views of those working in deprived area, those in more affluent areas reported the opposite experience:

GP1_practice3

Yeah, it's quite a middle class, well-educated population… And I guess there is, one of the things that I do see is that there's, people seem to recognise something to help them… I guess, and their parents might have been more

aware of what's there, so it might be more than education, it might be to do with their upbringing and things as well.

Another GP reinforced this perception:

GP2_practice4

Yes, to a degree. I think there's an educational element to it, you know, if people have had more education and a bit more sort of world experience in a job, talk to more people, they're much more likely to know about these sorts of services than, you know, somebody who is a bit more socially isolated, sat at home and doesn't really, you know, see as much of the wider world as somebody else might.

There was the suggestion that the more privileged population had greater access to information and more ability to 'rationalise' their healthcare choices: *"that's interesting. Perhaps they're able to rationalise their best healthcare provider and their skill set"* (Physio2_FG2_B6). What was clear was that different sociocultural characteristics resulted in differences in access to information and the ability to make sense of the information and choices thereafter. The following lengthy quote summed up the complexity of the analysis of the characteristics of those patients using, or not using, FPCP.

Physio2_FG3_B7

Yeah. Well, I mean you don't want to always make judgements, but ultimately if you're an older adult who is internet savvy, got access to a decent computer… I mean you need money to have the internet to start with, so if you're struggling to put food on your table every week you're not necessarily going to have the fastest broadband speed and the best equipment to access it. But having said that, a lot of people have got smart phones, so you know, you could counter argue. But again, its behaviour patterns, you know. If you are someone that, you know, wants to be curious about something going on with yourself, you might well explore that. But if you're someone that's reliant, you know, a bit more passive in your

responsibilities within your life, then you might seek to get guidance, you know, go to somebody in a position to help, like a doctor basically.

The final section of this quote dovetails into the next theory which is one that emanated from the realist review- 'autonomous health seeking behaviours' that is considered in the following section.

It was clear from the synthesis seen in this section that FPCP was implemented into a complex social system. The result of this social complexity was difficulty in characterising a 'typical' patient who accessed FPCP. The evolving theory demonstrated the importance to explore access to FPCP as it exposed several cultural determinants.

For example, there was evidence that the older population contextually regarded the GP as the default FPC practitioner (Context). However, when exposed to information about FPCP through signposting (M-Resource) the elderly were receptive (M-Reasoning) to attending FPCP (Outcome). Over time, as FPCP became embedded (M-Resource) the older population became confident (M-Reasoning) and the service became normalised (Outcome). Furthermore, the motivations, or disincentives, to attend FPCP varied and some of this variance was due to cultural and socioeconomic determinants. Considering these factors will be important if equity of access to FPCP is to be ensured in the future.

Table 7.13 represented the complexity of the characteristics of patients accessing FPCP. Suffice to say this diagram is unlikely to be totally comprehensive and inevitably it presents some generalisations. However, it is data driven and presents some theories that warrant consideration. Importantly, it demonstrated the specificity required in any initiative, FPCP and beyond, in terms of implementation, and the facilitation of access to resources, which is clearly not equitable across communities and sociodemographic distributions.

Table 7.13: Context-Mechanism-Outcome characteristics of patients attending FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Elderly patients Existing multiple comorbidities	Limited exposure to disseminated information on FPCP Socially isolated Perceive GP as default FCP	Poor awareness of FPCP Poor understanding of FPCP	Default to GP as FPC
Lower socioeconomic groups	Psychosocial characteristics: Limited exposure to disseminated information on FPCP Dependence on medical model of healthcare Fewer incentives to maintain good health	Reliance on GP Poor awareness of FPCP Poor understanding of FPCP	
Elderly patients accessing care in their general practice	Information disseminated through signposting	Receptive to signposting Adaptable to novel interventions	Utilisation of FPCP
Young patients Male patients	Incentives to maintain good health	Motivated to consider alternative to GP	

Female patients Higher socioeconomic groups Higher educational level	-Employment -Hobbies/pastimes -Children/caring role Ability to rationalise health complaint and choices	Increased understanding of FPCP	

7.3.11 – CMO representation 11: Autonomous health seeking behaviour and patients attending FPCP

The previous theory made a distinction between those people who might and those who might not access FPCP based on certain characteristics and this was not straightforward. The realist review had suggested the characteristic of autonomous health seeking behaviours was seen more frequently in those patients attending FPCP. This theory was explored in the interviews and focus groups and the emerging theory was complex. The overriding impression, from evaluation participants, was that the association between autonomous behaviour and attendance at FPCP was likely to be accurate, *"I think that would also make sense, because I think a lot of what they're being told to do is these are some exercises you can do and you need to go home and do them, rather than here's a pill you can take"* (Admin1_practice3).

However, the general consensus was that autonomous health seeking behaviour, in the public, remained the exception:

INTERVIEWER

Do you think that demonstrates a change in people's sort of attitudes towards health that we've got to look after ourselves generally?

Admin1_practice1

No.

Admin2_practice1

> *No, I don't think a lot of patients want to take the responsibility on themselves.*

Admin1_practice1

> *Except a certain group of people. Not that I've noticed that certain group of people in practice, but there's a lot of people, they just want everything done for them.*

Admin3_practice1

> *They just want you to do everything for them, and not do anything for themselves.*

It was apparent that there were socioeconomic characteristics influencing the adoption of autonomous health seeking behaviours. The following quote was from a GP working in a deprived inner city area.

GP2_practice4

> *Have I noticed a change? I can't say that around here there have been huge changes to people's sort of health beliefs. I've worked in different practices and in some more affluent areas there's a lot more people who take these sorts of things on board, and are a lot better at healthy eating. I think there's a lot of resistance in somewhere like this, where they have a fairly low sort of social economic population. A lot of the patients just don't have the interest, money potentially, to sort of take up some of these things.*

Moreover, it appeared that there was a problematic dichotomy. The existing national health agenda expected that people would take on more responsibility for their own health care. However, at the same time, as a consequence of advances in health care provision there were greater expectations of patients being 'provided with a cure'. As one commissioner stated:

Commissioner_3

> *Because their expectations are increasing, so they're expecting more, so that doesn't necessarily mean that they're trying to help themselves more because clearly they're not. You know, so yeah, I don't get that impression.*

This sentiment was reinforced by a GP who described the increase in patient expectations as a consequence of a greater range and efficacy of healthcare interventions. This synthesis reported important findings that require future consideration when implementing initiatives, such as FPCP. As had already been exposed, programmes like FPCP, which advocated greater personal responsibility, needed to consider the methods by which information pertaining to the initiatives was disseminated. The data suggested methods of increasing personal responsibility for health was not necessarily well disseminated, articulated or interpreted.

GP1_practice4

> *Yeah, yeah. And I think what happens is the wrong message gets through. So the message is be slim and, you know, instead of doing that in a balanced way, you know, they'll have special cup a soups from a diet, you know, where…*

The result of this was a perceived scarcity of people taking greater responsibility. Furthermore, the model of FPCP that advocated a BPS approach aligned badly with the evident lack of autonomous health behaviours. This had the potential to result in patient disappointment and non-engagement.

Patient_2

> *Yeah. Because if you've got quite an active job, and you've got an ailment that causes you from doing the normal duties, it's going to get you down, you know. And you want to take a pill and everything's fine. Or you want to be told okay, you need an operation, so you can prepare yourself for it. But to do what seemingly feels like silly exercise for six months, and you don't see the benefit but subconsciously you've got to give it time to work…*

INTERVIEWER

That's quite a commitment isn't it, on behalf of the patient?

Patient_2

A lot of people will do it for a week, two weeks, and then think okay it's not working so I'm not going to carry on. And that's obviously physio, that's not the idea of it. The idea is a prolonged period of time. And over time your muscles get stronger and the ailment gets better.

The overall sense was that there was limited population-wide change in patient behaviour in terms of the assumption of autonomous health behaviour.

INTERVIEWER

And have you seen over the years a change in the number of people who are taking, prepared to take more responsibility for their health?

GP1_practice2

There is some improvement, not a lot. I would like this to be a bit better than what it is. There is lots of media and all that, and everywhere we are trying to encourage them to change their behaviour. So there might be some improvement, but not enough.

INTERVIEWER

But your impression is it's slow, okay. Yeah.

GP1_practice2

It is not enough I think. I mean we, our practice is in such, it is an area with lots of deprivation so probably that does contribute; the psychosocial factors contribute to it as well. There's lots of dependence really on the medical services.

Despite this, a number of patient participants were able to make useful reference to the role of autonomous health seeking behaviour. The fact that these patients had all attended FPCP and had agreed to take part in the evaluation means they may not be truly representative.

Patient_3

I was like great, because it was physio I wanted to see anyway. And when I heard I could get straight in without having all the palaver of seeing a doctor yeah, I was really pleased.

INTERVIEWER

Okay. And why were you pleased about..?

Patient_3

Because I… the injury came from my new hobby of running, and I wanted to get it sorted as soon as possible. So I thought that would be a quicker way.

This individual had received information (Context), had some form of an understanding (M-Resource[1]) of the role of FPCP and had an incentive (M-Resource[2]), in this case to return to their hobby, which facilitated their decision (M-Reasoning) to access FPCP (Outcome). It is easy to hypothesise that in the absence of one, or any combination, of these mechanisms the outcome could be different.

The above individual had personal contexts that were perhaps more facilitative of this process, *"Yes. I think because I'd Googled a lot, and because I'm in a running group, they were recommendations from people that that might be what was needed"* (Patient_3). In this case the information came from both the internet and a social support group. Contextually, these mechanisms of information dissemination that may not be available to disadvantaged groups such as the older population or those in lower socioeconomic groups. Furthermore, and relating to the previous theory that explored the characteristics of patients who attended FPCP, any individual also needed the ability to rationalise the information they received.

The final feature that was synthesised from the data and warranted mention was the cultural differences that might influence choice-making as these various quotes demonstrate:

GP1_practice3

More so from our overseas patients, I would say.

INTERVIEWER

More so wanting to see the GP?

GP1_practice3

Wanting to see a doctor – sometimes, even a male doctor. Just because that's what they're… but particularly Saudi, Oman, Middle East, just have this perception still that it's that way round.

As a patient participant from a minority group remarked some cultures might be put off by their expectation of the need to get undressed:

Patient_10

Well some would probably think you've got to get undressed and, you know.

INTERVIEWER

And do you think that would put people off?

Patient_10

Yeah. Yeah.

Furthermore, some cultures may have healthcare expectations that are contradictory to the current NHS model of evidence base practice and the contemporary BPS model of physiotherapy care. This was evidence by the physiotherapist quotes that follow.

1. **Physio1_FG2_B6**

So I guess for example, people from very different countries may have seen doctors, physiotherapists in their own countries, where they have been told they need something, and it often is things that we would class as not evidence-based for long-term management of conditions.

And:

2. Physio1_FG3_B6

Okay. So I think depending, different cultures have got different belief systems around what makes you feel better when you are unwell. And a lot of them have a belief around massage, so I think that's quite large in the Asian community. But even so, there's less requests for it I think, as time goes on.

Or for the following patient:

Patient_8

A lot of ladies, from whichever culture, would like to basically see a female physiotherapist. But obviously, because I've had lots of physio, I'm willing to see anybody because I understand where they're coming from. But yeah, so some of the ladies are very reluctant to see a male physio.

These cultural contexts, along with those of age and socioeconomic status are extremely important to consider if access to FPCP is going to be equitable to all. This will be deliberated more in the discussion.

Table 7.14: Context-Mechanism-Outcome autonomous health seeking behaviours and patient attending FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Patients cognisant with modern health agenda Motivations to maintain optimal health Ability to rationalise health complaint and choices	Assume responsibility for own health Actively seek information to support maintenance of good health	Increased awareness of FPCP Increased understanding of FPCP	Utilisation of FPCP

Lower socioeconomic groups Improving healthcare interventions and outcomes	Greater expectations of curative healthcare Poor engagement with health initiatives Expectation of physiotherapy in medical model Poor understanding of FPCP	Resistance to assuming responsibility for own health Unwillingness to undertake physiotherapy in BPS model	Default to GP as FPC
Sociocultural determinants -Gender -Race -Religion	Sociocultural belief systems -Primacy of GP in healthcare -Beliefs around undressing -Beliefs around gender of healthcare professional -Beliefs around passive treatment modalities	Poor understanding of FPCP Resistance to assuming responsibility for own health Unwillingness to engage in BPS model of healthcare	

7.4 – Summary

This chapter described the finding relating to programme theory 1- patient understanding of FPCP. The following chapter describes the findings relating to programme theory 2- roles and boundary definitions in the FPCP initiative. The following chapter also describes the discussions arising from the evaluation, the strengths and weakness of the evaluation and a summary of the evaluation.

Chapter 8 – Findings: Programme theory 2; Roles and boundary definitions in the FPCP initiative

8.1 – Introduction

Chapter 7 reported findings associated with the first programme theory exploring the relationship between patient understanding of FPCP and its subsequent operationalisation. This chapter describes the findings related to the second programme theory which positions FPCP as a professional project and the consequences of this project on roles and boundary definitions. The realist review identified some important theories that should be considered for those looking to implement FPCP services including outlining roles, and boundary, definitions. This evaluation developed these theories more deeply and exposed further new knowledge. This chapter concludes with a discussion of the findings, a review of the strengths and weakneses of the evaluation and a conclusion of this empirical research.

8.2 – Findings

The following findings are presented sequentially with an initial narrative representation of the theory followed by a diagrammatic representation of the CMO components of the theory configuration (Goodman et al. 2017).

8.2.1 – CMO representation 1: Evidence to support FPCP as a professional project

Evidence from the realist review demonstrated that physiotherapy as a profession, and clinical physiotherapists, had used various strategies to disseminate information in support of the FPCP initiative. When this was explored empirically all participant groups were cognisant of this narrative with particular reference to the pressure for patient appointments and issues related to GP workforce recruitment and retention.

Admin2_practice1

> *I think it goes back to the appointments though, don't it. Because we struggle for appointments, it did suit us didn't it, because like I say, it freed others up. But is everybody's like that anyway, all surgeries are, aren't they*

The following quote from a GP participant was consistent with this demand-reducing position:

GP1_practice3

> *But then we've got a huge shortage of GPs, it's difficult to recruit, so people are looking at other ways of working.*

The physiotherapists were also cognisant of this narrative and frequently spoke of how FPCP had the potential to contribute to alleviating some of the pressures experienced by the GP workforce:

Physio1_FG2_B6

> *…if we think back as to why this FPC was made in the first place it's because evidence suggested that a third of GPs* [one third of GP appointments are attributed to MSDs]*, you know, and then that's evidence. I don't think that's from the CSP, it's not from the governing body, that's just general evidence. And timeframe wise, the time constraints on GPs, they were struggling with that workload.*

Further professionalisation characteristics that were consistent with the sociology of the professions literature were evident

- Developing and using an evidence base

The realist review had shown that physiotherapists saw the importance of demonstrating efficacy through the generation of an evidence base. This evaluation supported that theory with the physiotherapy participants speaking of providing evidence via locally collected data. The following quote described the collection of patient satisfaction data. Further reference was made, in the interviews, to empirical data supporting clinical and financial efficacy from previous service evaluations.

Physio2_FG1_B7

I think in the main most patients appreciated what service that they got. Clearly, one of the practices did a friends and family test and got a really, you know, really good result from that so patients were obviously happy with the service they received.

The physiotherapists also had insight with regard to the professional project. The CSP had suggested a reduction in GP workload. The following extract showed that the physiotherapists were aware of this agenda, the role of their professional body and the potential dangers inherent in this profesionalisation narrative.

Physio1_FG2_B6

But also I think patients often go in with multiple different problems. So if they've got one problem that's an MSK problem, and they've got something else that's, they're not in control of their asthma, you know, we can't do both of those things, whereas their GP potentially could review both of those things.

Physio2_FG2_B6

So the headline from the CSP for example, 30 per cent of patients MSK, it almost feels like a bit of fake news in a way.

Physio1_FG2_B6

Potentially. It's difficult, it's really challenging. That's a reasonable suggestion.

INTERVIEWER

What do you mean, it's really challenging?

Physio2_FG2_B6

Because I suppose as a professional body the CSP is certainly going to want to demonstrate its worth and justify its presence within the healthcare service.

Previous work supported this cautionary approach and demonstrated that the proportion of patients with MSDs were often not clearly defined in practice (Moffatt, Goodwin and Hendrick, 2018). As such the predicted impact on GP workload was likely to be more complex than the CSP rhetoric.

- Formal training to justify FPCP

The realist review had provided evidence of physiotherapist recognising the need for formal credentialing to support their professional project. There was evidence in this evaluation that made reference to formal training for the role. In this respect the physiotherapists described a perceived parity with doctors.

Physio2_FG1_B7

> *I don't think people even know what you have to do in order to get in to university, you know, it's a highly competitive degree to get on, you need really strong A-levels, you know, they're not far off the medical profession. You know most of them are asking for three A's, or certainly 2 A's and a B, you know, at worst.*

Beyond basic undergraduate training there was also the advocacy of postgraduate, specialist MSK training as a method of legitimising the FPCP role. At the time of this research there was no agreed competency framework for FPCP. However, the physiotherapists spoke of advanced practice, Masters level education, clinical competencies and the dissemination of skills as supporting the development of the FPCP role.

Physio2_FG2_B6

> *I think that's a reflection of the fact that within our service we've always had quite a culture of that* [comprehensive in-service training programme]*. So I think with a lot of the Band 7s, for example, doing that Masters module, a lot of that information has sort of filtered down to us.*

Also evident, with respect to the possession of a specialised body of knowledge, was how the FPCP role constituted a new way of working for physiotherapists. The physiotherapists saw the role as advancing their practice and assuming a more GP-

centric model of working with an emphasis on a medical screening assessment first and considering MSK related interventions any risk had been considered.

Physio2_FG2_B6

> *Yeah I mean, so we've all three of us been fortunate enough to do the advanced practice diagnostics module at the 'X' Uni, and I think one thing which was impressed upon us was that physios traditionally perhaps have this sequence of history taking whereby we start off with all the MSK stuff first, and then we screen for red flags as an addition to that. Whereas perhaps medical colleagues might reduce their index of suspicion of anything serious initially, be reassured that it is probably MSK, and then manage it.*

Masters level training, peer support and local training provided local contextual features that resulted in the physiotherapists feeling comfortable with the FPCP role. Nevertheless, the physiotherapists made comparisons to the medical profession and this was clearly a source of frustration for them, from two perspectives. Firstly, they felt hindered by their perception of a medical dominance and secondly they felt their level of competence was not acknowledged by the public or within healthcare. The following two extracts from two separate focus groups demonstrated these frustrations.

1. **Physio4_FG1_B7**

   I think people's perception is you know, you've got to be really clever to get into medical school, and it takes this many years, and they don't know anything about our training

2. **Physio3_FG2_B6**

   It just feels potentially a little bit frustrating doesn't it, because at the end of the day we've got that skill, this is what, you know, this is what we've been taught to do, why we should be any more different than how the doctors assess these musculoskeletal conditions? In fact we should be better. Are better.

The evidence generated resonated with theories from Programme Theory 1 which evidenced a lack of public understanding. It also introduced the potential for interprofessional tension. This is considered later in this chapter. The physiotherapists extended this sentiment to GPs, suggesting that despite the fact that the undergraduate requirements were "*not far off the medical profession…I don't even necessarily think the medical professionals understand that either*" (Physio2_FG1_B7).

The realist review had reported the primacy of the GP position in general practice and this emerging theory suggested this extended to a perceived hierarchy in knowledge. The physiotherapists could foresee how GPs lack of understanding, with respect to their knowledge base might impact the FPCP initiative. When asked why GPs might have concerns about the FPCP role one physiotherapy focus group saw how this lack of understanding of physiotherapy practice and governance, might lead GPs to take a protectionist stance.

Physio2_FG1_B7

> *I think this, again, goes back to this lack of understanding of our professional qualifications and what roles, you know, we have. I mean I would probably counter that, and if you've got a very experienced MSK physio that they're, if anything, more competent at screening for these things than GPs. So, you know, clearly it's the CSP, or our professional body, need to do even more to allay those fears I think.*

Physio5_FG1_B7

> *I think there's inevitably an element of protectionism on their part as well, you know.*

Physio3_FG1_B7

> *Fear of the unknown.*

Physio5_FG1_B7

> *Yeah. You know, like you say, they've been the gatekeeper within primary care for such a long time, and they've had that established role, and they*

might feel as though that might be being eroded by other professions taking on some of their workload.

The novel information that emerged led to the generation of a new theory whereby, in the context of GPs having a lack of understanding of physiotherapy, there was associated low GP confidence in FPCP which resulted in a simultaneous protectionist response from GPs.

However, there was evidence from GPs that contradicted this, as the two following GPs attest.

1. **GP1_practice3**

   But physiotherapy is a several year degree, by the time you get into the community you've probably rotated around hospitals and things, so actually I'd imagine there would be some teaching about red flags. So you are professional in your own right, so you do have some obligations and some training, so actually I would feel comfortable with it. And I think happy with them to manage that and spot red flags and things.

2. **GP1_practice4**

   I think, you know, there's a, you know, everybody sees physios as having a, you know, a very robust training, very robust knowledge. Having a high standard of care generally.

Somewhat contradicting the physiotherapists concerns, the above quotes evidenced GP understanding of physiotherapy training. It also appeared that this resulted in them feeling comfortable about the physiotherapists' competence.

- Demonstrating the impact of FPCP

The realist review had identified that physiotherapists were cognisant of the need to demonstrate the impact of FPCP to enhance their professional project. One method of evidencing impact was via gathering GP opinion. The following two quotes described how FPCP resulted in a reduction in GP workload and the endorsement of the advanced practice nature of the FPCP role.

1. **Physio1_FG1_B7**

   … there was some [GPs] *that said they'd felt a large reduction in their MSK workload, which I find incredible to believe with the amount of, you know, the amount of time that we were there. And some saying they'd felt a small, you know, a small difference, which I think is more, you know, more likely.*

2. **Physio1_FG1_B7**

   … the comments on the GP satisfaction surveys, probably the most common positive thing that was said was split 50/50 between how quickly patients could get access to physio, and how impressed they were with the quality of the safety netting, and the thoroughness of the assessment, and all of those things. That actually, I think, they were quite surprised by some of the things that the physios were doing during their assessment, or testing, or whatever, checking their blood pressure and picking those things up and raising concerns.

This suggested FPCP provided increased efficiency and clinical efficacy. Furthermore, GP surveys had shown they were confident in the physiotherapists' clinical competence. An objective of the physiotherapy rhetoric was to expand jurisdiction and achieve sustainability for the FPCP initiative. The rationale was that evidence of efficacy (M-Resource) would lead to stakeholder confidence and satisfaction (M-Reasoning) which would result in substantive commissioning (Outcome). However, despite the process of gathering evidence of efficiency, efficacy and GP satisfaction the pilot FPCP service had not been recommissioned. It was unsurprising that physiotherapist frustration resurfaced. The argument of providing a sound evidence base to secure support for the FPCP project was undermined.

A number of interesting mechanisms were synthesised when this commissioning decision was discussed. The lack of GP financial commitment was frequently articulated.

Physio1_FG1_B7

> *… at the end of the first year when there was a potential that they* [GPs] *needed to encourage the funding to be maintained to get the service to continue for a following year, they were extremely enthusiastic about how they needed more of this, because they weren't paying for it themselves. At the end of the second year when they* [GPs] *knew the service was disappearing, there was far less, far less positive comments, and far fewer GP satisfaction surveys that were returned. So I'm slightly cynical.*

INTERVIEWER

> *Because of the finance?*

Physio1_FG1_B7

> *Because of the finance. While it was something that was being provided for free they* [GPs] *were thoroughly enthusiastic about it. At the point of which possibly they may have had to start to fund it themselves for it to continue, it suddenly got slightly quieter.*

Physiotherapist participants were sceptical that despite being able to demonstrate *"that it's safe primarily, and has good outcomes…the golden dollar question, is it more affordable?"* (Physio1_FG3_B6). It was clear that money was *"omnipresent in everything that we currently do"* (Physio2_FG3_B7). The frustration was that, despite the evidence the FPCP pilot had not been recommissioned and this decision was perceived to be financially motivated. Physiotherapists' perceived that GPs had a significant influence in this process. It appeared that the GPs lack of commitment undermined the enthusiasm they had articulated for the initiative.

Physio1_FG1_B7

> *Because I think if you really valued this, these are your patients that we are seeing, this is your workload that you are reducing. If you really value this that much then, and you have a shortage of GPs… nobody has any spare money I appreciate that but… why not dig into your pocket for some physio rather than for a locum GP to fill the gap.*

The above quote also pointed to a sense of professional protectionism whereby the GPs priority would be a further GP or locum. The physiotherapists were cognisant of the dual clinical and commissioning role that GPs held and the control that was inherent in that.

Physio2_FG3_B7

> *So, and I think, because essentially medics hold a lot of the sway when it comes to healthcare politics, you know, often they dictate how things are, you know, run and …*

Physio1_FG3_B6

> *I mean now they're commissioners in part, aren't they. And that's important, because that is control.*

In summary, this evaluation showed physiotherapists using evidence to support the FPCP initiative. They were able to provide evidence of clinical and economic efficacy and patient and GP satisfaction. Furthermore, they spoke of training and competencies as methods of authenticating the FPCP role. This evidence supported the theory generated in the realist review that the FPCP initiative contained all the constituents of a professional project. However, the physiotherapists' deemed these strategies as ineffective as demonstrated by the subsequent non-recommissioning. From a physiotherapy perspective the GPs were, in part, responsible for this decision-making and had control over such decisions. This feature was explored in later sections.

Table 8.1: Context-Mechanism-Outcome use of the evidence base to support FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Where FPCP implemented FPCP as a professional project Increasing pressures on general practice and GP workforce	Physiotherapy rhetoric to support FPCP -Clinical efficacy -Financial efficacy -Stakeholder satisfaction -Formal training	Physiotherapist comfort in FPCP role GP confidence GP perception of clinical competence in extended role	GP support for FPCP
GP role in commissioning Primacy of the GP gatekeeping role	GP influence	Protectionist decision-making -Financially -Clinically Physiotherapist frustration	Non-commissioning of FPCP

8.2.2- CMO representation 2: FPCP as a method of increasing physiotherapists jurisdiction

The previous theory demonstrated that physiotherapists exploited the political agenda of the time as leverage for their professional project. Furthermore, they were relying on sociologically recognised methods to justify their project. These included leveraging formal training and utilising empirical evidence to support the FPCP initiative. From this contextual framework physiotherapists' attempts to broaden their professional jurisdiction were explored.

The FPCP role encroached into traditional GP jurisdiction through physiotherapists' assumption of responsibility for the cohort of patients presenting with MSDs. A number of the extended scope elements of the FPCP role encroached further into traditional GP jurisdiction. On first inspection this broadening of jurisdiction was supported by staff. This support was justified from the viewpoint that it improved patient experience. This support was described by all stakeholder groups, as evidenced below.

- Administrators:

Admin1_practice3

> *Yeah. If you see a physio and if they think you need an X-ray, or they think you need painkillers, they'll arrange that I think is a good message.*

- GPs:

INTERVIEWER

> *… one of the agreements was that he could refer on to, you know, for diagnostics or to secondary care. So do you think that would reassure patients in terms of increasing the sort of, their likelihood to access that sort of service?*

GP1_practice3

> *Yeah. I mean, yeah I think so. Yeah, yeah. And, yeah, I think it would. And I think it's one of these, it's one of these things that once people realise and experience it, it'll take off and become more and more popular.*

- Physiotherapists:

Physio1_FG2_B6

> *…at the end of day, you know, you are trying to help them out. And if you work together with them, like being non-*[medical] *prescribers, it just makes it so much more fluid for the patient, and more streamlined, and actually it does take the pressure off the GP.*

Further justification had been made in that the extended role would more wholly manage the MSDs burden and alleviate the demand on GPs. On the whole this explanation was supported by GP participants as was the rationale for an extended scope of practice. Conversely, GPs expressed concern about physiotherapists without these competencies assuming the FPCP position.

GP1_practice3

> *So I think, I think like all of these things, doing a pilot and having an experienced physio doing it can demonstrate clearly that it works. But then if you try and extrapolate it by then putting in inexperienced physios in, who haven't necessarily got the experience, that may be more risky.*

Interestingly, the extended scope capacity was not viewed as essential by the physiotherapist participants. They did view an extended scope of practice as facilitating patient care and optimising FPCP. However, alongside this was an acknowledgement that the extended scope components of the role were required in as few as 15 per cent of the patients who attended. As a consequence there was a sense that the profession should be pragmatic in its project. Purely promoting the extended scope aspect of the role could result in physiotherapists pricing themselves out of the market. A more rational approach to skill mix might be required

Physio2_FG1_B7

> *I think, moving forwards as a profession, we've got to be really careful that what we don't do is force primary care to only employ ESPs* [extended scope physiotherapists] *when we know that probably for 80–85 per cent of patients that access the service, they don't need those extended skills. Because it's just going to be too costly, commissioners aren't going to necessarily want to pay for that, GP practices won't necessarily want to pay for that. So we need to have a bit of a blend of skills, in terms of physios in GP practices. So, you know, I think moving forwards, I think if commissioners or providers are going to look at this, they maybe want to look at it more*

from a service model, rather than just individual clinicians. You know, can we offer a mixture of clinicians for different practices.

Nevertheless, a concern was expressed that, while there was a danger of pricing themselves out of the market, physiotherapists also needed to be mindful not to undermine their role by diluting it.

Physio2_FG3_B7

I don't want to be precious, but I do think we should be respected for certainly the skills, knowledge and experience we have.

Extended roles were well received by all stakeholders and optimised the FPCP role, widening it into traditional GP jurisdiction. However, physiotherapists were cognisant that extended roles were more expensive and this could negatively impact commissioning decisions. This presented a dilemma for the physiotherapists who acknowledged that, with a political agenda seeking alternatives to apparently unsustainable pressures in general practice, it was a case of 'physiotherapists or someone else'.

Physio2_FG2_B6

I think there is a need for some professions to demonstrate their worth, and I think quite strongly that if we don't have a presence within GP practices, advanced nurse practitioners will. So, and it's within our skill base to do so, so it would certainly be a missed opportunity if we didn't.

This concern, for the physiotherapists, aligned with the evidence from the realist review and evaluation in Programme Theory 1. There was an impression of a contested MSK professional field. One physiotherapist spoke of working alongside an ANP who was performing a similar role. Another spoke of paramedics performing comparable roles – assessing and manging minor injuries in general practice. This concern, about surrounding professional competition, was exaggerated by the general populations' lack of understanding of roles, in particular the distinction between physiotherapists, osteopaths and chiropractors.

In summary, it was apparent that in its most advanced iteration the FPCP role extended physiotherapy boundaries and, as a consequence, encroached into traditional GP roles. While the evidence presented to date demonstrated stakeholder comfort with this, there were concerns in terms of safeguarding, finance, and withstanding the challenges of other non-doctor professions.

Furthermore, there was an early indication that some concurrent interprofessional issues may also exist. Within this theory any tensions, tentatively uncovered, existed in the context of GPs influencing commissioning decisions and in terms of GP concerns associating patient safety with physiotherapist experience and skill. This aspect was explored in more detail later within these findings.

Table 8.2: Context-Mechanism-Outcome FPCP as a method to increase physiotherapist jurisdiction

	Mechanism		
Context +	Resource	Reasoning	= Outcome
FPCP as a professional project Increasing pressures on general practice and GP workforce Physiotherapy rhetoric to support FPCP	Physiotherapy justification made for increasing jurisdiction	GP support for increased jurisdiction GP concern over patient safety with lesser skilled physiotherapists Physiotherapist support for increased jurisdiction	Increased FPCP physiotherapist jurisdiction
Lesser skilled physiotherapists providing FPCP	GP concern over patient safety	GP anxiety regarding patient risk Commissioning decision not to invest in FPCP	Non-commissioning of FPCP
Environment of limited financial resourcing	Physiotherapy advocacy for varied skill mix Physiotherapy concern over cost of extended scope FPCP roles		
Extended FPCP role Contested MSK practitioner marketplace Established GP role	Extended scope FPCP role regarded as expensive Parallel professions advocacy strategies		

8.2.3 – CMO representation 3: Reduction in GP workload as a consequence of FPCP

A reduction in GP burden, as a consequence of the redistribution of workload, had been widely cited in recent professional rhetoric (Middleton, 2015; 2016; CSP, 2016, 2016a, 2016b, 2018; BBC, 2016) and evidenced in the realist review as justification for the FPCP initiative. There had been no indication in the realist review to evidence any reduction in GP burden being quantifiably achieved. More so, previous research suggested this feature was complex (Moffatt, Goodwin and Hendrick, 2018). As such, and taking into account the apparent importance of this, as justification for the FPCP initiative, the issue of the impact of FPCP on GP workload was explored in the evaluation.

Contextually, FPCP was introduced into an environment of increasing pressures on general practice. All participants acknowledged that GPs' work had changed in recent years. There was also evidence that the general practice was already seen, by patients, as a wider team and more than just 'the GP'. However, the impression was that to date, the modern multidisciplinary nature of general practice had made no impact on alleviating GP burden. The following quotes outlined these features in the context of the modern-day general practice. The first quote, from a GP, highlighted the multidisciplinary nature of general practice and the impact on the GP caseload.

GP2_practice2

> *I've been here since 2001, and I remember, and it still happens now but more rarely, being on call for an emergency day and just seeing lots and lots and lots of coughs and colds, and things like that. Which increasingly our nursing staff are looking after very well, and the pharmacist as they should do…they are seeing much more minor illness, but also minor injury, which works.*

However, it appeared that if lessening GP burden was a desired outcome it had not been realised. In fact the consequence of this restructuring appeared to have had the opposite outcome as the administration staff focus group discussed.

Admin1_practice3

But again, I mean it goes, in the nine, ten years I've been here, and 'Jane' will probably say the same, the docs impression of their workload is not so much they're seeing more patients, but actually it's more intense. Because there's stuff like…the simpler cases they used to see as a doctor, are now being seen by the nurses.

INTERVIEWER

Okay. So the GPs are being left with more complex..?

Admin1_practice3

Yeah. So each ten minute slot is a lot more intense in terms of the patients, they're not seeing the sort of coughs and colds, and sort of simple stuff they used to do. It's more intense.

This group of administrators went on to describe increasing levels of paperwork and targets applying further demand on GPs with the impression that the demand *"just grows and grows and grows"* (Admin3_practice2). This impression was consistent with that of the GPs themselves, who saw their diaries being as busy but their caseloads more complex. As one GP commented when asked what a GP's caseload looked like subsequent to these changes.

GP1_practice2

Depression, psychosis, mental illness, acute infections.

INTERVIEWER

More complex?

GP1_practice2

Inevitably, yeah. And our work now is the work of hospital consultants 20 years ago.

A number of accompanying issues were synthesised alongside the increasing complexity of GP workload. The first was support for multidisciplinary team (MDT) working, the second agreement that the subsequent complexity in caseload was

appropriate. The third issue that was new evidence was how the provision of the MDT– somewhat responsible for increased complexity – had the complementary characteristic of supporting the GP. The following extracts highlighted these findings.

- MDT optimised patient care:

GP_FMC_2

> *Well, I think one of the main reasons is that it's more and more recognised that the wider sort of primary healthcare team is really there to help with the serious complexity of patients' problems. It's also pretty widely known I think that general practice has been under a lot of strain for a lot of years, and there's a lot of people with good skills who could be brought in to see patients, like physios who can do just as good a job, if not better, in seeing and assessing patients like this.*

- A complex caseload should be the mainstay of a GP's work:

INTERVIEWER

> *Yeah. So schemes like first point of contact physiotherapy are almost a double-edged sword for you GPs because… it sounds like it has potential of actually making your work more complicated, and more tiring almost?*

GP1_practice4

> *Yeah, perhaps. But I think that that's appropriate. I think that seeing twenty complex people, which is the sort of capacity you can see in half a day comfortably without getting into difficulties. You know, we all accept that that is doable, that…*

INTERVIEWER

> *Right, that's the job of a GP?*

GP1_practice4

> *That's the job of a GP, you know. It's tough but, you know, we get paid well and you know, if we had to see the musculoskeletal stuff as well, they're*

either not being seen because demand is too great and they're just left, or you're seeing them on top as well.

- The MDT brought a clinically supportive environment to the practice:

GP1_practice4

I think that one thing that helps burnout and fatigue is to have a cohesive professional team around you so that, you know, I think it is great that you could go to… so for instance in my team there are people I can go to and say look, tell me a little bit about what's happening about this patient. Or, you know, even tell me a little bit about what you're an expert in because I don't quite, you know, know as much as you do. And that's not necessarily a doctor that could be a nurse… I think that a GP can be isolating, but it never feels like it here because we've got people in the team and an open culture to discuss things.

A corollary impact was a change in the nature of the GP–patient relationship. There was discourse suggesting that the relationship with the patient that was previously evidenced as being so strong, and indeed a potential barrier to the FPCP initiative, was evolving. However, this analysis was not straightforward and the following extract from an exchange with a GP, appeared to highlight something of a contradiction:

INTERVIEWER

And certainly some of the other GPs I spoke to sort of said that sort of sense of the importance of that sort of family doctor connectedness is getting less as time goes by.

GP1_practice3

Yeah, and you see lots of things that erode that…so yeah, things change. Things change. But the fundamental basis of me being around when you're, you know, living out your last days, and having an overview of your care, if I know you, is still pretty important.

Hypothetically, this acknowledged the changing nature of the relationship while, at the same time, its steadiness. The GP described how a series of changes had potentially diluted the relationship but despite this its primacy appeared stable. Other GPs were less anxious about the challenge to the traditional relationship:

GP1_practice4

> *But I think the world has changed, and we've got to move on. You know, doctors don't want to be the family doctor anymore, they don't want to be 24/7, talking to patients in the supermarket, in the pub, don't mind being rung up at home or someone knocking on their door. You know my grandfather did that, but I'm not going to do it. And certainly the younger doctors are not going to do it.*

Furthermore, there was evidence to suggest that patients were moving to expect more than just a GP in the offer of a general practice.

GP1_practice4

> *I think patients do see it as a wider team and will access somebody that they think is the most appropriate for them.*

This new emerging evidence suggested that the proposed reduction in GP burden, related to MSDs was not straightforwardly achieved. The pilot FPCP service, and this was common to most FPCP services, was accessible for two half days per week in each practice. The impression was that "*from a service like that, we won't see much of an indent… "* (GP1_practice4) on GP workload. Not only was the limited capacity an issue but patients *"don't come to the doctor just with their back pain, it's one of, it's the third or fourth thing they come with. So they want to talk about their pill, about their funny rash, and also they've got this wrist pain, or shoulder pain, or back pain"* (GP2_practice3).

Quite clearly, for FPCP to have an impact on alleviating some of the GP workload more sophisticated modelling was required. The realisation of a measurable reduction in GP burden highlighted as unrealistic when put into context through the following GP's reflection.

GP2_practice3

> *Sixteen a week* [FPCP pilot service capacity]*. So at any given time in this building we're seeing I think twenty-eight or twenty-nine people every ten minutes pretty much. So I mean that's not all for musculoskeletal things, but we've got almost twenty doctors here. So I suppose if twenty doctors are seeing, you know, 20 per cent of what they see might be musculoskeletal, that's, it might not all be appropriate for the Physio First* [FPCP service]*, it might not be a new problem, but I think you would probably need quite significantly more for us all to notice a difference.*

New evidence had emerged pertaining to a reduction in GP burden as a consequence of the implementation of FPCP. It supported the notion that FPCP was situated in a context of increasing demand on general practice and a changing GP caseload that was, to some extent, a consequence of the contemporary multidisciplinary nature of general practice (Context). The impression from the data suggested an atmosphere of GP support (M-Resource) for the FPCP initiative. However, in terms of outcome there did not appear to have been sufficient capacity (Context) within FPCP service modelling to bring about a reduction in the MSDs burden on GPs (Outcome). Any impact on GP workload was likely to be further complicated by the multi-morbidity of patients. Patients with multi-morbidity were described as likely to consult their GP as the default FPC practitioner (M-Reasoning). This likelihood would be increased where they had a poor understanding of the FPCP service (M-Resource). These are both mechanisms for which evidence was provided in the realist review and further developed in Programme Theory 1 of this evaluation. In terms of GP experience there was evidence that FPCP, alongside the evolving multidisciplinary nature of the general practice workforce, provided support to GPs (M-Reasoning) for which they were grateful.

Table 8.3: Context-Mechanism-Outcome the reduction in GP MSDs burden as a result of FPCP

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Increasing pressures on general practice and GP workforce Changes to GP workload	Patient perception of general practice being a MDT Provision of wider skill set inherent in MDT	GP feels supported by MDT GP support for widening skill set inherent in MDT Poor patient understanding of FPCP Perception of GP as default FCP	No reduction in GP MSDs burden Increasing complexity of GP case mix
Complex GP case mix Provision of wider skill set inherent in MDT	GP acceptance of increasing case mix complexity		
Limited FPCP capacity	Extended scope FPCP role regarded as expensive Parallel professions advocacy strategies		

8.2.4 – CMO representation 4: Experiences of parallel professions that could inform the FPCP initiative

The theory that emerged from the data making reference to FPCP reducing the burden on GPs was not straightforward. It demonstrated that it was not as straightforward as the movement of one cohort of patients from GPs to physiotherapists. The recommendation was that greater consideration had to be given to the Demand and Capacity modelling of FPCP services for this to be realisable. It was clear that to realise this potential greater resources had to be invested in the FPCP services, than had been invested in pilot services to date.

Participants spoke of their experiences with similar initiatives that sought to redistribute general practice workload. As such the data were explored and the following theory developed. There was an interest in whether these initiatives had impacted GP workload or provided evidence of any barriers or facilitators that could inform the FPCP initiative.

As demonstrated previously there was generalised support for the development of a broader MDT in general practice. This was seen as providing the most appropriate clinical care, addressing increasing demands and satisfying the changing professional aspirations of the GP workforce. Most discourse referred to nurses who had previously sought to establish a place alongside GPs.

GP2_practice3

> *Because for a long while now we've been pushing nurses forward as being the first point of contact in triage, minor illness, minor injuries a lot of the things autonomously. And the things we used to do as GPs a few years ago. So they're at the front line far more.*

Other services were discussed including pharmacists, phlebotomists and mental health workers. Physiotherapists were seen to sit alongside these options.

GP1_practice4

> *I'm old enough to remember where everything came through the doctor. And it actually feels much better that people are going, you know, straight to the nurse for their diabetic check, and getting advice about their long-term condition, you know. They're going straight for a blood test to a phlebotomist. They're going, you know, straight to an IAPT* [Improved Access to Psychological Therapy] *team to have their therapy.*

The impression from participants was that where nursing alternatives were satisfying a demand it was for the management of more 'straightforward' health issues. As one group of administrators reported, *"…the simpler cases they used to see as a doctor, are now being seen by the nurses"* (Admin1_practice3). This aligned with the previous theory within this evaluation that reported a consequential increase in complexity in the GP workload. However, there was no impression of any discernible decrease in overall GP burden as a result of this multidisciplinarity.

Data analysis highlighted some tensions that had accompanied the expansion of nursing roles. A number of GP reactions were described that corroborated findings from the realist review. Resonating with the work of Bélanger and Rodríguez (2008) GPs expressed concern with regards to the relative training of GPs and nurses. Bélanger and Rodríguez (2008) described how this GP control had the potential to impede a more active role for nursing staff. The following quote from an administration group articulated this concern.

Admin1_practice3

> *I think it, yeah; it takes me back to my original point earlier about the nurses. That was part of the concern.*

INTERVIEWER

> *What, they were taking over some of their role?*

Admin1_practice3

> *Yeah. I'm a doctor, I've trained for nine years for this, they've only done three, was some comments I heard from people that have now left here.*

Furthermore, *"the concern from one or two of the doctors at the time was well, they're prescribing something but under the doctors authority, and we don't know whether they're qualified, and…therefore* [they] *wouldn't have prescribing nurses"* (Admin1_practice3). These administrator concerns were confirmed by GPs. The following quote adds some contextual detail in attributing the perceived threat to older GPs.

GP1_practice3

> *I think maybe some of the older GPs might see it as a threat, and certainly we looked at having a pharmacist coming in and there was some nervousness from some of the partners about how they may fit in.*

The GPs' concerns, when they articulated them, were around the qualifications of staff to adequately perform the role and the GPs' sense of responsibility, for them, as an employer. This sense of responsibility aligned with the literature in terms of GPs evolved hybrid clinical: managerial role.

GP1_practice3

> *I mean now that they have their own registration they practice more autonomously, I suppose increasingly if they're non-medical prescribers as well. But if there was a problem I'm sure the GP would be questioned…because it could be levelled that maybe we hadn't put in the necessary training, because they're our employees.*

Although these concerns were highlighted, associated evidence suggested that they lessened over time and associated with this was an increase in GP confidence in the ANP role. It appeared from the data that throughout the development of the nursing role the GPs had maintained control of professional jurisdictions and role boundaries. As a result there was no overt discourse with regards to these services fundamentally threatening the primacy of the GP. There was a pervasive sense that it remained at the GPs discretion as to how these emerging roles were constructed and their jurisdiction which extended to the more straightforward, simpler cases such as 'coughs and colds'.

Evidence of this control, and some concomitant inconsistency, was also provided in the following quote from a commissioner.

Commissioner_1

I am aware that there is a wide range across the Nottingham City practices in the area of work that practice nurses are able to, and encouraged to, get involved in.

INTERVIEWER

Okay, so a bit of a lack of standardisation really, in terms of?

Commissioner_1

Absolutely yes, yeah. And that's very much down to, I guess, the individual preferences of the GPs in those practices.

This control was also evident in the GPs own discourse, as evidenced by the following GP quote.

GP1_practice3

If I genuinely felt it was going to make a huge difference to my workload then we would do it. But it needs to be cost-effective, and you may well have some persuasive evidence about that. But then you're pitting yourself against a nurse practitioner or a salaried GP, and a salaried GP can do everything. And I don't know how long the physio sessions were, but a salaried GP would do everything in 10 minutes, a nurse might be cheaper but might not be able to deal with everything. So I guess it boils down to the fact that I'd have to pay for it out of my own pocket, and it may be a service that would be provided elsewhere, a patient can self-refer by just ringing a number.

The physiotherapists agreed with the sentiments of the commissioner above in interpreting the control lying in the hands of the GPs.

INTERVIEWER

Do you think, in terms of the practice, the general practice, do you think they are the top, you know, we've got practice managers in now, you would think the term manager would imply that they were managing the GPs.

Physio2_FG1_B7

Well it still very much feels as though the GPs are the top of the hierarchy, they're the ones in charge of the practice.

Physio3_FG1_B7

No, GPs… GPs pull the strings.

Evidence of GP influence in the commissioning process had been described. GPs influenced commissioning at both their individual practice level and via their contribution to CCG commissioning boards. The GP above described the choice-making process in this commissioning decision at a practice level. From a business perspective their decision-making logic appeared justified for that specific context. Where an equivalent MSK physiotherapy service was already available to patients it was reasonable for them to question commissioning a parallel FPCP. Once again this highlights the contextual complexity of broad social systems and this was an important, and not previously articulated, consideration for those looking to develop a case of need for FPCP in the future.

GP concerns in response to jurisdictional boundary changes were articulated as GP 'nervousness' and a sense of 'threat'. There appeared to be parallels between the development of ANPs and FPCP. As such, it would be likely that GPs shared similar concerns with regards FPCP. However, alongside the evidence of some GP concern there was corresponding evidence to suggest GP support for the evolving MDT make-up of general practice. Nevertheless, the evidence demonstrated that GPs were in control of the nurses' boundaries and roles and these were, on the whole, restricted to more straight forward health complaints.

The new evidence that emerged from this research substantiated the parallel experiences seen in the evolution of ANPs in general practice. Firstly, the realist review provided evidence to suggest that GPs who had experience of working alongside physiotherapists were generally supportive of their role. The evaluation built on the findings of the realist review with empirical evidence describing parallels with ANPs. There was no overt evidence of the anticipated contested boundary definition negotiations. However, as will be evidenced later in this chapter interprofessional disputes and tensions can exist, and be exercised, in more subtle ways.

This theory provided efficacy for enterprises, particularly those of ANPs, which resembled the FPCP initiative in that they provided an alternative to solitary GP care. However, the contexts in which these initiatives were seen to be successful were apparently restricted to more 'simple' clinical conditions and the boundaries within which they were executed appeared to be demarcated and controlled by GPs.

Nevertheless, within these parameters the benefits of such initiatives, which established a multidisciplinary nature to the general practice team, were seen as valuable. There was evidence to suggest that the initial concerns of GPs, which were articulated in terms of professional competencies, employer responsibilities and service efficiencies, lessened over time, and systems that facilitated effective communication supported this evolution. These supportive communication systems are considered later in this chapter.

Table 8.4: Context-Mechanism-Outcome the experiences of parallel professions that could inform the FPCP initiative

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Increasing pressures on general practice and GP workforce Changes to GP workload Nursing profession professionalisation FPCP	GP support for MDT working Changes in GP professional aspirations	GP control over boundary definitions	Nursing staff jurisdiction limited to straightforward cases No reduction in GP MSDs burden Increasing complexity of GP case mix
	GP concern of qualifications GP sense of responsibility GP concern over clinical competence GP control over boundary definitions	GP anxiety over accountability	

8.2.5 – CMO representation 5: Argument for an equivalence in practice in FPCP

The previous theory synthesised original material, from the experiences of participants, which drew parallels between the experiences of the nursing profession and the FPCP initiative. This section explored data from the interviews

that connected with literature from the sociological analysis of the professions pertaining to the negotiation of roles.

An argument observed in the literature for a professionalising occupation was 'equivalence in practice' (King et al., 2015). This argument was evidenced as a tactic used by physiotherapists in the realist review. Previous research had shown doctors generally (Al-Nammari, James and Ramachandran, 2009) and GPs specifically (Smith et al., 2013) lacked confidence in the management of patients with MSDs. Conversely, physiotherapists claimed the management of MSDs as a core skill and competence (Foster, Hartvigsen and Croft, 2012). The findings from this evaluation were mixed with regards to GP confidence and competence.

To some extent the confidence reported may have been skewed by the fact that two of the GP participants had a special interest in MSDs. The GP with a special interest agenda, had been proposed as a method of mediating referrals to secondary care (Foster, Hartvigsen and Croft, 2012). It could be interpreted as a professional project, for the GP profession, in its own right. Furthermore, it could also be construed as presenting a barrier to the FPCP initiative. It certainly added to a contested professional MSK marketplace which already included osteopaths and chiropractors. There was data that suggested this could, indeed, be a factor. The following GP, who was also a GP with special interest, suggested he was aligned with FPCP in its most complete iteration:

INTERVIEWER

> *And what would your thoughts be if there was like a three line whip, anybody who has got a MSK problem needs to see the physio. Because I suppose theoretically that would then have a genuine impact on GPs workload, wouldn't it?*

GP1_practice3

> *Yeah, yeah. I mean I quite enjoy seeing it…But I mean, yeah, I'd have no problem with that.*

However, one of the physiotherapy focus groups described a different experience of GP protectionism:

Physio3_FG2_B6

> *Yeah, that's true. Because there was a doctor at one of the practices that I think had a bit of an interest in MSK conditions, so was it that he wanted to keep all those patients to himself?*

If a supporting argument for FPCP was of equivalence of practice or superior efficacy – as the realist review had reported – this evaluation provided contradicting evidence. Evidence of GP competence was expressed by several patient participants, including this suggestion from one patient who felt GP care had actually improved.

INTERVIEWER

> *So do you think that's a change in the GPs as well?*

Patient_1

> *Yes. But for the better.*

INTERVIEWER

> *Okay, so describe that change to me?*

Patient_1

> *Well at one time they would never have suggested exercises, would they, you know. Years ago my mother would never have come home from the doctors and gone they've told me to do some exercise. It would be more oh, they gave me a painkiller.*

Alongside this was a parallel concern regarding physiotherapists' management. One GP reported a sense that the physiotherapists could be overly cautious in their approach, over-referring to both secondary care and for diagnostic investigations. This would clearly undermine the objectives and justifications for the FPCP initiative articulated by the physiotherapy profession and found in the realist review.

Furthermore, the same GP felt their position afforded them a better understanding of processes and pathways.

GP1_practice2

> *Because we might be in a slightly better position to know whether that's appropriate or not…sometimes, some of the investigations, for example ultrasound scans and all that, sometimes we hold the request, we don't quite agree with that kind of services, because often we have been told that you don't keep doing ultrasound scans on like shoulders and stuff. They might be positive sometimes where there's not a real problem, or when you do an arthroscopy, the ultrasound scan may not show what you see. So it's not a good judge. So some of those things may not be, but it might be a problem with one or two physiotherapists. It's not something which is all the way, but we can make our own clinical decision. In that case I must say what happened sometimes; they could be a different patient expectation if we say no this is not appropriate. There can be a little bit of a problem because if the physiotherapist has said it is needed, and we say no we don't think it is needed.*

This lengthy quote introduced a number of competing, complex issues. Firstly, there was a sense of superiority in GP knowledge *"we might be in a slightly better position to know whether that's appropriate or not"*. Secondly there was evidence of GP control *"sometimes we hold the request, we don't quite agree with that kind of services"*. This control however appeared to be exercised covertly. Finally, this interprofessional clinical contradiction undermined patient expectation, and one would imagine confidence, *"*[there] *could be a different patient expectation if we say no this is not appropriate. There can be a little bit of a problem because if the physiotherapist has said it is needed, and we say no we don't think it is needed".*

The physiotherapists in the FPCP pilot service were not working at extended scope and any such referrals were initiated through the GP. As such, GPs maintained control over physiotherapist jurisdiction. The subsequent decision to follow, or withhold, the physiotherapists' requests, demonstrated further control over their

professional jurisdiction. The GP control demonstrated above was also evident in other GP discourse:

GP1_practice3

> *Okay, so occasionally I was asked to arrange an MRI in a patient, and I had some mixed feelings. If it was someone that I knew, I would feel more confident in their assessment. But if it wasn't someone that I knew, given that it was quite an expensive resource, I might feel that I would prefer to see the patient myself and make my own judgement.*

As well as providing evidence for GP control over boundary work, the above statement reinforced an important emerging theme of therapist consistency. The impression was that this consistency strengthened the GP–physiotherapist relationship and there was a resultant increased GP confidence in the physiotherapist.

This theory exposed a degree of explicit and implicit GP confidence in their own management of MSDs. Their competence appeared to be supported by some patient feedback. There was evidence of some GP concern over the extended role of the FPCP practitioner and evidence of GPs exercising control over physiotherapist jurisdiction.

However, with regards to GP management of MSDs there were far more frequent concerns expressed, than endorsements. These concerns were consistently reported from all stakeholder participants with the sense being that a GP was a *"bloody good all-rounder I say, but he can't be the master of everything"* (Pt_1a_whitebritish_65_knee_2weeks_no). A somewhat more disparaging account came from the following patient:

Patient_6

> *Well I mean, the doctor couldn't do anything for me, and he'll just oh, go to physio, I mean perhaps its muscle related or this and that. And he knows nothing about muscles, he sends you for an ultrasound or something, it's easy, he just, I mean doctors don't treat you now they just send you somewhere to do something.*

In general, this sentiment was corroborated by the GPs themselves. As the following GP stated:

GP1_practice4

> *…it's also most appropriate, you know, that patients can access a physio rather than a doctor for that kind of thing, you know. What's the point of going to a doctor who says well, it's a bit of a strain, here's some ibuprofen. It's a bit of a waste of everybody's time.*

Alongside this was a parallel recognition, again from all stakeholders, of physiotherapist competence. The following two quotes from a commissioner and GP encapsulated these sentiments. They both demonstrated confidence in the physiotherapists' skills. They also contradicted the anxiety expressed by doctors that FPCP might put patients at risk through the non-identification of masquerading medical problems, as evidenced in the realist review.

1. **Commissioner_1**

   Give me ten GPs and ten physios, I'd put more money on the physios to diagnose cauda equina, or to pick up a spinal tumour, than the GPs. We accept that you are absolutely the super specialities, super specialists around musculoskeletal conditions.

2. **GP2_practice4**

   So my expectations is that they get a really good expert opinion on what is specifically wrong with, I don't know, let's say it was a shoulder joint or something like that. So a more thorough assessment than I would manage in ten minutes, and then some targeted sort of intervention.

Evidence from the physiotherapy focus groups reinforced the sentiment that GPs lacked MSK knowledge and skills and reversed the rhetoric suggesting this placed patients at greater risk. This proved frustrating for the physiotherapists as not only did patients continue to default to the GP as the FPC practitioner but they did so when a potentially more efficacious and safer alternative was available.

1. **Physio4_FG1_B7**

   But I think they think it's got to be the GP [who patients want to see] *because they need to make the diagnosis. And actually, as we know, that's not always the case, and it's not always accurate.*

2. **Physio1_FG2_B6**

   I think they have a time pressure, and they've got to make some clinical decisions. But I also think if they don't have the knowledge base then don't say anything.

From the data, the complexity in the role negotiation process was evident in that negotiations were absent and control was concealed. There was some contradictory data, reporting evidence of a GP concern and control, set against their seeming support for FPCP.

The outcome that was synthesised from this theory was complex with GP control appearing to be the most influential mechanism. Previous theories had provided evidence of direct GP influence on commissioning decisions both within their own practice and through their privileged position on commissioning groups. This theory provided evidence that this control extended directly into the clinical setting and influenced the realisation of the extended scope of physiotherapist practice.

Notwithstanding this more negative influence there was also evidence of GP support for the FPCP role and acknowledgements of how FPCP developed the MDT, benefited patients and resulted in GPs feeling supported. Nevertheless, there was a pervasive sense of GP control underpinning the theories.

Table 8.5: Context-Mechanism-Outcome the argument for equivalence in practice

	Mechanism		
Context +	Resource	Reasoning	= Outcome
GP as default FPC practitioner GP with special interest in MSDs	GP confidence in management of MSDs GP concern regarding physiotherapist management of MSDs	GP control over role boundaries and physiotherapist activity Physiotherapist frustration	Non-realisation of extended scope of FPCP physiotherapist Non-commissioning of FPCP
Consistent physiotherapist in FPCP role	GP confidence regarding physiotherapist management of MSDs Relative patient confidence regarding physiotherapist management of MSDs	Lessening of GP control over role boundaries and physiotherapist activity GP feels supported	Effective MDT working Extended scope of FPCP physiotherapist realised

8.2.6 – CMO representation 6: Evidence of interprofessional tensions

Despite evidence describing the persistent nature of GP dominance in the realist review and the emerging evidence of GP control in this evaluation, there had been no evidence of overt GP resistance to the FPCP initiative. Indeed, there was evidence to suggest GPs recognised physiotherapists as *"super specialists around*

musculoskeletal conditions" (GP1_practice4) and that their presence enhanced the MDT and provided support to GPs.

However, there was also evidence of GP influence, whether this was around controlling finance, controlling role boundaries or uneasiness regarding the efficacy of FPCP and physiotherapist competence. The consequences of these complexities were seen in various guises ranging from the overt non-commissioning of FPCP services through to the covert control exercised in GPs gatekeeping patient referrals. For the physiotherapists this provoked a sense of frustration. As a consequence, and in anticipation of such issues, this current theory explored interprofessional tensions directly with participants.

The established contexts into which FPCP was introduced were likely to be influential and necessitated reflection. Contextually, FPCP was implemented into an environment where the GP was considered the default FPC practitioner. Furthermore, it appeared that GPs had a privileged position and subsequent influence over certain commissioning decisions. Additionally, evidence had suggested that some GPs interpreted the FPCP initiative as a threat.

This sense of threat was explored explicitly and it was attributed to older GPs. This sentiment was shared across all stakeholder groups. The following two quotes supporting this finding coming from a patient and a commissioner.

1. **INTERVIEWER**

   Do you think there's a flip side to that and some GPs might feel threatened by all these other professions taking…?

   Patient_4

   I think the older GPs might, but I think the younger ones might take it on board as part of the training maybe.

2. **Commissioner_1**

   So the older, I was going to say single practice, single handed practice but I've got no evidence of that. So it's the older GPs that are more inclined to not delegate work downwards.

INTERVIEWER

Okay, okay. So a bit of a cultural, generational..?

Commissioner_1

I think so, yeah.

The constructions of GPs roles were considered the resource mechanisms that were inherently introduced as part of the programme of FPCP implementation. First was the 'sense of authority' intrinsic to the GP role. Second was the 'sense of responsibility' attached to the GP role and finally there was the 'sense of control' that was integral to the GP position. The following table provides evidence for these three mechanisms (Table 8.6).

Table 8.6: CMO representation 6, M-Resources

Authority inherent in GP role
INTERVIEWER *Does that give them some sort of power and **authority** that everyone else hasn't got?* **Ad_LV_1** *Yeah. The doctor, a GP, knows everything. They know how to solve everything, or this is people's perception, they know how to solve everything, they'll make them better. So all you need to do is come and see a GP, because the GP is some sort of God.*
Responsibility inherent in GP role
GP_CR_2 *So I've seen a lady this morning with chest pain, chest pain of course can be all sorts of things. Young girl who has been on the pill recently, she's got a bit of chest pain, I think it's musculoskeletal, I think its costochondritis. And the physio might agree with me. But what if actually there was some subtle signs, and because the doctor hadn't seen them, and the physio hadn't perhaps asked all the right questions because they've not had the medical training. What if we'd missed a coronary embolus, or something cardiac? And I suppose always the nagging doubt in a doctor led service, or the **responsibility** sits with the doctor at the end of the day, would be well if it did, what would happen if there was something more.*
Control inherent in GP role
Phys_FG3_2_B7 *I think, because essentially medics hold a lot of the sway when it comes to healthcare politics, you know, often they dictate how things are, you know, run and…* **Phys_FG3_1_B6** *I mean now they're commissioners in part, aren't they. And that's important, because that is **control**.*

Although there was evidence of GP resistance from the realist review, to challenges to the primacy of their role the only other evidence that related directly to FPCP came from statements from doctors' governing bodies (Chan, 2015; BBC, 2016). These governing body concerns were interrogated explicitly and inevitably the findings were complex. From a straightforward patient participant perspective these sentiments were interpreted as demonstrating an awareness of, and concern about, the encroachment of physiotherapists into traditional GP jurisdiction. Both administrators and patients recognised these motivations as seen in the two following quotes.

1. **Admin3_practice2**

   [I]t's possible that they may have been fearful for their own GP members, that they somehow have a fall off of patients coming through. I don't know.

2. **Patient_1**

   Alright, they're probably thinking well they're going to take that away from us.

   INTERVIEWER

   Right, okay. So you think they might sort of think okay well if they take, like any profession if somebody else comes along…

   Patient_1

   It's the start, it's the thin edge of the wedge. If they take that away, what's going to be next?

There was acknowledgement from GPs themselves that this governing body response was professional protectionism.

GP1_practice3

What? So I'm a member of the BMA, and I have sat on the General Practitioner's Committee of the BMA, and that is just protectionism of our profession.

INTERVIEWER

Okay. Okay.

GP1_practice3

Hugely protective of our profession.

However, other than in the older GP population there was a majority impression that this protectionism, as demonstrated by the governing bodies, was not representative of grass roots feeling.

GP1_practice3

What exactly did the BMA say?

INTERVIEWER

They said they felt the services would be overwhelmed and patients would be put at risk, because of red flags I think.

GP1_practice3

No. They are completely wrong. Physio is much better at diagnosing cauda equina Syndrome than a GP, so they've got that completely wrong. That's classic protectionism. That's professional protectionism.

INTERVIEWER

Okay. And again, just to clarify, you think that's the professional body almost taking their role, but grass roots GPs probably don't feel that?

GP1_practice3

Correct.

While this grass roots support was encouraging it was clear that the medical autonomy, that FPCP challenged, was entrenched. As this GP stated, when asked if the resistance to challenges to medical dominance were softening:

GP1_practice3

Well shifting a little bit doesn't mean a lot does it. The medical profession is the medical profession. We still, I think, are arrogant enough to believe that we're very important, and will want to preserve that status

Previous analysis demonstrated that there was direct evidence of GP resistance to boundary encroachment. GPs were described as feeling threatened and the preceding quotes provided evidence of the somewhat predictable reaction to professional boundary encroachment. However, an alternative interpretation was that FPCP could be constructed as bringing benefits to GPs, as the following insightful patient comment demonstrates:

Patient_2

> *There's two sides to it. One is they've got to think of patient care, and that's a positive thing for patient care. But being very selfish they might be thinking if they take a quarter of my workload, which means I'm not needed to do my job. Where their brain should be well if they're taking a quarter of my workload then I can spend 75 per cent, I can spend 100 per cent doing 75 per cent of the work I used to do.*

This quote summed up the competing theories, and subsequent motivations, succinctly. Patient care was potentially improved and, while the GPs could feel threatened, FPCP may release extra time for them. For one physiotherapist this release of time may be contributing, in its own way, to GP concern and subsequent resistance.

Physio2_FG1_B7

> *I think what I'm trying to say is that I think the GPs perception was by losing some of this caseload, all that they were ending up doing was examining even more complex patients, and that made their day just full of complex patients. And that almost, some of the MSK things were just interesting and gave a bit of variety in terms of their caseload. I could envisage it would be really nice to have somebody with an ankle sprain that I can get out in 15 minutes, and I've got 15 minutes to kind of do something else with that appointment time. And I could imagine as a GP, if you've got a list of 10 minutes, someone that you think they've come in, they've had a flare-up of their knee, they can be in and out of the door with 2 minutes with a referral to physio, and now I've got 8 minutes to just catch up a little bit. I can see*

how losing those patients might not necessarily be that attractive on one level obviously.

If there was evidence to suggest some GP protectionism there was also evidence of how this protectionism might be expressed. Evidence had already been provided of GPs screening referrals and expressing some concern about physiotherapist practice. Furthermore, GPs had been described as deliberately retaining their MSDs caseload and in doing so diluting the objectives of the FPCP initiative. In addition, evidence had articulated GP concerns about physiotherapist experience correlating with the threat to patient safety. Evidence of further GP resistance was provided in data suggesting some GP reluctance to provide supervision to physiotherapists.

Physio4_FG1_B7

[W]hen I did my injection module, and I asked for supervision from my local GP surgery, they said no because they didn't want to lose the skills themselves.

Likewise, one commissioner spoke about how GPs' behaviour might sabotage the FPCP system. When questioned about the lack of patient uptake there was the suggestion that *"sometimes it's the GPs that are telling the reception staff no, you've got to book everything through* [to them]*. Do you know what I mean?"* (Commisioner_4).

Finally, as was evidenced in the previous literature that explored contested boundary work, there was evidence of GPs engaging in atrocity stories of their own. Evidence had already been provided with regards to GP concerns about inappropriate referral requests and there were also descriptions of physiotherapists' behaviours that further critiqued their competence.

Commissioner_1

So I had to rewrite some letters with X earlier in the year, which stopped the physios saying please refer this patient to a pain service for neuropathic pain treatment. I'm sorry, I don't really want physios cranking up opioids, and pregabs, and gabapentinoids in these patients. Often it's the last thing they need and we've put them in with the physio to avoid that.

In summary, this theory provided evidence of some GP protectionist behaviour in response to the encroaching characteristics of FPCP. GP control was seen to extend from day-to-day decision-making to more systems wide influence on general practice commissioning. From this perspective GP control had resulted in the non-realisation of the full FPCP potential.

It was clear that GPs prioritised the GP workforce as the principal resolution to the travails faced by general practice. They justified this positionality through a number of arguments. For example, it was clear that GPs saw the general practice caseload as complex and extricating the MSK component from it, was not necessarily straightforward. For GPs this diluted the potential impact of FPCP. Consequently, the priority for GPs was, and would remain, the GP workforce. The following three GP quotes that follow demonstrated this point clearly.

1. GP1_practice4

Yes, because my GP can do everything, my physio can't.

2. GP2_practice4

I mean I think that there's not enough money in the pot, you know, there is, the first point of call is that we're swamped with everything, what the first thing we need is probably another doctor to try and sort of… that's the first kind of theme that you think about. So there is sort of competing interests within a very small pool of resources.

3. GP1_practice2

Because there is a problem at recruiting GPs as well, so we do need, if I'm given a choice now, we do need a GP rather than a physio for, because we need more GP time. So that is not that we don't need physio, but given the financial constraint, we do need GP more because there is a problem in recruiting. But that doesn't mean that, no, physio service is quite important. But at the moment, well that's the issue, we really need a GP.

The complexity of a broad social system was clearly highlighted with this evidence resonating with CMO representation 3 (Reduction in GP workload). Reduction in GP workload, a driving argument amongst the FPCP advocates, would not be realised

where the Demand and Capacity modelling of any FPCP was insufficient. Evaluations in this context it would inevitably undermined outcome data and dilute the justifications made for FPCP. Consequently counter-arguments for maintenance of the status quo would be reinforced. The consequences of this chain of events was evident in the non-recommissioning of the FPCP pilot. Quite understandably this caused a sense of frustration for some participants. Evidence of physiotherapist frustration had been provided previously but this GP concurred.

GP1_practice3

> *Intuitively and in reality it's got to make financial sense to have a physio seeing a patient, compared to a GP. And especially given that we want to, we want GPs to be dealing with lots of other stuff that they haven't got time to do.*

For the physiotherapists, this frustration was directed towards GPs for their role in commissioning decisions. For this GP responsibility for the commissioning decisions lay with *"senior leaders, our finance leaders, and our directors, who continue to destroy the really successful low hanging fruit"* (GP1_practice4) and the commissioning system itself.

GP1_practice4

> *[F]inancially it should make sense for the NHS. But it's this thing of practices getting a lump sum, and it doesn't cost the CCG any more for pushing more work practices way*

INTERVIEWER

> *So this sort of funding of the GPs is a barrier really, the way that GP practices get this lump sum of money for their population?*

GP1_practice4

> *The expectation was that practices would pick it up, but yes, they don't get any additional funding for offering this wider range of services.*

It would appear essential that the funding systems, which seemed to have inhibited the commissioning of FPCP, and provided an important contextual characteristic of general practice are given greater consideration for future FPCP initiatives.

Table 8.7: Context-Mechanism-Outcome the evidence of interprofessional tensions

	Mechanism		
Context +	Resource	Reasoning	= Outcome
GP as default FPC practitioner Older GPs Single handed GP practice	GPs feel threatened by FPCP initiative FPCP initiative challenges GP authority FPCP initiative challenges GP sense of responsibility	Individual GP and GP governing body resistance to FPCP initiative GP concern over boundary encroachment in FPCP initiative GP control over role boundaries	GPs don't delegate work to others Non-realisation of extended scope of FPCP physiotherapist Non-commissioning of FPCP
FPCP implemented Increased complexity of GP case mix	GP reluctance to provide supervision to physiotherapist GP fear of losing MSK caseload and skill set		
Increasing pressures on general practice and GP workforce Current system of funding general practice	GPs prioritise GP recruitment		

8.2.7- CMO representation 7: GPs and physiotherapists working together

Evidence of some GP resistance to the FPCP initiative has been discussed. However, no examples of direct clinical confrontations in the boundary negotiations inherent in the FPCP initiative were evidenced. Any resistance was concealed and appeared intrinsically linked to the established primacy of the GP role. This role appeared aligned to the historically situated dominance of the medical profession more generally. Programme theory 1 revealed how the entrenched nature of medical dominance influenced patients' beliefs and subsequent behaviours. This was demonstrated though the tendency to default to the GP as the legitimate FCP. The dominance of the medical profession had been shown to privilege GPs with fundamental decision-making and control within general practice which had the potential to negatively impact FPCP. It was into this complex system that FPCP was introduced.

Evidence had also been presented describing widespread confidence in physiotherapists as MSK specialists and stakeholder satisfaction with FPCP services. The realist review had provided evidence of the maturation of relationships as FPCP services embedded. This section explored empirically the GP-physiotherapist relationship which developed as a consequence of working alongside each other.

The pressures on general practice were increasing and GPs' workload and case mix were increasing and becoming more complex. As a consequence there was an acknowledgement of the need for general practice to continue to evolve to meet these demands. Nursing staff had already contributed to the evolution of the general practice MDT and physiotherapists were spoken about adding to this general practice 'offer'.

GP1_practice4

> *I can remember the times when there wasn't a practice nurse, everything came to the GP. And you know, we are all diversifying more and more so, you know, we've recently just got our first actual advanced nurse practitioner, who is actually prescribing and diagnosing, and things like that. So slowly we*

are diversifying our nurse roles. On the other end we've got healthcare assistants doing a lot of the tasks that nurses used to do, and it seems entirely reasonable to have physio embedded in primary care on a GP practice basis.

Although some GP concerns had been highlighted with the broadening of nursing roles there was evidence to suggest that they lessened over time. A feature that emerged as enhancing working relationships was the consistency of the FPCP physiotherapist. This was shown to develop trust as described here:

Admin1_practice3

*…having the same person doing it built a bit of continuity, it built some **trust** with the clinicians that they need to work with, and with the staff, and it just makes it a lot nicer isn't it, if you know who is coming in each week.*

A number of other outcomes were synthesised as a consequence of this developing confidence and trust. The first was the addition of MSK specialist skills capability within the general practice team. Associated with this was the development of an extended and cohesive team. Thirdly was the development of additional capacity within the MDT. Finally, the increasing complexity of the GP case mix was discussed. Table 8.8 presents evidence from the data to support these outcomes. Table 8.9 presents the components to support the theory of GP: physiotherapist working relationships.

Table 8.8: Theory 7 outcomes

MSK skills within general practice team
GP1_practice3 *And the GP, because this was a really big learning point for me, and I'm sure for many colleagues, which I think we're still missing and we can do a lot with this, depending on how we develop services. I hadn't appreciated that the physio will see any MSK problem. I was just thinking backs, knees, ankles, shoulders. Not particularly elbows, wrists, hands, carpel tunnels. So that was really helpful in really optimising the physio first model. If there was anything that was MSK or pain, that they could see it. That was really good.*
Extended general practice team
Admin4_practive1 *Well they became a part of our team.* **INTERVIEWER** *So you saw them like that did you?* **Admin2_practice1** *Do you see what I mean? I mean although they weren't employed by us as such, they were a part of our team.*
Increasing capacity within MDT
Admin1_practice2 [*B]ecause all of those patients that were booked into those two half days would have initially wanted a doctor. So they were happy to go to a physio, which took the relief off the demand on that day. Because we book a lot of same day booking appointments, so they were quite happy to go to the physio which took however many patients that was that week, that took away the demand for that many doctors' appointments.*
Increasing complexity of GP case mix
Admin3_practice2 *Because all that happens is the patients go and see other practitioners, and the demand for the GPs just grows and grows and grows. Yes. Yeah. Because we're able to take away some of the lower level things to other healthcare professionals, which leaves the GPs with the really complex stuff.*

Table 8.9: Context-Mechanism-Outcome GP and physiotherapist working alongside each other

	Mechanism		
Context +	Resource	Reasoning	= Outcome
FPCP implemented GP and physiotherapist exposure to joint working Increasing pressures on general practice and GP workforce	Acknowledgement of need for general practice to evolve to meet demands Stakeholder satisfaction with FPCP	GP confidence in FPCP role GP trust in physiotherapist	Increase in MDT MSK clinical capability Extended general practice MDT Increased capacity in MDT Increased complexity in GP case mix

8.2.8 – CMO representation 8: Systems that facilitate FPCP working

Previous theories within this evaluation provided evidence of a number of associated features. They introduced the existing system of GP funding as a context into which FPCP was introduced. Without attention to this, future non-commissioning decisions were interpreted as being likely. In addition, the theories challenged the protectionist positioning of GPs, providing evidence for confidence, trust and satisfaction in FPCP. Undoubtedly, this was with the caveat that any initiative appeared to be fundamentally under GP control.

A theory that had not been articulated in the realist review but emerged from the empirical data was the importance of certain systems that supported FPCP. This current section explored the data for systems that supported FPCP. In practices where FPCP was implemented, evidence was provided for several systems that provided support.

The realist review, and the current evaluation, had described the importance of signposting training. From a practical perspective this training constituted one, or two meetings, which articulated the purpose of the FPCP service. For the administrators this was important to ensure there were "*fairly clear guidelines of this person can see this type of condition, but will not see this type of condition. So we try not to put people with the wrong person"* (Admin1_practice2). Beyond the importance of ensuring that the practice staff knew the purpose of FPCP the training was also seen as central to facilitating the patient journey. The training also increased administration staff confidence to signpost.

The awareness that the physiotherapists could access patients' records and could refer for diagnostic procedures and secondary care was important for the administrators, allowing them to confidently pass this information on and alleviate patients' concerns. Even when the scope of the physiotherapist was limited, for example not being able to prescribe medicine, as long as this could be communicated explicitly it was not seen as problematic.

Admin1_practice3

> *And I think part of the signposting was the physio will refer you if he then thinks, or she then thinks, that you need painkillers etc., they can sort that out at the time. Because that was the agreement we had, you know, you couldn't prescribe, but you'd knock on the door and say actually can I have some painkillers.*

INTERVIEWER

> *Yeah, yeah, and they'd sort it out.*

Admin1_practice3

> *So that, I think, reassured people that they weren't, this wasn't an alternative to getting a painkiller, it was, well, wasn't stopping you getting something, it was just an alternative route.*

This clarity gave the administrators confidence and allowed them to reassure patients. A feature that was frequently reported, and evident in the quote above, was the open door policy. This was seen as facilitative of effective team working and appeared to talk to a number of parallel processes. Firstly, it appeared to support role boundary work, particularly where the FPCP role required GP support – such as prescribing. Secondly, it appeared to have been a process that increased mutual confidence between the GPs and physiotherapists.

GP2_practice4

> *They often worked in the room literally next door to mine, so I would often have perhaps a bit more feedback than others do. So, for example you might see a patient who you booked in with the physio, and then they come through and explain things in a bit more detail, and perhaps what they could do is fairly limited, but the physios were really good in making suggestions as to what might be the way forward for that particular patient. So there was a little bit of sort of two-way feedback really. So I think that was the most valuable bit probably, of having them in the practice to be honest, from my point of view.*

In the previous pilot service, where the physiotherapists' scope was not fully extended, the need for this type of communication was more frequent. It appeared that this communication exerted even greater impact, as this physiotherapist attests:

Physio2_FG1_B7

> *I think interestingly, and I know that a few clinicians said this to me, the fact that the Band 6s had to go and talk to GPs about maybe some of their more serious pathology, or non-MSK stuff, actually added to reassure the GPs that we were competent at doing those roles.*

It was clear that GP practices were busy environments and effective, efficient systems that facilitated communication were essential. This GP described a number of local systems that facilitated communication:

GP2_practice3

> *It's not always easy, because as I say it's a big busy building, but they managed. And they managed very well. And it didn't intrude, it was fine. But we have various mechanisms. We have screen messaging, we have pigeon holes so that, and there's notes passed around, so there's various ways of getting messages across. And we've all got our own secretaries as well, so we could always use mechanisms like that.*

The importance of the ease and speed of communication was reiterated by this physiotherapist:

Physio2_FG2_B6

> *To do the role effectively you had to have, or be confident to be able to communicate with other members of the staff, such as the medical team, quite quickly. Whether it's for an analgesic review, or whatever. And I suppose going into a practice as an, on an ad hoc basis, you wouldn't have that flexibility to do so, or know who to necessarily go to.*

The above quotes illustrated a number of practical systems and resources that facilitated the sharing of information. Firstly, it reinforced the perceived importance of the consistency of the FPCP physiotherapist; attending on an 'ad hoc' would not be as facilitative. Not only did it assist reassurance, trust and confidence but it also familiarised the physiotherapist with processes and systems within the general practice. What was also evident in both this statement, and other supportive data, was the importance of the physiotherapist being integrated within the GP practice team.

Once again, the embedded nature of the relationship was important whereby working alongside one another led to confidence and support. Alongside embedding, communication was frequently reported by participants as important. GP–physiotherapist communication was facilitated via a number of practical processes and systems. These facilitative mechanisms included an 'open door policy' between the physiotherapist and the GP and a wider culture of open

communication within the practice. These administrators discussed the importance of this.

Admin1_practice2

> *Yeah. And I think most of them, like most of the doctors, well all of the clinicals, they've all got sort of open door policies. We go to each other a lot, don't we, and communicate a lot.*

Admin2_practice2

> *Yeah.*

Admin1_practice2

> *Face to face and verbally, it's not just through the system. And we all just work together; we're all just one team across the board.*

There was evidence that the physiotherapists welcomed this approach also:

Physio4_FG1_B7

> *I can give an example of where it did work well, and that was at 'X' practice, where they were very welcoming and so grateful to have us there. I could knock on his* [GP] *door anytime; he would write a prescription for me, if I needed investigations doing, or just to ask his advice.*

These systems of facilitated communication, provided reassurance to GPs who became increasingly confident in the physiotherapist as this extract confirms:

Admin1_practice3

> *I think what was very, very welcome was knocking on the door saying excuse me, I've got this problem with this patient, or… I think that adds to the reassurance that actually you're not going, they're not going to take on something that they're not sort of qualified to do.*

Quite clearly an open door policy would be redundant if the physiotherapist was not co-located and this was seen as important practically. Not only did the feature of being co-located allow physiotherapists' easier access to GPs but, in doing so it acted a clinical safeguard. As this GP states:

GP2_practice4

> *Obviously we are a big training practice so we are very used to people coming in, sticking their head through doors, and saying oh, can I ask you about this or that. Because sometimes the poor physios got asked about other things that were just not their department, like they'd say that they'd been having some shortness of breath or something, or some chest pain or something, and you need to think I'll get some advice about it*

Beyond these practical issues the integrated nature of the physiotherapist was seen as important more generally. Repeatedly, there was talk about how the physiotherapists grew to be seen as part of the general practice team. The consequences of this were multiple; greater team bonding, increased confidence with regards to clinical competence and an almost expectant reliance on the newly acquired physiotherapist skill set within the team. The following GP quote sums this up:

GP1_practice4

> *I think people bond much better, don't they, to a face, a personality in the team. You know once they're there, and they're known to be there, and you know, they can then get across their professionalism and that kind of thing through those methods. If they're there at meetings and you see their face and you know, they're talking to you about your patients and saying sensible things, you're thinking, you know, oh yeah, they're good, I'm going to ask them for their advice, you know. I'll use them.*

It was evident that having the physiotherapist on site was regarded as fundamental. This facilitated communication which led to increased confidence and subsequently a better sense of 'being a team' and effective team working. Furthermore, there was corresponding historical evidence describing where staff were less embedded in the general practice it "*very much feels like their first, their first team is the physio, the district nurse, the health visitor, the midwife. And they don't feel as integrated"* (GP1_practice4).

Beyond the facilitative practical feature of having an open door policy a number of other systems supported communication. Repeatedly, electronic patient record systems were spoken about. It was clear that alongside the sense of teamwork that was created, as a consequence of a co-located nature of a FPCP service, it also facilitated physiotherapist access to patient records. This allowed the physiotherapist access to "*the full medical record in front of him…Just the same as a GP, you can see the active diagnosis, he can see the medication"* (GP1_practice4). Furthermore, it facilitated communication with the wider staff team through the direct messaging system facility. Conversely, where the physiotherapists did not have access to the same systems communication was compromised.

Admin1_practice1

> *I think the only major problem there was we're on EMIS web, physios were on System One. So then they had to do their consultation on System One, print it off, then it had to get scanned in to EMIS, and then sent to the doctor, and the doctor had to look at it.*

Interestingly, and corroborating evidence found in an earlier evaluation of FPCP (Moffatt, Goodwin and Hendrick, 2018), the shared system access allowed practice staff the opportunity to see the physiotherapists' records. This provided them with reassurance and confidence as the following two examples demonstrate.

1. Admin5_practice1

I used to see it on the reports when they would send, if they'd seen red flags. So it was there, they knew what they were doing.

2. GP1_practice3

Unfortunately they [the physiotherapists] *were using a different clinical system, and so that meant that, I think stuff was inputted in our system in some way, but I think having them using the same computer system would be useful. So that if the patient did come to see me, and I would really value to look and see what the physio's thoughts were.*

Another system that facilitated communication, and team work, and reinforced the importance of integrating the physiotherapists within the practice was their attendance at practice team meetings.

Finally, there were several examples whereby physiotherapy activity, and their records, had been reviewed, and this audit had been used to provide reassurance. In the following example an administrator discussed reviewing cases with a GP to alleviate any concerns.

Admin1_practice3

> *But it did come back to actually reassuring them. I mean we went through a lot of the cases with them and said this is what, they've signposted, it may be appropriate, and you didn't need to see it.*

An interesting consequence of these systems was the associated support that the physiotherapists perceived. Most of the rhetoric from the physiotherapy profession had been about maximising professional scope to minimise associated risk. However, as evident in the following exchange between two physiotherapists, a coherent, supportive GP practice environment might actually be interpreted as safer for the physiotherapist.

Physio1_FG2_B6

> *And that's where that consistency with physios came in, because having the knowledge of, at that practice, which GP was on call and available for you to have a chat with at point in time was important in being able to kind of be efficient with that loop a little bit.*

Physio2_FG2_B6

> *You're potentially working in a safer environment than what you would be within a physiotherapy service.*

In summary, this theory provided evidence for a number of concurrent ideas. There was evidence that training for practice staff, around the objectives of the FPCP service, was essential both to clarify the role boundaries and in allowing them to articulate this to patients, with confidence. In turn patients were reassured about

the nature of the service and the comprehensiveness of their care. It appeared that the most facilitative contexts were where the physiotherapist was co-located, an open door policy was encouraged, the attending physiotherapist was consistently the same, they attended meetings and they shared access to electronic medical records.

These systems facilitated effective communication channels which generated a greater sense of coherent MDT working. It also provided reassurance to practice staff and patients and engendered confidence in the physiotherapists' competence. This seemed congruent with patient expectations of a modern-day general practice whereby they expect to *"be greeted by, you know, a competent team, a small team"* (GP1_practice4). Further reassurance of physiotherapist competence was provided through systems of benchmarking, or audit. From the evidence this included administration staff and GPs reviewing physiotherapists' referral practice and case reviewing their records. Interestingly, these appeared to be systems implemented covertly and this might be useful to explore in greater depth.

Table 8.10: Context-Mechanism-Outcome systems that facilitate FPCP working

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Where FPCP implemented Training provided Access to shared patient records Open door policy Extended scope of FPCP	Clear definition of FPCP role and boundary definitions articulated Support for boundary working Methods of information sharing	Confidence of administration staff in signposting patients GP and physiotherapist confidence in boundary working	Patient reassurance regarding FPCP service Physiotherapist becomes integral to general practice team Improved MDT working Improved communication

Physiotherapist attendance at practice team meetings Audit of physiotherapist activity			
Where FPCP implemented Limited scope of FPCP physiotherapist			
Clear definition of FPCP role and boundary definitions articulated	Confidence of administration staff in signposting patients	Patient reassurance regarding FPCP service	
Limited scope of FPCP physiotherapist	Increased need for GP and physiotherapist to communicate	Increased GP confidence in physiotherapist competence	
Physiotherapist becomes integral to general practice team	Increased opportunity for GP and physiotherapist communication Provides safeguarding process for patient safety		

8.2.9 – CMO representation 9: Evidence for the influence of medical dominance

As already stated, the FPCP pilot service was not recommissioned despite empirical evidence to support the efficacy of the FPCP service and the satisfaction of patients and GPs. The assertion was that the complexity of the commissioning process and

the influence of GPs within this system acted as barriers. Earlier in this evaluation GP control within the general practice setting had been exposed and this current section explored this more directly by looking for evidence of medical dominance in the FPCP initiative. The realist review had generated a CMO suggesting FPCP (Context1) challenged the traditional hierarchical medical model of healthcare delivery (M-Resource) and some GPs felt threatened (M-Reasoning) by this innovation and were resistant (M-Reasoning) to FPCP and this negatively influenced collaborative working (Outcome).

Evidence from Programme Theory 1, within this evaluation, suggested FPCP was implemented into a context where GPs held the pre-eminent position and this positionality acted as an obstacle to novel service innovations endeavouring to provide an alternative first point of contact. There existed *"a cohort of patients who, no matter what they come in for, will not see anybody else but a GP. They think we're trying to fob them off"* (Admin3_practice2).

Throughout the evaluation there was little evidence of overt, measurable GP resistance to FPCP. There was evidence of GP control via the screening of physiotherapists' referrals, the determination of clinical practice boundaries and their global influence within the general practice but these were interpreted as more implicit and/or covert. The most direct GP influence was described through their influence in the commissioning process. This influence was exaggerated through the apparent unwieldy nature of commissioning in general practice.

GPs were perceived as having considerable influence in the commissioning process. This influence appeared to be reinforced as a result of commissioners' reliance on GPs. While the advice that commissioners sought was not exclusively from GPs, it was clear that GPs had most clinical influence. Information might be gathered from hospital consultants, other clinicians or service managers, but when this information was brought back it was GPs who were represented on the clinical council. Commissioners acknowledged the potential conflict of interests in terms of clinical provider motivations as demonstrated in the following quote:

Commissioner_1

> *I guess when you're talking to providers in the private sector then you need to be cognisant of the fact that there is a profit motive there, and that may influence to some degree what they're telling you… yes… that is an issue, yes.*

However, this concern regarding potential conflicts of interest did not extend to GPs. When external help in commissioning decisions was required this was often outsourced to other GP doctor groups. For example, GPs from another geographical region.

Commissioner_4

> *Yeah, you might need that expertise. So we do have those that we can tap in to. Like…when I was cost modelling some services which would be a conflict of interest for GPs in the area, I outsourced it to GPs outside, in Derbyshire, who actually did the cost modelling for me and everything.*

Or local GPs with a special interest:

Commissioner_4

> *I mean what we, in the city as with other areas, is we will have GPs that actually have a specialist interest in something. So where we are aware of that we will actually utilise them more.*

In addition, there appeared to be an almost naïve, historically situated, trust in the involvement of GPs in the commissioning process which this one commissioner reflected on during their interview:

Commisioner_1

> *Every Wednesday we will have seven, eight, nine GPs in this building, and I take them as being representative of the GPs out in general practice. And I'm probably deluding myself. They are a self-selecting bunch of nine GPs, who are here because they are interested and engaged in commissioning. I think…*

INTERVIEWER

> *And I would imagine that selection is pretty stable is it, or?*

Commisioner_1

> *Absolutely, yeah, yeah. It hasn't moved at all in three or more years. No, they've been very stable.*

The evidence from this evaluation demonstrated the consequences of this GP influence on this commissioning process via the non-commissioning of the previous pilot service. Evidence from GPs reinforced this perception as they articulated their decision-making process.

GP1_practice3

> *I guess if I genuinely felt it was going to make a huge difference to my workload then we would do it. But it needs to be cost-effective, and you may well have some persuasive evidence about that. But then you're pitting yourself against a nurse practitioner or a salaried GP, and a salaried GP can do everything. And I don't know how long the physio sessions were, but a salaried GP would do everything in ten minutes, a nurse might be cheaper but might not be able to deal with everything. So I guess it boils down to the fact that I'd have to pay for it out of my own pocket,*

A quite understandable justification in GP thinking was the parallel provision of existing, alternative physiotherapy services that sat alongside the new FPCP initiative. As one GP matter-of-factly said when discussing the waiting times to access the existing MSK physiotherapy service:

GP1_practice3

> *…actually I feel bad that they'll* [patients] *have to wait three or four weeks for their appointment, but actually that's not something that I'm necessarily commissioned to provide.*

It was clear, and this was highlighted in CMO representation 3 of this evaluation, that if the capacity: demand modelling was insufficient to realise the potential impact of FPCP then justification for non-commissioning of FPCP was reinforced.

Despite there being widespread acknowledgement of the need to do things differently in general practice, in the face of the ever increasing pressures, there was still a perception of GP dominance in terms of financial decision-making and the primacy of the GP role. The following excerpt synthesises these features.

INTERVIEWER

So there's some evidence that suggests that GPs are happy to give away bits of their role that they're happy to give away, but other bits they are sort of more protectionist about.

GP1_practice3

We don't like giving away money. Let's be frank. We're very happy to share workload and have extra resource to help us. We don't usually like giving away money. Who does?

INTERVIEWER

No, because everybody I've spoken to, practice managers as well, when I sort of propose that sort of model they've said well my priority would be, if I've got GP vacancies, would be to recruit GPs to those vacancies.

GP1_practice3

Yes, because my GP can do everything, my physio can't.

Reinforcing the primacy of the GP role was a sense of the importance in the traditional GP standing in the practice population. This was demonstrated in the following exchange.

INTERVIEWER

…certainly some of the other GPs I spoke to sort of said that sort of sense of the importance of that sort of family doctor connectedness is getting less as time goes by.

GP1_practice3

Yeah, and you see lots of things that erode that, particular IT, you know, now you can go to Babylon and Skype a GP anywhere. So yeah, things change.

Things change. But the fundamental basis of me being around when you're, you know, living out your last days, and having an overview of your care, if I know you, is still pretty important.

The power of this positionality was seen in the following quote. When asked what lies behind the patient defaulting to the GP this GP replied as follows:

GP1_practice3

Trust, faith, anxiety, knowledge, uncertainty.

INTERVIEWER

So trust, faith, of..?

GP1_practice3

Me.

INTERVIEWER

As an individual?

GP1_practice3

So it may be that I diagnosed their lung cancer ten years ago, or their depression. Or that they shared with me their history of sexual abuse. And they have, yeah, it's almost like a cult thing, it's remarkable. And this is part of why, nationally general practice is the most revered profession of them all.

INTERVIEWER

So do you think it goes beyond the individual, there's a trust, faith in GPs?

GP1_practice3

No, no. I think it goes at an individual level which is then extrapolated to a corporate level.

Quite clearly the primacy of the GP standing in a community was regarded deferentially. Programme Theory 1 articulated this from a patient perspective and this programme theory demonstrated that this positionality was also valued strongly by GPs themselves. Simultaneously, the physiotherapist participants

described how this medical dominance led to frustration. They affirmed the sense of the primacy of the GP in general practice. GPs were seen as sitting on top of the general practice hierarchy and *"… GPs pull the strings"* (Physio2_FG1_B7). Alongside the protectionist interpretations, described previously, some physiotherapists expressed a sense of unfairness.

Physio2_FG1_B7

> *In actual fact we're, you know, we're clearly autonomous and if anything we should all be on a level playing field. But I still don't feel as though that is the case. But that's because we've been a medically dominated health service for the last seventy years*

Physiotherapists were left feeling subordinate, or allied, to GPs within this system *"we're a bit subservient to GPs… we are… in our title, an allied health professional, we're there to help the medical profession"* (Physio2_FG1_B7). Indeed, counterproductively there was evidence of the physiotherapists potentially reinforcing this hierarchy through their everyday responses.

Physio1_FG1_B7

> *I know you sort of say physios who had been with one particular practice for a long time, they had kind of worked out with the GPs what the best way was to communicate with them, in terms of if somebody needed a sick note, if somebody needed a prescription, whatever, did they want a task, did they want knocking on the door, did they want a message, leaving notes. I think little subtle things like that make a difference as well*

This approach could be interpreted as facilitating working relationships in the reality of clinical practice. However, the evidence suggested physiotherapists often lacked assertiveness, in the face of the perceived medical hierarchy. The impression was physiotherapists in the clinical setting tended to take the path of least resistance in their daily dealings with GPs:

Physio2_FG1_B7

> *But I would tend to go towards a couple of GPs as my first point of contact, purely because I, you know, you go in and you have a good experience with them, and you think I'll go again. But it was so infrequent that I would do that, I think it was just a lot easier to go back to the same people.*

The implication was that those GPs who were less receptive were perhaps avoided. For the physiotherapy participants there appeared to be an inescapable and pervasive dichotomy. On the one hand there was a sense of overwhelming justification for the FPCP initiative but this sat alongside a context of perceived medical dominance and control. Furthermore, although there was apparent comfort and confidence in their ability to fulfil the FPCP role there was a sense of frustration. Some of this frustration appeared to be directed intra-professionally, in terms of professional leadership. The following quote, from a physiotherapy participant sums this up:

Physio2_FG1_B7

> *…if you've got a very experienced MSK physio that they're, if anything, more competent at screening for these things than GPs. So, you know, clearly it's the CSP, or our professional body, need to do even more to allay* [any] *fears I think.*

Consequently, there was an impression of resignation in the face of the dominance of medicine, *"I think it's again just still this perception that there's a hierarchy within primary care, that the GP is the gate holder for the patient's care and that they are the first point of contact, you know, irrespective of what condition they go for"* (Physio2_FG1_B7).

It would be reasonable to hypothesise that the sense of subservience that physiotherapists carried into the FPCP initiative and their apparent lack of assertiveness did little to challenge the medical dominance that so frustrated them. An impression existed that it was perhaps most productive to rely on more passive approaches:

Physio1_FG1_B7

> *I don't necessarily think that the public knowing that we've all done degrees and this that and the other, would automatically make them think they're going to see a physio rather than a GP in their local surgery. I think it's more, in the same way as we've talked about with the nurse practitioners, just time and experience and slowly changing culture and expectations. But I don't think people go to see their nurse because they know that a lot of nurses have degrees and have done post-graduate training. I think it's because they've been to see the nurse before and thought actually no, this is fine, and that's what happens in my practice. And it's just time.*

Evidence from the realist review advocated physiotherapist assertiveness in the role negotiation and implementation processes and this evaluation reinforced that impression. From a clinical perspective, the physiotherapy participants attributed responsibility to the CSP to *"allay* [any] *fears"* (Physio2_FG1_B7). More widely commissioning organisations and provider organisations were expected to lead in the marketing of FPCP. However, it appeared that as much as the hierarchy in general practice effected patient behaviour it equally influenced the physiotherapists.

Table 8.11: Context-Mechanism-Outcome evidence for the influence of medical dominance

	Mechanism		
Context +	Resource	Reasoning	= Outcome
Primacy of GP role Perception of GP as default FPC practitioner MSK demand and FPCP capacity not matched	GP influence on commissioning process GP cognisance of financial management Perceived lack of impact and efficacy of FPCP Physiotherapists acquiesce to GP	GP justified in non-commissioning of FPCP Commissioner prioritisation of GP recruitment Physiotherapist frustration	FPCP not commissioned Primacy of GP role maintained
Parallel MSK service available in locality			

8.3 – Discussion realist evaluation

The aim of this evaluation was to explore the experiences of participants who had been exposed to the FPCP initiative with the objective of generating findings that would inform future practice. By this measure, the evaluation was successful. It was clear that the profession of physiotherapy was engaged in a professional project (Larson, 1979). New evidence was generated that related to the two programme theories of 'patient understanding of FPCP' and 'roles and boundary definitions in the FPCP initiative'. Furthermore, the evaluation provided novel evidence relating to all levels of social strata: micro (relating to individual), meso (relating to interpersonal), and macro (relating to institutional, infrastructural, and cultural) (Shearn et al., 2017). For example, at a micro-level an individual's age, gender and ethnicity all need to be considered when evaluating an individual's tendency

towards prioritising the primacy of the GP position. At an interpersonal level particular methods of communication were shown to facilitate communication between physiotherapists and GPs. Finally, at an institutional/infrastructural level the existing commissioning process was shown to play a significant role in the implementation of FPCP. Each programme theory is now discussed.

8.3.1 – Patient understanding of FPCP

This evaluation, and the realist review before, demonstrated that although the profession of physiotherapy was well recognised in the public consciousness, FPCP was not. Furthermore, the public understanding of the clinical application of physiotherapy was poor and their understanding of FPCP was negligible. This was consistent with the little evidence that existed where general support for FPCP was reported but poor understanding was evident (Holdsworth et al., 2008; Webster et al., 2008). Although physiotherapy was described as an established, mainstream profession (Nicholls, 2018) there was little evidence of the public understanding thereof. What evidence there was described a general lack of awareness and uncertainty in terms of its applications (Ogiwara and Nozoe, 2005; Dissanayaka and Banneheka, 2014). This was important, as when patient expectations of physiotherapy treatment did not align with their first-hand experience, non-compliance with treatment was more likely (Campbell et al., 2001; Dobson et al., 2016).

The evaluation demonstrated that the traditional advertising strategies used to disseminate information pertaining to FPCP had been generally ineffective and services were, on the whole, invisible to the public. It was evident that more thought should be given to the development, dissemination and evaluation of FPCP marketing strategies specifically, but beyond that physiotherapy generally. Furthermore, evidence was synthesised that demonstrated the need for specificity in terms of the dissemination of information. Access to, and interpretation of, information varied considerably due to a number of sociodemographic and socioeconomic determinants. There was no evidence of this having been considered during the implementation of the FPCP service explored in this evaluation. Recently authors have suggested that marketing is novel for physiotherapists (Zadro, O'Keefe

and Maher, 2018). They go on to recommend *"evidence-based marketing will increase public awareness…and most importantly, create realistic expectations so that patients leave physiotherapy appointments satisfied"* (Zadro, O'Keefe and Maher, 2018: 1). This was an important finding and an area that physiotherapists need to consider, both in terms of design, implementation and evaluation.

In the face of the lack of understanding that the evaluation revealed, the size of the challenge for the FPCP initiative was evident when set alongside the intransigence and primary of the GP position as expressed by the participants and the consequent tendency for patients to default to their GP as the FPC. Word of mouth was shown to be an effective method of disseminating information about the FPCP service and as Zadro, O'Keefe and Maher (2018: 1) state this is perhaps the "cheapest and most effective type of marketing" available.

In the absence of effective advertising strategies it was the signposting, predominantly by GP practice reception staff, that most facilitated patient access. The only previous evidence that explored the administrators' role in FPCP specifically suggested they viewed it positively for its ability to create capacity within the general practice system (Moffatt, Goodwin and Hendrick, 2018). This evaluation reinforced that signposting was welcomed by reception staff. However, it also introduced new stresses for the receptionists who had primarily responsibility for the navigating patients. GP receptionists *"have become central to the functioning of general medical practices"* (Ward and McMurray, 2011: 1583) and emotional labour and stress is endemic within their role. The findings of this evaluation reinforced the importance of the administrator role as integral to managing the processes essential for the delivery of a FPCP service. Building on the work of Moffatt, Goodwin and Hendrick (2018) this evaluation demonstrated that formal training for these staff members can be effective in developing confidence in the signposting role. The additional stress associated with signposting could be further ameliorated when staff felt they were in a supportive environment that valued signposting. These supportive systems become essential considering that the FPC receptionist role is seen as a lower status role (Swinglehurst et al., 2011). A frequent barrier to patients accessing services is their dislike of having to speak to a

receptionist about their symptoms (Moffat et al., 2016) and this evaluation reinforced these concerns. There was a current paucity of literature relating to the signposting role and FPCP this warrants further investigation.

As with the realist review this evaluation reported the process of 'embedding' as essential. As a FPCP service embedded the service became more visible, patients became more aware and familiar with the service, reception staff became more confident in signposting, and patients became more amenable to being signposted. As a consequence utilisation to FPCP services increased and this allowed for a realignment of patient understanding. Although embedding appeared to permeate many dimensions of the FPCP initiative there appeared to be little evidence that explored this phenomenon. Bélanger and Rodríguez (2008: 591) describe the need to allow time for *"regularising new roles"* and previous evidence of self-referral physiotherapy reported increases in patient access over time, as patients became more familiar with services (Swinkels et al., 2014). However, it remains unknown whether this increase in utilisation correlates with an increase in patient understanding or just use of an additional resource.

In addition, it was also apparent that embeddedness was relative. Physiotherapy generally, and FPCP specifically, were measured against the deeply entrenched and embedded nature of the GP role. It was clear that FPCP was implemented into a context where the GP remained the default FPC practitioner. This positioning had been shown to be highly regarded by patients and resistant to change (Shoemaker 2012; Pullon et al., 2014). As such, physiotherapy must take an active approach to providing evidence of the efficacy of FPCP and the wider dissemination of information, as described above.

Reassuringly, despite the misunderstandings and barriers, stakeholders described clinical efficacy and patient satisfaction with FPCP, with those patients who attended once likely to attend again in the future. Once gain this was consistent with previous research looking at self-referral and FPCP (Webster et al., 2008; Ludvigsson and Enthoven, 2012; Goodwin and Hendrick, 2016).

8.3.2 – Roles and boundary definitions in the FPCP initiative

It appeared from the evaluation that physiotherapists were cognisant of the comparatively disadvantaged position of their professional project, relative to the established standing of GPs. The physiotherapy participants were equally aware of the need for, and methods of, professional advocacy. It was evident that the national FPCP professional initiative had been effective in influencing political policy and clinical practice. Despite the physiotherapy participants' alignment with the FPCP initiative it appeared that their hopes were moderated by pragmatism. They suggested tempering expectations in terms of proposed reduction in GP workload and questioned the usefulness of wholesale extension of the scope of FPCP practice. This caution had been expressed elsewhere (Moffat et al., 2016).

At the same time the physiotherapists expressed frustration at the primacy of the GP position in general practice and GP dominance in role jurisdictional determination and the commissioning process. One objective of the transfer of responsibility for commissioning to GPs was the potential for their input to facilitate engagement of other clinicians (McDermott et al., 2017). However, in their realist evaluation McDermott et al. (2017) saw this happen infrequently. The scepticism articulated by the physiotherapy participants appeared understandable in the face of reports of frequent conflict of interest where GPs are involved in commissioning (Iacobucci, 2013; Moran et al., 2017).

Additionally, physiotherapy participants were cognisant of the crowded MSK clinical provider marketplace and inherent challenges to the profession from other professions such as osteopaths and chiropractors. This concern seemed reasonable considering the wider public confusion around providers of MSK related healthcare (Ogiwara and Nozoe, 2005; Dissanayaka and Banneheka, 2014) and evidence of other emerging professions such as paramedics (Woollard, 2015) and physicians associates (Drennan, 2015; Drennan et al., 2017). Despite the recommendation that physiotherapists play an active role in boundary negotiations (Xyrichis and Lowton, 2008) there was no evidence of this. Furthermore, on a day-to-day level the physiotherapists lacked assertiveness during the operationalisation of FPCP. Further research to explore these contradictions would be useful.

FPCP was interpreted as encroaching into what was traditionally GP jurisdiction. From the sociological literature such encroachment was expected to generate some opposition from the incumbent profession (Abbott, 1998). The inductive nature of the analysis revealed such resistance from the GPs but it was somewhat veiled. It appeared that where GPs and physiotherapists worked alongside one another in a FPCP service mutual respect, trust, reassurance and confidence developed. This correlated with previous research looking at GP: physiotherapist relationships (Ferguson et al., 1999; Holdsworth et al., 2008; Ludvigsson and Enthoven, 2012; Dufour et al., 2014). There were practical systems that facilitated this development. Nevertheless, the evidence suggested that the boundary negotiation predominantly remained at the bequest, and within the defined parameters, of the GP.

In summary, this evaluation provided very useful evidence pertaining to the FPCP initiative specifically. However, due to the interprofessional nature of the research and the pervasive nature of medical dominance in the sociology of the professions literature the results are transferable to similar initiatives. It was clear that the pre-eminence of the GP in general practice pervaded all participant groups. While, superficially GPs expressed concordance with FPCP, and similar initiatives that encroached into their established jurisdiction, the evidence suggested they hung on to the primacy of their traditional GP role, determined which elements of their role could be liberated and retained dominance both operationally, within the GP practice, and outwith sociopolitically. However, there was also an impression that the expectations of GPs were changing. There was a sense that a new GP image was evolving and this was one more aligned with innovations such as FPCP. Physiotherapy, or other appropriating professions, need to be cognisant of these professional issues during their role, and service, negotiations. Suggestions for future research, which is seen as imperative, are considered in the next chapter.

8.4 – Evaluation strength and limitations

The principle strength of this evaluation was the production of new evidence that had the potential to inform the current FPCP initiative. As such this evaluation, and the wider thesis, were extremely timely. Added strength was brought about as a result of the application of the realist approach. This was the first prospective empirical examination of FPCP to use a realist approach and this evaluation was strengthened by the systematic development of guiding theory generated in the preceding realist review. The subsequent realist emphasis on extrapolating the generative mechanisms achieved greater insight than other methods would have allowed.

Nonetheless, a number of the strengths of this evaluation are, at the same time, potential limitations. While the realist approach allowed for a greater ontological understanding and emphasis on causal mechanisms, Pawson and Tilley offer no methodological rule book (Pawson and Tilley, 1997; Rycroft-Malone et al. 2010). As a consequence it was up to the researcher to determine the approach used and benchmarking is challenging as the existing literature is varied and inconsistent. Certainly there was no precedent in the field of physiotherapy.

In the same dichotomous manner, the use of realist interviews was both a strength and a weakness. The strength lay in the predetermination of the theories to be interrogated and the subsequent focus on theory refinement and development and this was evident in the findings. This was further supported by the development of the guiding theories in the previously described realist review. However, this approach may also constrain the findings as the predetermined 'schedules' have the potential to restrict the width of participant discourse. Within this evaluation the number of theories that were introduced to the participants was significant and it could be argued the researcher faced considerable challenge to identify new, emerging theories.

Methodologically, the use of a single data collection method could be interpreted as a limitation. Pawson (2013: 21) suggested that theory development "cannot be done through anecdotal information alone" recommending that

outcomes need to be tested in a pre and post intervention fashion. However, this evaluation did not seek to test the efficacy of FPCP, more so what happened around the FPCP initiative and how these happenings were interpreted and what they meant to participants; their experiences, behaviours and interactions (Teherani et al. 2015). To achieve this, qualitative methods were most appropriate. Notwithstanding this there is a case for further quantitative research that explores FPCP. It was acknowledged that theories will always be partial (Collier, 1994) and the theories generated in this evaluation provide useful stepping off points for future research.

Participant engagement and recruitment was a particular strength of the evaluation with participants recruited seamlessly. However, the purposive sampling and self-selected nature of staff participants could be indicative of ulterior motivations, particularly given the interprofessional nature of the research. Despite this concern, the impression throughout the data collection phase was that the participants were honest, candid and balanced. A limitation that could be apportioned to the patient participant group is the lack of ethnic diversity, with all but one of the ten patients describing themselves as white English. A limitation that arose as a consequence of this successful recruitment, and subsequent volume of data, was the evaluation thereof. Realist research analysis, and synthesis, had been acknowledged as complex and time-consuming (Dalkin, 2015; Adams et al. 2015). It would be reasonable to suggest that this demand, in the context of a PhD project, was challenging. Methodological processes, described in chapter 6, to ensure rigour were put in place to safeguard against untrustworthiness of the research findings.

The final challenge was the positionality of the researcher in the project. It has already been acknowledged that the professional status, and standing, of the researcher introduced potential partiality. It has also been described how the application of reflexivity and strategies to ensure methodological rigour sought to ameliorate this potentiality. Continuing with the dualist strengths-limitations theme, the researcher's disposition gave for greater insight, understanding and subsequent elucidation during the data collection, analysis and synthesis process.

Of more practical concern, this evaluation took place in one English city. Therefore, some caution needs to be exercised in extrapolating the findings to geographically and demographically dissimilar regions. However, the findings have been articulated at a middle range and this extends their transferability.

8.5 – Summary

8.5.1 – Summary: patient understanding

The realist evaluative approach proved extremely successful in generating original and important theories pertaining to the programme theory of patient understanding of FPCP. The complexity evident in the above findings and the exposure of the multiple generative mechanisms was likely to have been overlooked with alternative approaches. The evaluation revealed important findings, hitherto unidentified, that will help inform future practice. This is extremely important if the full potential of FPCP is to be realised and patient care optimised.

There was a general public awareness of physiotherapy, as a profession but there was a poor awareness of FPCP. Awareness of, and subsequent access to, FPCP appeared to be mainly related to embedding of services and concurrent signposting, predominantly undertaken by GP practice administration staff. For administration staff to feel confident in signposting a number of supportive mechanisms needed to be in place. These were the provision of signposting training, a culture of signposting within GP practice, and administration staff experience. There was the potential for signposting to increase patient understanding, beyond simply increasing awareness, but this had not been evaluated to date. Traditional methods of advertising, such as posters, were ineffective. Furthermore, there was little investment in these approaches and they were not well planned or evaluated and this warrants further investigation.

Alongside the general public awareness of physiotherapy the participants had a broad understanding of physiotherapy practice which was, on the whole, attached to the treatment of MSDs. However, this understanding was poorly aligned with modern physiotherapy practice and FPCP. When people attended FPCP

services, with a poor prior understanding, it resulted in patient dissatisfaction. Where understanding of FPCP improved it appeared to be achieved via signposting or word of mouth but this was dependent on the information that was disseminated being accurate. The effectiveness of these approaches at increasing understanding of FPCP had not been evaluated.

The intransigence of the GP position as the default FPC practitioner was an obstacle to the FPCP initiative. This was evident via a number of mechanisms whether this was patient trust in, and reassurance arising from, the GP–patient relationship, an associated lack of confidence in non-GP clinical competence, or media reinforcement of this GP-led model of care.

Certain sociodemographic and socioeconomic constituents were also found to be important in the realisation of the FPCP initiative. On the whole these were also related to the imbalance in understanding between GP care and FPCP. Beyond this the evidence provided important socioeconomic contextual characteristics that influenced awareness and understanding of FPCP, and patient motivations to adopt new behaviours. It would appear essential that these features are considered when designing and implementing FPCP models in the future.

8.5.2 – Summary: role and boundary definitions

The realist evaluation approach proved successful in generating original and important theories pertaining to the programme theory that explored roles and boundary definitions in the FPCP initiative. Investigations into social systems are always likely to be complex and it is likely that alternative approaches would have overlooked several of the generative mechanisms that the realist approach synthesised.

This theory corroborated evidence from the background literature and the realist review to support the proposition that the FPCP initiative constituted a professional project. Strategies typical of this profesionalisation approach were identified in both the realist review and this evaluation. Sociologically, there was broad participant awareness of the sociopolitical drivers for such an initiative as articulated in government policy (NHS England, 2014, 2019).

Physiotherapy participants expressed concern about some of the professions claims to justify the FPCP initiative. In particular caution was expressed with reference to the proposed reduction to GP burden and the requirement for the FPCP role to be an extended one. Alongside the proactive strategies evident in the professional project was a sense of frustration amongst the physiotherapists with regards to the lack of perceived parity with the medical profession and the lack of awareness and understanding of FPCP. This lack of awareness was observed to extend to all stakeholder groups including patients and the medical profession themselves.

The FPCP initiative provided a method of increasing the clinical jurisdiction of physiotherapists and this appeared to be supported by stakeholders as it was envisaged as improving patient care and experience. There was contradictory evidence with regards to the extended scope role of the FPCP physiotherapist. Advocates suggested that the extended role enhanced clinical efficacy and improved patient safety. The alternative view suggested that extended roles were necessary in a few as 15 per cent of patients and this could position physiotherapist unfavourably alongside cheaper alternative practitioners. Alongside this caution the physiotherapists appeared mindful of the need for them to seize the opportunity afforded them as a consequence of the sociopolitical environment. To not do so would leave the opportunity open to other occupational groups.

The general practice workforce had already evolved, in response to the changes described, with ANPs playing a greater role. A result of the changes was increasing complexity in the GPs' case mix, with no corollary reduction in burden. It appeared that in the case of ANPs, GPs had determined the role boundaries and this has essentially resulted in the diversion of more 'straightforward' clinical cases to the ANPs. The GPs workload was subsequently regarded as more complex and specialised. It was evident that for FPCP to have an impact on GP workload, more comprehensive Demand and Capacity modelling was required. Previous initiatives had failed to realise this objective due to insufficient capacity.

Although the potential for interprofessional conflict had been anticipated this was not overtly evident. Nevertheless, GP participants expressed some concerns about patient risk and physiotherapist competence. Furthermore, there was evidence of GP protectionism both at an individual and professional level. GP participants appeared committed to the pervasive nature of the primacy of the GP–patient relationship and attached the attributes of authority, responsibility and control to this role.

The evaluation demonstrated that where physiotherapists and GPs worked alongside each other, concerns dissipated over time. There was a parallel satisfaction with the FPC physiotherapist's role and GPs became reassured with respect to boundaries of the role, and their confidence and trust in the physiotherapist grew. It was evident that certain systems supported the successful implementation of FPCP.

In summary, there was some evidence of GP protectionist behaviour and of continued medical dominance within general practice. Clinically, physiotherapists persisted in a deferential stereotypical role that did little to actively challenge the traditional medical hierarchy. Both of these features warrant further research if the full potentiality of FPCP, and similar initiatives, are to be realised.

Chapter 9 – Discussion

9.1 – Introduction

This chapter discusses the overall findings of this research project and draws conclusions and recommendations related to the aim of this study. Previous chapters described the successful application of realist methods to previously published literature (Realist review – Chapter 5) and prospective data (Realist evaluation – Chapters 6, 7 and 8). The overall research project generated new knowledge that will inform future implementation of FPCP services. However, beyond FPCP, the outputs of this research provide information that is transferable to comparable innovations. Furthermore, this research adds to the academic literature relating to the sociology of the professions.

Both the realist review and realist evaluation (which was informed by the findings of the realist review) augmented the existing evidence base. Originality was provided via the application of realist methodological principles to FPCP and, more generally, physiotherapy. The findings of this research will be useful to all stakeholder groups, from commissioners, to providers to patients, in the design and implementation of future services. Furthermore, the lessons learned with regards to the methodological approach will be useful for future researchers wanting to use realist approaches.

The chapter begins with a brief review of the aim of the research. This is followed by a discussion of the findings and their relationship with extant literature. The challenges of the research project are then considered. The lessons learned from the research are considered in terms of their real-world application. Areas for future research are discussed. The thesis finishes with a closing, reflective comment.

9.2 – Aim of the research study

The aim of this research was to explore the reactions and responses of the multiple stakeholders to the FPCP professional project and investigate why their reactions were constructed as such, how they were articulated, in what circumstances and how they influenced operationalisation of FPCP. It was hoped that any lessons taken from the investigation with regards to the design, implementation and utilisation of FPCP could provide transferable lesson for future service implementation projects.

The application of realist approaches meant that the emphasis of this research project was the development of theories that explained the responses and reasoning's of stakeholders in response to the professional project, where the FPCP initiative introduced certain programme resources. The objective was not to demonstrate the efficacy of FPCP as an intervention for people experiencing MSDs. Indeed there was an emerging body of evidence that suggested clinical efficacy (Ludwigsson and Enthoven, 2012; Goodwin and Hendrick, 2016; Moffatt at al., 2017). The concern of this realist research was the development of middle range theories (Merton, 1968). This research project realised the ambition of generating theories and provided explanations that articulated the generative mechanisms, evident in stakeholder reasoning to the resources inherent in the FPCP project (Pawson and Tilley, 1997; Pawson, 2013).

9.3 – Summary of the findings

Chapters 5, 7 and 8 presented programme theories exploring 'patient understanding of FPCP' and 'role and boundary definitions associated with FPCP', conceptualised as a professional project. The findings were articulated through a number of narrative descriptions presented alongside associated CMO configuration tables. In doing so the mechanisms that influenced stakeholder reasoning, to the resources in the FPCP initiative, were exposed (Pawson and Tilley, 1997; Pawson, 2013). The main findings from each of the two programme theories are discussed in the following sections.

9.3.1 – Patient understanding of FPCP

Physiotherapy was seen as an established profession in the English healthcare system. However, the realist review and the realist evaluation both highlighted poor public understanding of the clinical application of physiotherapy. Webster et al. (2008) described a survey reporting 88 per cent of the public supported self-referral to physiotherapy. However, as they stated, "*what is not known is whether they were expressing their support for the concept… or whether they actually had existing knowledge from which to make an informed decision"* (Webster et al., 2008: 142). Their empirical research confirmed poor patient knowledge with less than 5 per cent of patients reporting themselves as very knowledgeable about self-referral physiotherapy. There was little other previous research exploring public understanding of physiotherapy and none pertaining to FPCP. The wider evidence was consistent with this research in that understanding of the clinical application of physiotherapy practice was poor (Ogiwara and Nozoe, 2005; Dissanayaka and Banneheka, 2014). The current evaluation demonstrated that the public had a general awareness of physiotherapy but no awareness of FPCP. The public understanding of the clinical application of physiotherapy for MSDs was confused and inaccurate and understanding of FPCP negligible.

There was broad acknowledgement, from the published data, of the need to disseminate information about FPCP to stakeholder groups. The evaluation developed this theory further suggesting that any information disseminated should include information about the nature of the service and what patients, might expect if they attended. Furthermore, it was seen as important to consider dissemination methods and information taking into account socioeconomic determinants. This information dissemination provided a resource mechanism to increase public awareness, and understanding of, FPCP. The realist review provided little information on how previous self-referral, or FPCP, services had been marketed and there was no evidence of how marketing approaches had been conceived or implemented. There was no evidence of any evaluation of marketing of physiotherapy services. Similar results were synthesised in the evaluation with the marketing strategies being traditional in approach and were on the whole invisible

to patients and consequently, the marketing strategies, applied to FPCP, were deemed ineffective. In realist terms, the objective was that the dissemination of information (M-Resource) would result in changes in patient awareness (M-Reasoning^{1}) and understanding (M-Reasoning^{2}) and lead to a behavioural change (Outcome^{1}) and increased access to FPCP (Outcome^{2}). However, this objective remained unrealised.

Recently, Zadro, O'Keeffe and Maher (2018) suggested that marketing was novel to the physiotherapy profession but it ought to be considered a component of service developments. In a recent pilot randomised controlled trial Bishop et al., (2017) described their own marketing strategy for FPCP as successful as measured by patient access to FPCP. Their approach involved mailing all eligible patients information about direct access with traditional methods such as posters readily available in intervention practices. Despite their reported success, genuine self-referral was still only evident in just 25 per cent of the physiotherapy referrals.

From this research it was clear that physiotherapy for the management of MSDs generally, and FPCP specifically, was poorly understood and this needs addressing in the future to optimise any potential impact of the FPCP initiative. The data in this review and evaluation suggested dissemination strategies should make use of modern resources such as the internet and social media to maximise impact. The evaluation data extended this theory by suggesting that marketing strategies required specific tailoring to target populations to maximise effectiveness. The evidence, from participants, extended to specificity in terms of tailoring to clinical conditions and also socioeconomic determinants. This aligned with research that suggested that certain groups are disadvantaged in terms of equity of access to health service provision and typically, this was the older population, ethnic and other minority groups (Fiscella, 2000; Corscadden et al., 2018).

The realist evaluation demonstrated a potential inequity in access as a consequence of sociodemographic and socioeconomic inequalities and suggested this extended beyond access to information but also the ability to rationalise the information and make subsequent healthcare choices. More widely it is suggested that those in lower socioeconomic groups are less likely to seek out health

information, have lower levels of self-efficacy towards obtaining health information, and are more apprehensive about trusting certain sources of health information (Richardson, 2012). This would appear to relate to the area of health literacy. This was not explored in this research but is an area that warrants further investigation.

Both the realist review and the realist evaluation demonstrated that there had been no previous systematic planning and marketing of physiotherapy services and any strategies applied and had never been comprehensively evaluated. As such, any future attempts to influence public reasoning should be robustly evaluated. It would be essential to involve all stakeholders in this process. Recent research (Anderson, Adamson and Birks, 2018) demonstrated that even when contemporary marketing methods are used there was under-representation of non-doctor professional groups in the information that was distributed. In such circumstances patients continued to lack sufficient information to make informed choices about consulting an alternative to their GP. The authors concluded that the potential for websites to disseminate information was not being maximised and services were resultantly underutilised (Anderson, Adamson and Birks, 2018).

As a consequence of the ineffectiveness of marketing strategies the majority of patients who accessed FPCP services in this thesis were signposted by general practice reception staff or as a consequence of word of mouth in the community. These were identified as two important resource mechanisms to increase awareness (M-Reasoning[1]) and understanding (M-Reasoning[2]) and facilitated subsequent access to FPCP (Outcome). Administration staff have been increasingly recognised as central to the modern general practice, playing a pivotal role and acting as an interface between the practice and patients (Stokoe, Sikveland and Symonds, 2016; Brant et al., 2018). Previous evidence suggested potential patient resistance to the signposting by receptionists (Moffat et al., 2016) and the role had been shown to increase receptionist emotional burden (Ward and McMurray, 2011). In their recent ethnographic study, Brant et al. (2018) reported that administration staff played a fundamental role in facilitating access to alternatives to GP appointments. However, the role was under-recognised and administrators were generally not involved in the implementation of such initiatives. Training for

this new, potentially burdensome role was patchy. This inattention to the importance of the administrator role appeared to correlate with poor administrator 'buy-in' and the authors suggested that this was associated with the general poor uptake of alternatives to GP appointments. Consequently, they concluded that there was little evidence of novel alternatives being associated with a reduction in GP workload (Brant et al., 2018).

The current evaluation reinforced these findings. Signposting was essential in facilitating patient access to FPCP and was, on the whole, welcomed by reception staff. Although there was some additional potential stress for reception staff, associated with signposting, it could be ameliorated by a collaborative team environment and adequate training. The administration staff in this evaluation also appeared aligned with the rationale of FPCP and did not view it as a 'second best' option as described in other work (Brant et al., 2018: e484). The administrators saw signposting as a method of educating patients and ensuring they received the best possible care and these were seen as integral aspects of their role. As such they were supportive of the initiative. The content and effectiveness of signposting training, with respect to FPCP, had not been investigated to date and this warrants further evaluation.

Both the realist review and evaluation demonstrated that patient understanding of FPCP was set alongside the entrenched dominant position of the GP. It was evident from the data that the GP was perceived as the legitimate FPC for patients and this position appeared socio-historically situated. This provided a context into which FPCP was implemented. The dominance of the medical profession has been described at length (Freidson, 1970, 2001; Larson, 1977; Starr, 1982; Coburn, 2006; Benoit et al., 2010; Wranik and Haydt, 2018). This realist evaluation suggested that certain sociodemographic and sociocultural characteristics influenced patients' decision-making and their predisposition to default to the GP. These characteristics included the age of the patient, the ethnicity of the patient and the patient's sociocultural beliefs.

Despite the reported lack of awareness and accurate understanding of FPCP the patient participants reported a high regard for physiotherapy as MSK specialists.

This was consistent with previous literature (Webster et al., 2008; Ludwigsson and Enthoven, 2012; Goodwin and Hendrick, 2016). Although not universal, the consensus from the realist review and the realist evaluation was that GPs were seen as less proficient in the management of MSDs and physiotherapists brought an MSK expertise to the general practice. However, the evidence from this research suggested patients still had a propensity to default to the GP as the FPC. The realist review findings suggest that this correlated to patients' concerns about the seriousness of their complaint. This was evident in the wider literature (Kearley, Freeman and Heath, 2001) and appeared to be the case even when patients were reporting MSDs (Sibbritt et al., 2016). It was clear that the dominant position of GPs was a barrier to the FPCP initiative.

A feature that permeated throughout both programme theories was that of embedding. This feature had not been articulated explicitly in previous literature but the findings in this research were consistent with a gradual increase in self-referral seen in previous research (Ferguson et al., 1999; Leemrijse, Swinkels and Veenhof, 2008; Swinkels et al., 2014). Embedding, by definition, described a process but in this research it was considered a context. Although a FPCP service may be going through the 'process of embedding' this embedding (Context) provided the resource of visibility (M-Resource) to patients which brought about changes in reasoning such as patient 'familiarity' (M-Reasoning^{1}) and 'confidence' (M-Reasoning^{2}) which resulted in subsequent utilisation of FPCP (Outcome^{1}) and resultant 'satisfaction' (Outcome^{2}). The realist review proposed a 'cycle of embedding' whereby this satisfaction increased the likelihood of re-attending the FPCP service.

Alternatively, something may already be embedded (Context). For example, where a culture of peer support and team working was embedded in a general practice (Context) it provided 'support' (M-Resource) to administration staff who subsequently felt more 'comfortable' (M-Reasoning) in the 'execution of their signposting role' (Outcome). The complex, cascading nature of CMO configurations was seen whereby this 'comfort in the signposting role' (M-Resource) produced 'administrator confidence' (M-Reasoning^{1}) to engage with challenging patients and

act as advocates (M-Reasoning[2]) for FPCP and patient utilisation subsequently increased (Outcome). This whole process was facilitated by comprehensive signposting training which sat alongside the embedded culture of peer support.

In this research the theory of embedding extended beyond patient access and was important in several aspects of FPCP and this feature warrants future investigation.

9.3.2 – Roles and boundary definitions in the FPCP initiative

The FPCP initiative was conceptualised as a professional project and the success of this project was evident in government policy advocacy (NHS England, 2014; 2019; Iacobucci, 2019). However, the implementation of FPCP was set alongside a deeply embedded and widespread belief in the primacy of the GP in general practice. This was frequently articulated throughout the research project by all stakeholder groups. Despite evidence of some initial governing body resistance (Bley Griffiths, 2015; Chan, 2015; BBC, 2016) the participants in this evaluation did not describe any overt interprofessional tension or boundary disputes. Furthermore, when working alongside one another, physiotherapists and GPs developed effective working relationships.

Data in both the realist review and the realist evaluation found medical dominance permeated general practice and, more specifically, the FPCP initiative. Some previous authors had suggested a decline in medical dominance (Alsop, 2006; Coburn, 2006; Currie et al., 2012). However, an alternative view was that medical dominance had evolved in response to the changes around it. Medical dominance was described as developing into a contemporary hybrid managerial/clinical form and the medical professions influence on organisations, institutions and professional boundaries continued (Noordegraaf, 2007; Currie et al., 2012). Some authors suggested that doctors struggled with this adjustment while others have suggested hybridised doctors have reconstructed themselves as a *"professional cadre in their own right, cementing their influence as a managerial elite"* (Croft, Currie and Lockett, 2015: 382). Currie et al. (2012) described how medical professional power continued undiminished in these contemporary circumstances.

A particular process, seen as indicative of medicine's professional dominance, in the face of external threats, had been described as 'policing' (Currie et al., 2012). Within this current research project policing was observed whereby GPs exercised control over physiotherapists' practice. This was seen most directly with GPs policing physiotherapists' requests for referrals for diagnostic investigations or to secondary care services. GPs control over physiotherapists activity, and subsequently their autonomy, was a mechanism whereby medical dominance was maintained and the full potential of the extended FPCP role was obstructed.

Further evidence from the work of Currie et al. (2012) resonated with this research project. Currie et al. (2012: 956) described how elite professionals *"invoke concerns of risk and present themselves as arbiters of risk"*. Risk was undoubtedly part of the initial medical professional response to the FPCP initiative (Bley Griffiths, 2015) and this was also identified in the literature analysed in the realist review. However, GP concern over clinical risk, as a consequence of physiotherapist competence was limited in this evaluation. The few concerns expressed were related to the substitution of experienced, extended scope practitioners with less experienced physiotherapists. Indeed, GPs were more likely to associate physiotherapists with a reduction in risk. The GPs in this evaluation suggested that physiotherapists would be more likely to identify medical conditions masquerading as MSDs than GPs. Primarily, GP concern, when articulated in this evaluation, and their subsequent 'policing', was associated with the operational aspect of their role and their responsibility in terms of patient governance and finance. While this did tacitly imply some associated concern regarding clinical competence it also reinforced GPs' managerial reconstruction of their role (Currie et al., 2012).

The majority of the discourse relating to anxieties with regard to clinical care of patients with MSDs, was directed towards GPs themselves. Although there was some contradictory evidence from patients the impression from the GP, administrator and physiotherapy participants was that any risk to patients was due to a lack of GP proficiency in the management of MSDs. It was also apparent in the

evaluation data that aspects of the physiotherapists' professional project were claims to equivalence and the use of atrocity stories (King et al., 2015).

The narrative around risk and role jurisdiction in the published literature had suggested that an incumbent profession's response to boundary encroachment was seen in their control over which particular aspects of its role to 'give-over' (Hughes, 1958; Nancarrow and Borthwick, 2005). Often the work they discarded was described as the 'dirty work', involving the simpler and more straightforward activities and tasks which were also inherently less risky (Hughes, 1958; Nancarrow and Borthwick, 2005). Evidence from this evaluation supported this proposition with administrators and GPs expressing how ANPs had taken on the management of the majority of the straight forward 'coughs and colds'. The wider narrative associated with FPCP was that MSDs constituted a straightforward component of a GP's caseload. Undoubtedly, the concern directed at FPCP, by the BMA and RCGP, was related to patient risk relating to patient presentations that masqueraded as simple MSDs but were in fact more sinister (BBC, 2016). The assertion was that GPs could accept physiotherapists taking on the straight forward, simple MSK work but there were risks inherent in even this.

The literature suggested a consequence of this response, to give-over the straight forward aspects of their role, was a concurrent step towards greater GP specialisation. Charles-Jones, Latimer and May (2003) described GPs' response to policy changes and threats to their autonomy as their reconceptualisation as super specialists within primary care. This was evident in the current evaluation with one GP participant describing the specialisation of their work and suggesting *"our work now is the work of hospital consultants twenty years ago"* (GP1_practice2).

The evidence generated in the evaluation appeared to suggest that whether motivated by pragmatism, altruism or professional specialisation the GP participants saw the evolution of their role as apposite. According to one GP the management of complex caseloads was appropriate to the GP role. *"I think that seeing twenty complex people, which is the sort of capacity you can see in half a day comfortably without getting into difficulties…That's the job of a GP, you know. It's tough but, you know, we get paid well"* (GP1_practice4). The same GP described

how, certainly the younger generation of GPs, expected a different experience to those who had gone before.

> *But I think the world has changed, and we've got to move on. You know, doctors don't want to be the family doctor anymore, they don't want to be 24/7, talking to patients in the supermarket, in the pub, don't mind being rung up at home or someone knocking on their door. You know my grandfather did that, but I'm not going to do it. And certainly the younger doctors are not going to do it.*
>
> GP1_practice4

This empirical evidence resonated with recent literature that suggested a generational change in general practice (Jones and Green, 2006). This research described younger GPs rejecting the 'old' models of paternalism and vocation. Instead they were looking for a good work-life balance, and a portfolio career with stimulating work. The new GPs in their study were also advocates of the polyclinic model in which members of a MDT brought their own specialisation to the team. This was envisaged as providing better patient care and a *"workplace culture, in which equality across the primary care team was valued"* (Jones and Green, 2006: 937). Jones and Green (2006) suggested some caution in that their cohort of GPs, early graduates of the remodelled Vocational Training Scheme, may not have been typical of early-career GPs more generally.

There was no overt conflict evident between GPs and physiotherapists in this current evaluation and in general the GPs voiced supported the FPCP role. The frustrations of the physiotherapists and the dominance of GPs was more hidden and indirect. All participants described being cognisant of a professional hierarchy in general practice and this hierarchy influenced patient, administrator and physiotherapist behaviour and was also evident in some protectionist behaviour by GPs. GPs appeared to exercise control, which was resistant to change, in role boundary definition and wider organisational issues such as commissioning. However, alongside this dominance the GP participants who were interviewed acknowledged the need for change and welcomed both the development of the

MDT, the contribution physiotherapists' played in the MDT and the corollary support that they received as consequence of a diverse MDT. This support correlated with previous research that showed FPCP could bring a MSK expertise to the general practice team (Moffatt et al., 2017). This has been an overlooked corollary of FPCP but it was an important feature that further supported the initiative.

Nevertheless, the more covert, historically situated dominance of GPs described in the realist review and seen in this evaluation had been repeatedly shown to inhibit service innovations. Previous research had predominantly focused on the emerging nurse practitioner role. Despite evidence of the efficacy of ANPs (Dierick-van Daele et al., 2009; Laurant et al., 2018) there appeared to be pervasive GP concern and resistance (Wilson, Pearson and Hassey, 2002; Schadewaldt et al., 2013). GPs' concerns were consistent with this current research in terms of threats to GP status and ANPs' clinical competencies and training.

However, even where general support for the nurse practitioner role was reported it came with conditional medical dominance. Research described GPs insistence on providing supervision for the nurse practitioners and there was discourse around the nurse practitioners 'knowing their limits' (Kraus and DuBois, 2017). Also resonating with this current evaluation was the apparent embedded subservience of the nurses with them often describing themselves as the GP's assistant, a position reinforced by GPs' view of the ANP role as 'supportive' (McInnes et al., 2017). Furthermore, the intransigence of this hierarchy was reinforced by the tendency, of some nurse practitioners, to hold on to the 'handmaiden' role (Parker, Keleher and Forrest, 2011).

This subordination was replicated in the current research with the realist review demonstrating that physiotherapists recognised the importance of the medical profession as a facilitator and/or a barrier of the FPCP initiative. At the same time there was no evidence of the physiotherapy profession attempting to influence the medical profession in the review. Equally, in the evaluation the physiotherapy participants appeared to avoid conflict and lacked assertiveness in the role negotiation process. Beyond nursing, similar GP resistance to role

diversification and boundary encroachment has been seen in community pharmacy (Löffler et al., 2017) and physicians' associates (Drennan et al., 2017).

From a commissioning perspective participants in this evaluation described frustration at the existing processes. For the physiotherapy participants the dual clinical/commissioning role held by GPs, and their inherent control, made them somewhat culpable in the adverse commissioning decisions that had been experienced. For the GPs the frustration was directed at the system which disincentivised the commissioning of FPCP. It was clear that some role boundary and professional jurisdiction issues extended beyond simple clinical practice. However, if a potential GP response to the FPCP initiative was protectionist commissioning decisions, and if physiotherapists recognised the need for them to influence commissioning organisations, these issues need considering and debating openly in the future.

In addition, the physiotherapists were cognisant of the dichotomy around the extended scope components of the FPCP role. On the one hand, it was suggested that these aspects of the role were required in as few as 15 per cent of the patients and so the profession should be pragmatic in its project. Alternatively, physiotherapists also needed to be mindful not to undermine their role by diluting it. The physiotherapy profession need to consider this issue in the future operationalisation of the FPCP project.

There was an apparent fundamental conflict for the GP participants in this evaluation. They were conscious of the reconceptualisation of GP role identity with the changing health environment and the increasing institutional and managerial prerogatives. Alongside this they were also aware of the primacy of the traditional GP model and the influence this maintained over the public. GPs' adherence to this traditional role was evident in their continued dominance seen in this realist review and realist evaluation.

These mechanisms of medical dominance could be articulated by participants:

- GPs advocating patients are signposted to a GP appointment
- GPs auditing physiotherapists' activity covertly
- GPs withholding physiotherapists' referrals to secondary care or diagnostic investigations
- GP determination of role boundaries and professional jurisdiction
- GP influence on commissioning process
- Patients' perception of primacy of GP position in general practice

Set alongside medical dominance, and its influence, was the support articulated by GPs for the FPCP initiative and the impression during the data collection process was that this sentiment was genuine and candid. It appeared that the GPs were unaware of the influence of their dominance within the general practice. They were naïve as to how it was manifested and how it subsequently inhibited the professional projects of others. As such this research adds to the sociological literature by suggesting that medical dominance has not been fundamentally eroded. It may have been reconstructed extending beyond the clinical domain to organisational and institutional domains (Noordegraaf, 2007; Currie et al., 2012; Croft, Currie and Lockett, 2015). However, it also appeared to be so institutionalised that GPs were unconscious to the expression, and influence, of their dominance. This was seen in behaviours that, at times, contradicted the intentions that they articulated. For example, GPs spoke of their confidence in the competence of physiotherapists' while at the same time policing their referrals to secondary care.

In the research exploring ANP practice, time was reported as essential in allowing these new, emerging roles to normalise and for trust to develop between professions (Drennan et al., 2017; McInnes et al., 2017). This was evident in the research project with time needed for a service to embed and the confidence and trust that developed as a consequence. Furthermore, previous research suggested that collaborative working could be facilitated by an open acknowledgement of any GP concerns and the negotiated clarification of ANP roles (Wilson, Pearson and Hassey, 2002; McInnes et al., 2017). Both of these features were evident in this

research project and provided important learning. It is worth being mindful that services implemented as short term projects may not realise full embedding and subsequently this may undermine any evaluations thereof. Furthermore, there was no evidence of any open, prospectively negotiated roles and jurisdictions and no evidence of ongoing negotiations in the face of the identified tensions. This would appear to be an important consideration and something that could inform future implementation.

9.4 – Challenges of realist approaches

Chapters 5, 7 and 8 reported the outcomes and outlined the challenges in the realist review and realist evaluation process respectively. It is not the intention, in this chapter, to restate these challenges. More generally the application of realist methodological approaches was challenging. There is considerable discussion as to what is realistic within the constraints of a PhD project. As has been stated Pawson suggests realist research is "not for novices" (Pawson et al. 2004: 38). It might appear logical to assume this excludes realist approaches from the PhD endeavour but realist PhDs appear to be increasingly popular. More recently Pawson (2019) offered further pragmatic and practical advice to the PhD candidate suggesting:

> *The real trick is to prioritise down to a very small number of programme/intervention theories. In yours you will encounter dozens of theories on why a programme might work. In RE field discussions with stakeholders the mechanisms will multiply. Go down to a few theories you feel are most fruitful and then think of the specific (and limited) amount of empirical materials that will help you test those particular ideas. You end up with a 'partial exploration of a partial set of ideas' about an intervention/programme/transition. And that is the definition of a PhD.*

Chapter 4 described the process whereby the researcher, and the wider stakeholder team, developed four initial rough programme theories to be tested, against the published literature in the realist review and how these were reduced to two. Previous literature (Adams et al., 2015) supported this decision and the recent guidance from Pawson further vindicates this pragmatic step. A consequence of this

decision was that additional data exists, relating to previously published literature and interviews/focus groups pertaining to the two discarded programme theories. These two programme theories were 'GP understanding of FPCP' and 'nonclinical staff understanding of FPCP'. A part justification for the methodological decision to focus on the two programme theories within this thesis, was the considerable overlap between the four theories. It is clear that evidence has been synthesised that does indeed relate to both GP understanding and nonclinical staff understanding of FPCP. Nevertheless, there exists a substantial body of retrospective and prospective data that remains unreported and the intention is to analyse this in its own right.

The overlapping nature of the programme theories was evident despite the pragmatic decision described above. This made the synthesis process lengthy, complex and challenging. For example, GP practice administration staff spoke about patients having an 'awareness of FPCP' but concurrently also spoke about 'patients' tendency to default to the GP as the FPC'. They attributed this behaviour to a long established socio-historical positioning of the GP at the top of a general practice hierarchy. It was evident that this data spoke to both programme theories ('patient understanding of FPCP' and 'roles and boundary definitions in FPCP'). This duality was evident throughout the synthesis process and was challenging to manage. The time demands inherent in realist research had been articulated elsewhere (Hewitt, Sims and Harris, 2014, Dalkin, 2015) and this was amplified in a PhD project where a considerable degree of work was undertaken independently by the candidate.

There is widespread heterogeneity in published realist literature, both in terms of subject area and methodological approach. Furthermore, there is no recipe provided for the application of realist approaches (Rycroft-Malone et al. 2010). As such, any realist researcher is required to develop bespoke practical methods while adhering to the fundamental principle of seeking to expose generative causal mechanisms. This was undoubtedly challenging but the researcher commitment to reflexivity and continued reference to the project group facilitated this process. This included the use of a reflective diary (Excerpt in appendix 7), reference to the

supporting theoretical literature and review of developing theories in project group supervision.

Any analytical process is ultimately dependent on the quality of the data. The quantity of published literature that was directly related to self-referral physiotherapy, or FPCP, was limited. The breadth of the selected literature was extended by snowballing but this was inevitably limited by practical constraints and time constraints. The breadth and depth of the literature could have been further expanded, resulting in a greater body of literature to review, by more extensive snowballing and searching in other fields. However, as Pawson (2013) states all knowledge, and subsequently any output from the review, is partial. As such, the decisions made, and the subsequent restrictions applied, do not undermine the review findings.

Equally, the boundaries imposed on the research process limited the participant sample size in the realist evaluation. Notwithstanding this limitation participant recruitment was seamless and indeed exceeded expected numbers. A total of three administrator focus groups were recruited, rather than the planned two. Four commissioners were recruited rather than three, and the dual commissioner/GP role of one participant increased both the GP and commissioner groups. Inevitably, this additional recruitment impacted on the burden of data synthesis.

A limitation that could be apportioned to the patient participant group is the lack of ethnic diversity, with all but one of the ten patients describing themselves as white English. This clearly challenges the transferability of the research findings, particularly when the need to consider sociodemographic and sociocultural characteristics was highlighted in the findings.

Despite these challenges which, in general, have been previously described, the realist approaches applied in this research project proved valuable in generating original findings that will undoubtedly inform future practice.

9.5 – Implementation lessons

This research was funded by Collaboration for Leadership in Applied Health Research and Care, East Midlands and sat within the implementation theme. Important implementation lessons were synthesised from this research that will inform future practice.

9.5.1 – Marketing

Lesson 1 – The profession of physiotherapy nationally, needs to establish an effective, co-ordinated initiative to disseminate information to the public with respect to the role physiotherapy can play in the management of MSDs.

Lesson 2 – The profession of physiotherapy nationally, local services and individual physiotherapists need to establish effective methods of disseminating information to the public to increase both awareness of FPCP, as a resource, and understanding of the role FPCP can play in the management of MSDs. It is important that any information disseminated, through marketing, uses methods and language that are specific to the target audience. This will vary according to a number of socioeconomic and sociocultural determinants. Any methods of marketing FPCP, which should utilise contemporary technologies, need to be systematically, and professionally, designed, implemented and evaluated.

9.5.2 – Signposting

Lesson 3 – The essential role that administrators play in signposting patients to FPCP services needs to be recognised and administrator input needs to be sought in the design, and implementation of FPCP. An effective model of signposting training needs to be developed and administrator expertise should be sought as part of this development process. Signposting training needs to be robustly evaluated. Patient experience of signposting to FPCP should also be evaluated to help develop this increasingly important role.

9.5.3 – Embedding

Lesson 4 – Embedding is essential in the normalisation of FPCP and this inevitably takes time. It is important that stakeholders, at all levels of the commissioner and

provider pathway, are cognisant of this. Short term pilot projects, which are so frequently implemented, may not fully realise this embedding process. The consequences of this are manifold, and run the risk of undermining the initiative. Embedding was facilitated by having a consistent physiotherapist in the FPCP role, having the role co-located in the general practice and using systems to facilitate communication. This should also include regular reviews of roles and jurisdictions and open conversations around multidisciplinary working.

9.5.4 Medical dominance

Lesson 5 – GPs at present retain the dominant position in the general practice hierarchy, but they may not realise that this could be having a negative impact on MSK patients who need physiotherapy. Physiotherapists need to be assertive in the negotiation and definition of role boundaries and jurisdictions. Systems that facilitate effective communication between GPs and physiotherapist need to be implemented in FPCP services. The importance of the co-located nature of the FPCP needs to be recognised and the corollary consequences of this, in terms of relationship building, upskilling and peer support, need to be evaluated.

9.5.5 – Capacity modelling

Lesson 6 – The profession of physiotherapy nationally, local services and individual physiotherapists need to influence all associated stakeholder groups. This would appear to require strong leadership, at all levels. It would appear that physiotherapists need to influence policy makers nationally, and locally, to ensure FPCP is implemented in such a way to maximise impact. The lessons learned to date need to be clearly articulated to outline the barriers to impact. Decisions regarding commissioning and implementation of FPCP can then be made in an informed manner.

9.6 – Future research

There is an urgent need and an enormous potential for further research into FPCP. There is urgency in that most models of FPCP to date have been implemented with suboptimal capacity. As such any evaluations are unlikely to demonstrate the full

potential of the FPCP initiative. At a time where the NHS is investing in FPCP (NHS England, 2019) it is important to be able to accurately represent the potential that FPCP has to contribute to the pressures experienced in general practice. This has the potential to subsequently optimise patient care and outcomes.

Research suggests that when initiatives are implemented their success is dependent on the plans being communicated to patients (Joyce et al., 2018). Fundamentally, the long-term success of FPCP initiative is dependent on patients accessing the service. As such, based on the findings of this research, a priority is the exploration of methods to increase public awareness, and understanding, of FPCP. The long-term objective, for the physiotherapy profession is that the public view physiotherapists as the default FPC practitioner for MSK care. It is acknowledged, and it was recognised by participants in the research, that this is a significant undertaking and one that will take several years. However, there is considerable opportunity to evaluate methods of information dissemination to patients using the findings generated in this research that suggested the use of innovative methods and specific targeting of marketing material.

The evidence of the primacy of the administrators' role in signposting, the acknowledged importance of training for this role and the lack of research exploring both the role and training specific to FPCP make this a research priority.

The majority of existing models of FPCP are unlikely to actualise the full potential impact of FPCP on the work in general practice work. There is considerable room to explore differing models of capacity to optimise the capture of the general practice MSK demand. One proposal would be to implement an FPCP service with capacity modelled to match the anticipated MSK demand. Evaluation of such a model would allow for a more accurate analysis of the potential for FPCP to alleviate GP burden.

An alternative study would evaluate the implementation of a side-by-side physiotherapist: GP specialist MSK clinic. This would satisfy a number of the findings synthesised in this research. First it would provide reassurance to patients who would be less challenged in their tendency to view the GPs as the legitimate FPC

practitioner and it would further reassure patients who had concerns over the 'seriousness' of their complaint. Second it would strengthen the MDT working within general practice. Thirdly, it would introduce a MSK clinical expert, in the physiotherapist, into the general practice and in doing so would allow for upskilling across the whole practice team. Finally, this co-working would allow for the maintenance of the GP–MSK skill set, the loss of which was a concern expressed in doctors' initial reaction to FPCP. This would also allow for a more systematic attempt to model service capacity with anticipated demand associated with patients experiencing MSDs. As such, it would allow for a more accurate evaluation of the impact of FPCP on the remaining GP workload. Clinical and financial, resource utilisation, comparisons could also be evaluated.

Beyond this there is the opportunity to do a more controlled trial of FPCP compared to usual GP care with both clinical and economic outcome measures. The researcher is committed to these opportunities.

9.7 – Closing reflections

FPCP undoubtedly has the potential to significantly contribute to the current primary care agenda. FPCP has demonstrated clinical efficacy, patient and GP satisfaction and early signs of financial benefit (Webster et al., 2008; Ludwigsson and Enthoven, 2012; Goodwin and Hendrick, 2016). To date, FPCP has not been implemented with sufficient capacity to result in a demonstrable impact on the pressures faced by general practice. This is common to other initiatives that have sought to introduce alternatives to GP care (Brant et al., 2018). Whether this has been due to lack of physiotherapy impetus, commissioner vision or GP resistance is not clear. However, this current research identified the pervasive nature of medical dominance in the healthcare system. Despite evidence of patient support for direct access from this research and previous literature (Webster et al., 2008) the public cannot be relied on to campaign for FPCP. As such physiotherapy, as a profession, has a responsibility to advocate for FPCP.

A theme that ran throughout this thesis was that of the sociology of the professions. As such this thesis concludes with a reflection that is altogether wider and potentially more concerning for the profession of physiotherapy. In their recent book The Future of the Professions (Susskind and Susskind, 2015) paint two visions of the future for the professions. The first is a familiar one with professionals operating as they always have but making use of technology to streamline their work. The second vision is very different with a wholesale transformation where increasingly capable systems actually displace much of traditional professional work.

At first glance this vision may not seem applicable to a 'caring' profession such as physiotherapy. Indeed an online tool that calculates an occupations risk of automation (BBC, 2015a) has physiotherapy ranked 335th most at risk out of 366 occupations. However, it is likely that this analysis was based on a physiotherapy profession that worked in the paradigm of the 'body-as-machine' (Nicholls and Gibson, 2010; Nicholls, 2018) and the biomedical approach to treatment that served the profession so well during most of the twentieth century. The literature suggests that physiotherapists, in their management of MSDs, have sought to apply a more humanistic approach, turning away from the biomedical model and the application of technical skills such as palpation, mobilisation and manipulation to one employing a BPS approach (Jones, Edwards and Gifford, 2002; Foster et al., 2003; Nichols, 2018). This turn is evident in the systematic rise of physiotherapeutic literature integrating various psychological interventions within physiotherapy. These include acceptance and commitment therapy (Godfrey et al., 2016), cognitive behavioural therapy (Hall et al., 2018), cognitive functional therapy (O'Sullivan et al., 2018), pain science education (Louw et al., 2016) and mindfulness (Phillips and Harris, 2019). Although a recent systematic review suggested the integration of psychological interventions enhanced physiotherapeutic interventions (Chester et al., 2018) it also reported poor quality research and suggested caution in interpreting the findings. The evidence repeatedly suggested that although physiotherapists appreciated the importance of using psychological interventions they lacked understanding and confidence in their application (Alexanders,

Anderson and Henderson, 2015; Driver et al., 2017; Richmond et al., 2018). The question arises are physiotherapists best placed to deliver care using these predominantly psychological interventions? Furthermore, these psychological interventions are themselves vulnerable to the advancing tide of technology with growing evidence to support the use of online psychotherapeutic approaches (Titov et al., 2015; Spijkerman, Pots and Bohlmeijer, 2016).

Might physiotherapists, currently engaged in the management of MSDs "*share the fate not of nineteenth-century wagon drivers- who switched to driving taxis- but of nineteenth-century horses, who were increasingly pushed out of the job market altogether"* (Harari, 2018. 30). However, to date online health consultation smartphone applications have not been a panacea with concerns over accuracy, the diversion of funds from essential services and actual increases in GP workload (Iacobucci, 2017, 2018; Rimmer, 2018). Nevertheless, the future for the professions is uncertain.

Somewhat reassuringly, physiotherapists have repeatedly shown their ability to adapt (Nicholls, 2018). This was evident in physiotherapy's response to the call for more masseurs in the World War I, how the profession embraced the EBM paradigm and the more recent adoption of the BPS framework. This research described FPCP as physiotherapy's most recent adaptation as it seized an opportunity created by the pressures faced by general practice (NHS England, 2014). The call for novel models of service design and delivery provided physiotherapy with an opportunity, or gap (Elden, 2017), to pursue the FPCP initiative, conceptualised as a professional project.

The lessons from this research will be helpful to stakeholders looking to maximise the potential of FPCP. In so doing FPCP can contribute to relieving some of the pressures faced by general practice and importantly provide the most appropriate care for patients.

It feels apposite that the final observation comes from a patient participant. It is, after all, patients who are set to benefit most from the maximisation of the FPCP initiative. One hundred and fifty years ago an individual, living outside London,

was as likely to have a 'tooth pulled' by a barber-surgeon or grocer. The success of dentistry's professional project is evident in the monopoly the profession went on to achieve. No one is now likely to see their GP for a toothache. Asked whether they could foresee physiotherapy attaining an equivalent monopoly in the market of MSDs management a patient participant responded thus:

Patient_5

> *Yeah. And the thing is the older population; in fifty years they're all going to be gone, obviously. The 30–40 range which I reckon would use it really, are going to be the old people then which will be using it because they've always used it. And the younger people, they'll be telling the younger people obviously, so they'll be using it. So I reckon it will take some time. Yeah, I mean Rome weren't built in a day, was it. And I think, you know, to get things rolling, you know, it's going to take time, you know, patience.*

INTERVIEWER

> *Because I often think like dentists, you know, if you had a bad toothache you wouldn't go to the GP would you? So you know, I sometimes think well perhaps there'll come a time when people wake up with a bad back they won't think of going to the GP, they'll think of going to the…* [physio]*?*

Patient_5

> *That's right, yeah. But like I say, it all starts, say this is when it starts, but you need the right kind of promotional things to get it going. And that timescale might be decades for that…It is because like I say, older people are blinkered, you know, a lot of them don't want to change their ways, still go to the doctors. But the age range just behind us who are moving up, they are going to be the ones, and then they are going to be passing the knowledge down obviously, to the younger people or the middle-aged people. Until it will be, you know, just if you hurt yourself oh yeah, I'll go to physio, you know.*

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Yeung, H.W.C., 1997. Critical realism and realist research in human geography: a method or a philosophy in search of a method? Progress in Human Geography, 21(1), 51−74.

Zadro JR, O'Keeffe M, Maher CG Evidence-based physiotherapy needs evidence-based marketing Br J Sports Med Published Online First: 27 October 2018. doi: 10.1136/bjsports-2018-099749.

Appendices

Appendix 1: Characteristics and contribution of literature

Reference	Methods	Population	Conceptual richness/Thicker description but not conceptually rich/Thinner description	What is the value? (considerable, valuable, limited value)
Bélanger, E. and Rodríguez, C., 2008. More than the sum of its parts? A qualitative research synthesis on multidisciplinary primary care teams. Journal of interprofessional care, 22(6), pp.587–597.	Qualitative research synthesis of multidisciplinary primary care teams. Taxonomic analysis of n ineteen qualitative studies about primary care teams in peer reviewed journal, 2001−2008.	Primary care multidisciplinary teams	**Conceptually rich**	**Valuable** Contributes to: Programme theory 2
Bury, T.J. and Stokes, E.K., 2013. A global view of direct access and patient self-referral to physical therapy: implications for the profession. Physical therapy, 93(4), pp.449–459.	A purposive online survey. Data were analysed using descriptive statistics, and content analysis was used to analyse open-ended responses to identify themes.	Member organisations of the WCPT	**Thinner description**	**limited value** Limited contribution to: Programme theory 1 and Programme theory 2

Bury, T.J. and Stokes, E.K., 2013a. Direct access and patient/client self-referral to physiotherapy: a review of contemporary practice within the European Union. Physiotherapy, 99(4), pp.285–291.	Cross-sectional, online survey using a purposive sample.	European member organisations of the WCPT	**Thinner description**	**limited value** Limited contribution to: Programme theory 1 and Programme theory 2
Dufour, S.P., Brown, J. and Deborah Lucy, S., 2014. Integrating physiotherapists within primary health care teams: perspectives of family physicians and nurse practitioners. Journal of interprofessional care, 28(5), pp.460–465.	Qualitative research using interviews, following interpretive phenomenology. To generate a wide range of perspectives and information-rich data, maximum variation sampling was used.	Twenty individuals from fourteen Local Health Integrated Networks in Ontario. Family practitioners and Nurse Practitioners were almost equally represented. Fifteen participants were female and six worked with a physiotherapist	**Thicker description but not conceptually rich**	**Valuable** Contributes to: Programme theory 2
Ferguson, A., Griffin, E. and Mulcahy, C., 1999. Patient self-referral to physiotherapy in general practice-A model for the new NHS? Physiotherapy, 85(1), pp.13–20.	Twelve-month service evaluation of a self-referral physiotherapy service.	Two fund holding GP practices, Scotland	**Thinner description**	**Valuable** Contributes to: Programme theory 1 and Programme theory 2

Foster, N.E., Hartvigsen, J. and Croft, P.R., 2012. Taking responsibility for the early assessment and treatment of patients with MSK pain: a review and critical analysis. Arthritis research & therapy, 14(1), p.205.	Critical analysis of literature pertaining to arguments for the GP-led and non-GP-led model of early assessment and treatment of patients with MSK pain.	Critical analysis of literature	**Thicker description but not conceptually rich**	**Valuable** Contributes to: Programme theory 1 and Programme theory 2
Goodwin, R.W. and Hendrick, P.A., 2016. Physiotherapy as a first point of contact in general practice: a solution to a growing problem? Primary health care research & development, 17(5), pp.489-502.	Twelve-month prospective service evaluation of a FPCP service with quantitative and descriptive data. Cost-per-case economic evaluation.	Two GP practices, England	**Thinner description**	**limited value** Limited contribution to: Programme theory 2
Holdsworth, L.K. and Webster, V.S., 2004. Direct access to physiotherapy in primary care: now?—and into the future? Physiotherapy, 90(2), pp.64-72.	Twelve-month prospective service evaluation exploring characteristics of direct-access patients.	One semi-urban general practice in Dundee	**Thinner description**	**Valuable** Contributes to: Programme theory 1 and Programme theory 2

Holdsworth, L.K., Webster, V.S., McFadyen, A.K. and Scottish Physiotherapy Self-Referral Study Group, 2008. Physiotherapists' and general practitioners' views of self-referral and physiotherapy scope of practice: results from a national trial. Physiotherapy, 94(3), pp.236-243.	Questionnaire survey containing a mix of open and closed questions were distributed to GPs and physiotherapists at the end of a year-long data collection period.	Sixty-four physiotherapists and ninety-seven GPs with direct experience of implementing systems of FCP to physiotherapy in primary care in Scotland	**Thicker description but not conceptually rich**	**Valuable** Contributes to: Programme theory 1 and Programme theory 2
Ludvigsson, M.L. and Enthoven, P., 2012. Evaluation of physiotherapists as primary assessors of patients with MSK disorders seeking primary health care. Physiotherapy, 98(2), pp.131–137.	An observational, retrospective cohort study reviewing medical records and a separate consecutive non-randomised study of patient satisfaction.	Cohort study – 432 patients with MSK disorders, primarily assessed by a physiotherapist. Satisfaction survey- fifty-one patients primarily assessed by a physiotherapist and forty-two patients assessed by a GP	**Thinner description**	**Valuable** Contributes to: Programme theory 1
Pullon, S., McKinlay, E., Stubbe, M., Todd, L. and Badenhorst, C., 2011. Patients' and health professionals' perceptions of teamwork in primary care. Journal of Primary Health Care, 3(2), pp.128–135.	Qualitative research, in-depth interviews, analysis using inductive thematic analysis.	Two New Zealand urban general practice, two GPs, two Practice Nurses and four patients	**Conceptually rich**	**Valuable** Contributes to: Programme theory 1 & Programme theory 2

Shoemaker, M.J., 2012. Direct consumer access to physical therapy in Michigan: challenges to policy adoption. Physical Therapy, 92(2), pp.236–250.	The Policy Analysis Triangle approach analysing the Michigan House Bill 5618 (Direct consumer access to physical therapy).	Michigan State, USA	**Thicker description but not conceptually rich**	**Valuable** Contributes to: Programme theory 1 and Programme theory 2
Soklaridis, S., Oandasan, I. and Kimpton, S., 2007. Family health teams: Can health professionals learn to work together? Canadian Family Physician, 53(7), pp.1198–1199.	Qualitative research, focus groups, analysis using grounded theory.	Thirty-six participants from nursing, pharmacy, speech language pathology, occupational and physical therapy, social work, and family medicine	**Conceptually rich**	**Valuable** Contributes to: Programme theory 2
Swinkels, I.C., Kooijman, M.K., Spreeuwenberg, P.M., Bossen, D., Leemrijse, C.J., van Dijk, C.E., Verheij, R., de Bakker, D.H. and Veenhof, C., 2014. An overview of 5 years of patient self-referral for physical therapy in the Netherlands. Physical therapy, 94(12), pp.1785–1795.	Five-year evaluation of national self-referral physiotherapy service using longitudinal electronic medical record data from general practitioners and physical therapists. Descriptive statistics and multilevel regression analyses used to analyse the data.	Netherlands general practice and FCP physiotherapy	**Thinner description**	**Valuable** Contributes to: Programme theory 1 and Programme theory 2

Webster, V.S., Holdsworth, L.K., McFadyen, A.K., Little, H. and Scottish Physiotherapy Self-Referral Study Group, 2008. Self-referral, access and physiotherapy: patients' knowledge and attitudes—results of a national trial. Physiotherapy, 94(2), pp.141–149.	Service evaluation using mixed methods questionnaire.	Twenty-six locations throughout Scotland, 3010 patients	**Thicker description but not conceptually rich**	**Valuable** Contributes to: Programme theory 1
Xyrichis, A. and Lowton, K., 2008. What fosters or prevents interprofessional team working in primary and community care? A literature review. International journal of nursing studies, 45(1), pp.140–153.	Literature review including ten papers using thematic analysis.	Primary care or community teams. Staff included GPs, practice nurses, practice managers, administrators, AHPs (including physiotherapists but not specifically)	**Conceptually rich**	**Valuable** Contributes to: Programme theory 2:

Appendix 2: Table of CMO configuration elements

Element	Description	Source
Context		
Context[1]	In context of FPCP	2,3,4,5,6,7,8,9,10,12,14,15
Context[2]	In the context of existing public support	2,3,15
Context[3]	In the context of existing low level of public awareness of FPCP	2,3,9
Context[4]	In the context of existing low level of public understanding of FPCP	2,3,9,11,15
Context[5]	In the context of places where advocacy strategies had been implemented	5,8,9,15
Context[6]	In the context of embedded FPCP services	1,5,10,14
Context[7]	In the context where the usual default FPC is the GP	6,12,15
Context[8]	The FPCP initiative provides the context of a professional project	2,3,4,5,6,7,8,9,10,12,14,15
Context[9]	In the context of the existing political policy of the time	7,8,12,15,
Context[10]	In the context of older GPs	11
Context[11]	In the context of where GPs had worked alongside physiotherapists	4,5,9,10
Context[12]	the context of negotiating team roles	1,13,16
Mechanism-Resource		
M-Resource[1]	Advocacy strategies as a programme resource	2,3

M-Resource[2]	Service user support as a resource	2,3
M-Resource[3]	Advocacy strategies should use a variety of media	2,3
M-Resource[4]	Advocacy strategies should be tailored to different stakeholders	2,3
M-Resource[5]	Advocacy strategies should be targeted locally	9
M-Resource[6]	Advocacy strategies should be targeted nationally	9
M-Resource[7]	Advocacy strategies using publicity in local papers	5
M-Resource[8]	Advocacy strategies using posters displayed in health centres	5,8,9,15
M-Resource[9]	Advocacy strategies using newsletters	8,9,15
M-Resource[10]	Advocacy strategies using word of mouth dissemination by primary care team	8,9,15
M-Resource[11]	Visibility of FPCP services as a resource	10,11,14
M-Resource[12]	Certain patient demographics as resources	5,8,14,15
M-Resource[13]	Autonomous health seeking behaviours as a resource	8,11,15
M-Resource[14]	Identification of GP as legitimate first choice practitioner as a resource	6,11,12,15
M-Resource[15]	Historically situated trust in the GP as a resource	6,11
M-Resource[16]	Perception of more trivial health complaint as a resource	5,10,11,15

M-Resource[17]	Arguments of justification for FPCP as resources	2,3,9
M-Resource[18]	Political arguments as a resource	1,2,3,8,9,12,15
M-Resource[19]	The evidence base for FPCP as a resource	2,3,4,5,6,7,8,9,10,12,14,15
M-Resource[20]	A continuing educational curriculum as a resource	1,2,4,5,6,9,12,14
M-Resource[21]	The resource of the FPCP initiative as a challenge to the traditional hierarchical medical model of healthcare delivery	1,6
M-Resource[22]	Mature relationships as a resource	4,5,9,10
M-Resource[23]	Negotiated roles and role boundaries as a resource	1,13,16
M-Resource[24]	GPs taking a lead role in negotiating team roles	16
M-Resource[25]	GP input in negotiating team roles as a resource	1,13,16
M-Resource[26]	Physiotherapy assertion in negotiating processes as a resource	16
Mechanism-Reasoning		
M-Reasoning[1]	An increase in public awareness of FPCP	2,9,14
M-Reasoning[2]	Physiotherapist not prioritising advocacy strategies directed at the public	2,3
M-Reasoning[3]	An increase in public understanding of FPCP	9,10,11,15
M-Reasoning[4]	No systematic planning or assessment of advocacy strategies	5,8,9,15

M-Reasoning[5]	An increase in public confidence in FPCP	6,9,15
M-Reasoning[6]	An increase in public familiarity with FPCP	10,14
M-Reasoning[7]	An increase in public support for FPCP	11,15
M-Reasoning[8]	An increase in public satisfaction with FPCP	7,9,10,11,15
M-Reasoning[9]	Public have most certainty in GP role	11,
M-Reasoning[10]	Public have most confidence in the clinical competence of the GP	10,11
M-Reasoning[11]	Stakeholders reassured	1,2,3,4,5,6,7,8,9,10,12,14,15
M-Reasoning[12]	GPs threatened by FPCP	1,
M-Reasoning[13]	GP resistance to FPCP	4,11,12,13,16
M-Reasoning[14]	GP comfort with FPCP	4,5,9,10,11
M-Reasoning[15]	GP support for FPCP	4,5,9,10,11
M-Reasoning[16]	GP acceptance of a redistribution of power	13,16
Outcome		
Outcome[1]	Increased utilisation of FPCP	5,9,10,14,15
Outome[2]	Increase in professional jurisdiction for physiotherapists	2,3,4,5,6,7,8,9,10,12,14,15
Outome[3]	Collaborative working	1,4,6,13,16

Key to Appendix 2

1. Bélanger, E. and Rodríguez, C., 2008. More than the sum of its parts? A qualitative research synthesis on multidisciplinary primary care teams. Journal of interprofessional care, 22(6), pp.587–597.
2. Bury, T.J. and Stokes, E.K., 2013. A global view of direct access and patient self-referral to physical therapy: implications for the profession. Physical therapy, 93(4), pp.449–459.
3. Bury, T.J. and Stokes, E.K., 2013a. Direct access and patient/client self-referral to physiotherapy: a review of contemporary practice within the European Union. Physiotherapy, 99(4), pp.285–291.
4. Dufour, S.P., Brown, J. and Deborah Lucy, S., 2014. Integrating physiotherapists within primary health care teams: perspectives of family physicians and nurse practitioners. Journal of interprofessional care, 28(5), pp.460–465.
5. Ferguson, A., Griffin, E. and Mulcahy, C., 1999. Patient self-referral to physiotherapy in general practice-A model for the new NHS? Physiotherapy, 85(1), pp.13–20.
6. Foster, N.E., Hartvigsen, J. and Croft, P.R., 2012. Taking responsibility for the early assessment and treatment of patients with musculoskeletal pain: a review and critical analysis. Arthritis research & therapy, 14(1), p.205.
7. Goodwin, R.W. and Hendrick, P.A., 2016. Physiotherapy as a first point of contact in general practice: a solution to a growing problem? Primary health care research & development, 17(5), pp.489–502.
8. Holdsworth, L.K. and Webster, V.S., 2004. Direct access to physiotherapy in primary care: now?—and into the future? Physiotherapy, 90(2), pp.64–72.
9. Holdsworth, L.K., Webster, V.S., McFadyen, A.K. and Scottish Physiotherapy Self-Referral Study Group, 2008. Physiotherapists' and general practitioners' views of self-referral and physiotherapy scope of practice: results from a national trial. Physiotherapy, 94(3), pp.236–243.
10. Ludvigsson, M.L. and Enthoven, P., 2012. Evaluation of physiotherapists as primary assessors of patients with musculoskeletal disorders seeking primary health care. Physiotherapy, 98(2), pp.131−137.
11. Pullon, S., McKinlay, E., Stubbe, M., Todd, L. and Badenhorst, C., 2011. Patients' and health professionals' perceptions of teamwork in primary care. Journal of Primary Health Care, 3(2), pp.128–135.
12. Shoemaker, M.J., 2012. Direct consumer access to physical therapy in Michigan: challenges to policy adoption. Physical Therapy, 92(2), pp.236–250.
13. Soklaridis, S., Oandasan, I. and Kimpton, S., 2007. Family health teams: Can health professionals learn to work together? Canadian Family Physician, 53(7), pp.1198–1199.
14. Swinkels, I.C., Kooijman, M.K., Spreeuwenberg, P.M., Bossen, D., Leemrijse, C.J., van Dijk, C.E., Verheij, R., de Bakker, D.H. and Veenhof, C., 2014. An overview of 5 years of patient self-referral for physical therapy in the Netherlands. Physical therapy, 94(12), pp.1785–1795.
15. Webster, V.S., Holdsworth, L.K., McFadyen, A.K., Little, H. and Scottish Physiotherapy Self-Referral Study Group, 2008. Self-referral, access and physiotherapy: patients' knowledge and attitudes—results of a national trial. Physiotherapy, 94(2), pp.141−149.
16. Xyrichis, A. and Lowton, K., 2008. What fosters or prevents interprofessional team working in primary and community care? A literature review. International journal of nursing studies, 45(1), pp.140–153.

Appendix 3: Ethics favourable opinion

NHS
Health Research Authority

North West - Haydock Research Ethics Committee
3rd Floor - Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0207 104 8012

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

11 August 2016

Professor Pip Logan
Professor of Rehabilitation Research and Occupational Therapist, Head of Division Rehabilitation and Ageing
University of Nottingham
Room B108a Medical School, Queen's Medical Centre
Nottingham
NG7 2UH

Dear Professor Logan

Study title:	**Exploring the role of the professions in the implementation of self-referral physiotherapy as an alternative to GP care: A qualitative study**
REC reference:	**16/NW/0618**
Protocol number:	**16055**
IRAS project ID:	**200346**

The Proportionate Review Sub-committee of the North West - Haydock Research Ethics Committee reviewed the above application on 11 August 2016.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Ms Rachel Katzenellenbogen, nrescommittee.northwest-haydock@nhs.net. Under very limited

circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Favourable opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. Provide evidence of insurance.
2. Make the following changes to the Participant Information Sheets:
    a. Inform participants that the interviews and focus groups will be digitally recorded.
    b. Advise participants on who will transcribe the recordings and when the recordings will be destroyed.
3. In point 4 on all the consent forms specify "digitally recorded" rather than just recorded.

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

Summary of discussion at the meeting

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

The Committee noted that the insurance certificate had expired and requested new evidence of insurance.

Informed consent process and the adequacy and completeness of participant information

The Committee noted the Initial Assessment for REC and agreed that the Participant Information Sheet should inform participants that the interviews and focus groups would be digitally recorded. Further the consent form should specify "digitally recorded" in point 4.

The Committee agreed that the Participant Information Sheet should also advise participants on who would transcribe the interview or focus group recordings and when the recordings would be deleted.

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
Covering letter on headed paper		

Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]		21 July 2015
Interview schedules or topic guides for participants [Programme theories]	Version 1	01 August 2016
IRAS Application Form [IRAS_Form_27072016]		27 July 2016
Letter from sponsor [Sponsor letter]		01 June 2016
Other [Application clarification (email)]		01 August 2016
Participant consent form [Consent/Focus Group]	Version 1	01 August 2016
Participant consent form [Consent/Interview]	Version 1	01 August 2016
Participant information sheet (PIS) [PIS/GP]	Version 1	01 August 2016
Participant information sheet (PIS) [PIS/Commissioner]	Version 1	01 August 2016
Participant information sheet (PIS) [PIS/Patient]	Version 1	01 August 2016
Participant information sheet (PIS) [PIS/Physio]	Version 1	01 August 2016
Research protocol or project proposal [Protocol]	Version 1	01 August 2016
Summary CV for Chief Investigator (CI)		
Summary CV for student		

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form

available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

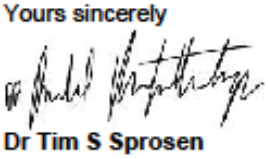
HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

16/NW/0618	Please quote this number on all correspondence

Yours sincerely



Dr Tim S Sprosen
Chair

Email: nrescommittee.northwest-haydock@nhs.net

Enclosures: List of names and professions of members who took part in the review

"After ethical review – guidance for researchers"

Copy to: Ms Angela Shone, University of Nottingham
Mrs Shirley Mitchell, Nottingham CityCare Partnership

Appendix 4: Participant information sheet – patient version

Division of Rehabilitation and Ageing
School of Medicine
University of Nottingham
Medical School
Nottingham, NG7 2UH

Participant Information Sheet- **Patient**

Version 3

8th June 2017

Title of Study: Exploring the role of the professions in the implementation of self-referral physiotherapy as an alternative to GP care: A qualitative study

Name of Researcher(s): Mr Rob Goodwin, Clinical Lead Physiotherapist and PhD candidate

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

This study is about understanding your views about self-referral physiotherapy for patients with musculoskeletal (MSK) problems. This has been offered as one solution to the problems faced in primary care – patients see a physiotherapist instead of, or before, a GP. This sort of service appears to be useful in managing these sorts of problems but so far it is only available in parts of the country.

We are aiming to explore what people think about self-referral physiotherapy to see if we can learn about the best ways of implementing it and if there are any barriers.

Why have I been invited?

You are being invited to take part because you have seen a physiotherapist in this way- without seeing your GP first.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you agree to take part you will be offered a convenient date and time to come in and chat with the researcher. This will be done by the researcher who will contact you to arrange a date and time. This will be at a local health centre.

The researcher will lead a discussion about self-referral physiotherapy. The researcher will come with some questions to guide the conversation but it will be quite informal.

The discussion will take between 30–90 minutes. You will only need to do this once and then your involvement will finish.

The discussion will be digitally recorded and following the discussion the researcher will write the discussion down to allow them to look more closely at what was said. After the research project has been completed the recordings will be destroyed.

Expenses and payments

Participants will not be paid to participate in the study. Travel expenses will be offered for any visits incurred as a result of participation.

What are the possible disadvantages and risks of taking part?

If you agree to take part the discussion group described above is all you will have to do. As such there is no real risk in taking part. However, if you feel distressed by anything that happens before, during or after the discussion group you can contact the researcher for support at any time.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help us understand how services like self-referral physiotherapy can play a role in helping primary care service development in the future.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. The researcher's contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Nottingham CityCare PALS (Patient advice and liaison service) on 0115 8839600.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept strictly confidential, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (address, telephone number) will be kept for 1 year after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?

The results of the study will be written up as part of the researchers PhD thesis. They may also be written up and published as journal articles. They may also be delivered at conferences. This is likely to be in 2018. In all cases you will not be personally identified.

Who is organising and funding the research?

This research is being organised by the University of Nottingham.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by North West - Haydock Research Ethics Committee.

Appendix 5: Participant consent form – focus group version

Division of Rehabilitation and Ageing
School of Medicine
University of Nottingham
Medical School
Nottingham, NG7 2UH

CONSENT FORM/ FOCUS GROUP

Version 2
31st August 2016

Title of Study: Exploring the role of the professions in the implementation of self-referral physiotherapy as an alternative to GP care: A qualitative study

IRAS Project ID: 200346

Name of Researcher: Mr Rob Goodwin

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 2 dated 31/08/2016 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐ ☐
4. I understand that the focus group will be digitally recorded and transcribed and that anonymous direct quotes from the focus group may be used in the study reports. ☐
5. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person taking consent Date Signature

2 copies: 1 for participant, 1 for the project notes

Appendix 6: example interview guide

1. Patient knowledge

Knowledge

Do you think that people have heard of physiotherapy?

Where/how do you think people have heard of physiotherapy?

What do people think physiotherapists do?

Where do you think they have got that knowledge?

You have been to physiotherapy- does that knowledge of what physiotherapists do match with your experience?

What did you think physiotherapists did before you went?

Where did you get your idea of what physiotherapists do?

So the first topic I want to talk about is patient knowledge of first point of contact physiotherapy

The evidence seems to suggest that most people don't know much about physiotherapy. Would you agree with this? What makes you say that?

And now FPC physiotherapy;

If I went into the waiting area and asked people if they knew what FPC physio was- do you think they would have an idea?

Do you think people generally know what FPC physio is?

As a patient would you say that before you went to see the FPC physio you had any idea of what it was?

Alternative explore if yes or no

What was the idea you had?

How did you get that idea?

Was it from talking to other people, from previous experience?

Was what you experienced when you went similar to the idea you had beforehand,

How did you hear about the FPC service in your own case? Were you aware of any advertising for the service? Were you aware of any information about what the FPC service was?

Do you think the FPC service could have been better advertised? What suggestions would you make to improve how the service could be advertised?

My reading tells me that physios are generally poor at advertising themselves- have you ever seen any adverts from physios? Is this something you think they could improve?

If the admin staff told you about it can you remember what they said? Was what they said to you clear, did it make sense, did they seem to know what they were talking about? Did they give you a choice about going or did you feel you had no

choice in the matter? Did you feel they intruded into your personal health when they spoke to you?

Patient demographics

My research tells me that the people who are most likely to use FPC physio are younger, generally men, are in work and maybe even have gone to

Can you tell me why you think that might be the case?

Do you think there are any more people who take an interest in their health/managing their own health than latter years?

Why do you think this is happening- can you think of any other initiatives that are doing this (eating/exercise)?

Do you think there are certain types of people who welcome these ideas? And what about certain people who don't?

NHS hierarchical structure

Do you think there is a hierarchy in the NHS?

Describe that hierarchy to me

Why do you think this exists?

Do you think it is changing at all- -people have spoken about doctors having a god like status- would you agree with this? Why do you think this is the case? Can you see that changing?

Do you think that is an obstacle to ideas like FPC physio? Why? What can be done about that to realise the full potential?

So you saw a physio in the FPC service but what might make **you** choose to see the GP rather than someone else

So there would never be/there would be a time when you might not choose to use a service like the FPC physio service?

There is some information that says that people still see the GP as 'top of the tree' in the NHS and would choose to see their GP first- most of, if not all of the time. Can you see that happening at all?

2. Professionalism

The next topic is what we call professionalism. This is where people think that there are some tensions between doctors and physios because physios might be seen, by some doctors, as taking over some of their roles by seeing patients before, or without, seeing their GP

BMA statement- what might make them say something like that? What might be their worries?

Some people say professions protect themselves against others- do you think there might be an element of that?

What do you think of that idea?

What makes you say that?

So you have never seen or heard of any resentment from either GPs or physios about the other? Do you think, from your experience, that there is any tension?

So do you think GPs generally think well, or less well, about physios?

And what makes you say that?

So do you think GPs know what physios do, or not? What makes you say that?

And what about GPs knowledge of MSK problems- do you think they know much?

And what about MSK problems- who do you think is best to see people with MSK problems? And do you think this applies to people generally?

So if that is the case why might people still choose to see the GP?

And the same question as before- if you have what you thought was a MSK problem- is there ever a time when you would still choose to see the GP rather than the physio? Why?

Appendix 7: Reflective diary (Excerpt)

1. Administration group 1

Post interview. 3 o'clock. Just completed admin first focus group.

The group took approx. 45 minutes and my thoughts are that it went ok. I think the first 2/3 to ¾ went well I think I was quite reflexive during the interview and demonstrated flexibility in jumping around topics as they came up. I am not quite sure if I dug quite as deeply as I wanted to but at times I am sure I can remember thinking that was interesting. So I need to listen back to it and just get an idea of whether dig deep enough and if any mechanisms came out and if I ned to make any changes to the schedule.

I was aware once or twice that I perhaps brought in some of my own personal experiences of having been involved with Cripps as a clinician and as a service lead in having developed the service. So what I mean by that I was involved in designing the training which they spoke about in the interview and I worked there so they had some familiarity of me as an actual clinician working in the service. Not that I think that influenced the content of what they said but just in term of the line between being a clinician and a researcher. This was just an awareness I had. But what I am aware of is that the potential tensions of the dual role had is that I spoke about some stuff wasn't the interview schedule and as such wasn't necessarily borne out in the realist review itself. This came more from experiential evidence from having been so involved clinically. It will be interesting listening back to the tape top see whether what we spoke about could be aligned to the programme theories that can form he review or outside of that framework.

2. Administration group 2 & GP interview 1

This is just a bit of reflection after having done 2 interviews this afternoon. The first one was with the admin staff from Practice 2. There were 5 of them and I thought it went quite well really. I had made some adjustment of my questions which I think worked well and I think I got a little bit more information. I did listen to the tape last night and again this morning and I don't think it went too badly and then I have just done my first GP interview which I think went quite well I think I will need to listen back to it. It seems that there is not a lot of interprofessional tension from the people I have spoken to so far.

3. Patient interviews 3 & 4

I have slightly revised my interview schedule following yesterday's patient interview. I have just made some slight adjustments. This is to make an attempt to pull out more of the mechanisms so these have been framed in terms of why? I'm aware that I have had a bit of a rush in the traffic and as such I'm a bit flustered but my general sense is that again I am looking forward to the interviews.

I have just finished the first of two patient interviews this afternoon and again I keep being left with the feeling that it's gone okay. It took about 45 minutes and we work through all of the topics but I still have a sense of uncertainty as to whether I am uncovering any of the mechanisms that lie behind the topics that I am talking about. I'm not sure whether this will become more apparent when I listen and read the transcripts having got them back. However I am finding this a little bit unnerving having this sense of uncertainty about the mechanisms and the depth of the interviews. Also, I felt that I pushed this patient quite a lot with regards to professional issues to the point where they said they were surprised with regards to the aspect of conflict. She said she hadn't thought of that so I'm a little bit mindful that I may be guiding the questioning. However it did come up spontaneously in the interview yesterday so I will just have to persevere with this topic. I have the sense that this will be important to dig with the GP and participants

4. Patient interview 8

It's 16 November and I have just finished my 8th patient interview. It only took half an hour and it almost feels like I am reaching a bit of saturation in terms of the answers that I'm getting back and that I can almost predict what they are going to say. It feels like a lot of the subjects are being repeated now and I may be seeing some saturation.