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Exploring what patients with musculoskeletal conditions want from first point of contact health practitioners

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Abstract

Objectives

This research was conducted to support the development of the Musculoskeletal (MSK) Health Capabilities Framework to ensure the framework reflected patients' priorities. The aim of this study was to explore what patients with MSK problems want from their initial consultation with a first contact health practitioner and from the patient perspective what characterises a good first contact health practitioner..

Methods

Focus groups were held in four locations across England. Sixteen participants with a self-declared MSK condition aged 19 to 75 took part (11 female, five male). Participants discussed the questions they want answered when first going to see a health professional about a MSK problem and how they would describe a good first contact health provider.

Results

Participants wanted answers to questions about: the nature of the problem, the management of the problem, where to get information and support to help themselves, what activities they can do and what the future holds. Values and behaviours they expect and value from first contact health practitioners include: good communication skills, appreciation of impact, a willingness to discuss alternative and complementary therapies, shared decision making and an awareness of own limitations and when to refer.

Conclusion

The MSK core capabilities framework for first contact health practitioners aims to ensure a person-centred approach in the first stages of managing any MSK problem a person may present with. The focus groups enabled the developers of the framework to achieve a greater understanding of patient priorities, expectations and needs and allowed the patient perspective to be included in this national framework.

Keywords

Musculoskeletal, first contact health practitioners, national framework, patients, qualitative.

Key messages

1. Findings from the study enabled the patient perspective to be included in the MSK Health Capabilities Framework.
2. The varied nature of MSK conditions and patients' diverse care journeys makes identifying priorities challenging.
3. Patients want to be supported to manage and make informed decisions about their own health.

Introduction

Musculoskeletal (MSK) conditions are the single biggest contributor to the growing burden of disability in the UK (1). MSK conditions have an enormous impact on the quality of life for millions of patients. They account for more than 100 million General Practitioner (GP) appointments each year and cost the National Health Service (NHS) nearly £5 billion per year (2). Whilst most NHS patients with an MSK problem will initially present to their GP they may present to a wide array of health professionals working in the community including nurses, podiatrists, physiotherapists, occupational therapists and others. Most of these professionals are not specialists in MSK health. For people presenting with undiagnosed MSK conditions to receive appropriate care, first contact health practitioners need to have the necessary knowledge, skills and behaviour to deliver a service that meets their needs. Before 2018, in England, there was no framework outlining the competencies required by first contact health practitioners to work with patients with MSK conditions. Therefore Health Education England and NHS England Medical Directorate commissioned the development of a MSK core capabilities framework in order to support the transformation of services, placing skilled MSK practitioners earlier in patient pathways. From its inception the framework focused on the workforce capability to support shared decision-making, care and planning, as well as prevention, self-management, fitness for work and meaningful behaviour change. Patient-centred care is at the heart of the framework and as such it is consistent with the Person-Centred Approaches framework which was published in 2017 (3).

The MSK core capabilities framework was developed using a modified Delphi consensus approach combining existing literature with the views of a heterogeneous, multi-professional group of expert clinicians and patients to identify core capabilities and behaviours needed by first contact practitioners(4). In addition, the project management group sought to include the voice of non-expert patients in the framework. This article describes this process and its outcomes. It also adds to the existing United Kingdom (UK) research exploring what patients with MSK problems want from their GPs and other first contact practitioners, in addition to their expectations of GPs in relation to MSK health (5-9). The aims were to explore what patients with MSK problems want from their initial consultation with a first contact health practitioner and to explore with patients what characterises a good first contact health practitioner.

Methods

Participants

Focus groups were held in four locations across England: Cornwall, Preston, Leeds, and London. Participants were recruited through local patient support groups, public-patient involvement groups, postings on social media sites relating to MSK health and advertising in local media. Participants were aged 18 or over with a self-declared MSK condition (current or within the last year). Sixteen participants aged 19 to 75 took part, 11 female and five male. Their conditions included inflammatory arthritis (IA), osteoarthritis, back and neck pain and sports injuries.

Data Collection

The focus groups were facilitated by researchers (JE and KCL) and held for approximately one hour. With the participants' agreement the focus group discussions were digitally recorded and

subsequently transcribed verbatim. The transcriptions were anonymised. JE is a social scientist with a background in public health and KCL is a senior lecturer in physiotherapy. Both facilitators adopted a non-judgemental, open, listening approach being aware of the possible power dynamics that can come into play with patient focus groups. They emphasised their reliance on and appreciation of the participants' knowledge about the phenomena under study, and on their willingness to share. JE emphasised to the groups that she is not a medical professional, encouraging participants to be open about their views.

Focus groups were conducted with the aid of a pre-determined topic guide which was developed following a narrative review of the literature, and informal discussions with clinicians and patients (see Table 1).

Analysis

The focus group transcripts were imported into NVivo v 11 (QSR International, Melbourne, Australia) and analysed using deductive thematic analysis by a researcher (JE) (10). All transcripts were initially reviewed and coded. Through an iterative process of reviewing transcripts and generating codes, the codes were further refined, grouped into concepts where similarities amongst codes existed, and key themes developed. One of the transcripts was independently coded by another researcher (MB) to check the degree of agreement between the two coders and to highlight alternative interpretations. The number of coders was restricted to two because of study time restraints. The two researchers were in general agreement in the coding of each specific unit and there were no significant areas of disagreement. Despite the different conditions and the different patient journeys taken of participants the key messages in relation to what patients with MSK problems want from their initial consultation with a first contact health practitioner and what characterises a good first point of contact health practitioner were very much shared. The analysts felt confident that data saturation, defined as the degree to which new data repeat what was expressed in previous data, was achieved.

The project complies with the Declaration of Helsinki. This research project was approved by the University of Leeds Ethics panel, ethics reference number MREC 16-009. Written informed consent was obtained from the focus group participants.

Results

It soon became apparent from the focus groups that the variation in the patients' journey according to the duration of MSK problem (i.e. acute, a recurring problem or long term) meant that neatly dividing questions into "first visit" and "follow-up visit" as was initially intended, did not match well with the patients' experience. Participants with long term conditions suggested that each episode of recurrence or exacerbation could be seen as a "first visit", e.g. a person with long term low back pain would need to re-access the health system for subsequent exacerbations. Therefore, the questions they may have and their expectations of their first contact health practitioner, are informed by previous consultations, experiences, and the nature of their condition. Consequently, in the analysis we have not categorised responses by first and follow-up visit but have looked more broadly at the key concerns of people in the first stages of presenting with an MSK problem. These concerns can be grouped into five key themes which are described below:"

QUESTIONS THAT PATIENTS WANT ANSWERED

1. The nature of the problem

When they go to see a first contact health practitioner about their MSK problem participants want to know **what is wrong and what is the cause of their problem**. However, they did not expect all first contact providers to be able to answer these questions. In three of the four focus groups participants expressed doubt that a GP would be able to answer these questions. Some thought it best to see a physiotherapist who were seen as “experts” in MSK problems or, for those with inflammatory arthritis, a rheumatologist.

F4: “GPs are limited, that’s why they are in general practice they have a little bit of knowledge about an awful lot of things but not specialised or in-depth.”

M4: “...not to mean any offense to any GPs but it’s like my back isn’t his speciality I think, so I wasn’t expecting him to know the answers... So I did want to know if he could tell me there and then kind of thing what it was. But he couldn’t at the time, so I also sort of waited for the physio to ask because that’s more of their thing.”

Most participants agreed that they would want to know **what to expect and what the prognosis was** for their condition.

F11: I mean I like to know what the other symptoms are, how long they’re going to last, whether they’re a bacterial thing or something. Whatever the symptoms are however long they’ll be around for, like medication, can they get rid of it. Just like what I’ll do. Just want to feel like I know what’s going on.

However, some participants who had long term IA questioned whether they would ask the first contact provider about their prognosis. They felt that this was a more appropriate for a rheumatology specialist.

M3: Where they [questions about prognosis] probably do come in is with a first appointment with a specialist, but I don’t think you’d ask those at your GP...because you wouldn’t expect GPs to have that knowledge.

2. The management of the problem

Patients wanted to know from their first contact health practitioner **what they could do to help them with their problem**:

M3: Yes, what can you do for me ..., “What can you do about my problem?”...

Patients wanted to know **what treatment is the most appropriate**. Some participants with IA did not expect first contact health practitioners (both GPs and physios were mentioned) to be able to answer this question.

F4: [person with IA] I think some of these questions would be more suited for the consultant level, certainly about treatments. GPs, as I say I do talk to mine and we talk about the biologic drugs, but I

probably have more knowledge than she does about exactly what they do and what they target. So, I think the GPs wouldn't be able to answer some of those questions because they don't have that in-depth knowledge.

How to manage pain and pain medication was an important issue for participants and was discussed in three of the four groups. It was recognised that the pain cannot always be eliminated but how to reduce it to bearable levels was a key question. For some participants the question they wanted answered was how to manage pain without resorting to "strong" medications, they didn't want to be just "palmed off" with pain killers and wanted to know which **management options** they have beyond medication and pain killers:

F6: *"I don't want to have lots and lots of drugs constantly so I may well have a little bit to un-inflate and I might have a bit of painkiller, but I don't want the doctor to say "have drugs go home", I want to get better properly."*

Patients also wanted to know **which management options they have** beyond medication and pain killers:

M2: *"...is there any way you can sort of give me some exercise to reduce the pain. Not to get rid of it, that's an impossibility but something to reduce the pain."*

F1: *"If I did see a GP about my hip, I would want to learn about it, new hip or yoga? Not just painkillers..."*

A question that all the focus groups said was important was **"What can I do to help myself"**. There was a recognition that the participants had to take control of their condition and they wanted to be given support to do this.

F1: *"...what can I do to alleviate it? ... to be able to be in charge of the condition and it not be in charge of you, that's my first priority."*

F7: *"...I wanted something that I felt like I could be in control of so with a physio you know that you're going to go and you're going to get exercises that are going to target the particular problem so that's what I guess I was looking for specifically. Yeah, to be able to manage it a bit better myself..."*

3. Where can I get information and support to help myself?

Participants wanted first contact health practitioners to answer their questions about **where they could get information, especially self-help resources and support**.

F8: *"Yes I think related to asking about what I can do to help myself – exercises, eating and whatever is asking for some information on where I can find stuff about self-help... it would be good if the GP or whoever could tell you about that."*

F6: *"I suppose the other thing I would ask is where can I get support if I need it – are there any groups locally that I can get in touch with?"*

4. What activities can I do?

Participants wanted to know **whether and when they could do the things they needed or wanted to do**; this included work. For some with acute or recurrent problems this was a key reason for going to see the first contact provider:

M4: *“I went and my main two issues at the time were am I still ok to work. Like I wasn’t doing any massive exercise but I was standing up for like 3-8 hours a day I could be standing up constantly so I was worried if pain would come from that.”*

However some participants found first contact health practitioners unable to answer those questions.

F8: *“My husband is a dairy farmer, he can’t just leave the cows and it’s difficult to get help so of course his first question to the GP was when can I get back to work? But to be honest he [GP] couldn’t answer that question.”*

Patients with long term conditions were concerned about their legal rights in relation to employment but felt this was beyond the remit of GPs.

M3: *“Am I able to work? Yes that’s something a lot of people are unsure about, what your legal rights and your employer, how much does he value you and what is he prepared to put up with...I don’t think that’s a question that can be answered directly by the doctor. Obviously he’s not going to counsel you on anything like your legal rights.”*

Other activities that participants wanted to know whether or not they could do and when were sports, going to the gym, activities of daily living such as maintaining personal hygiene and being able to drive.

F1: *“I get a lot of pain across the shoulder. Doing things like washing your hair... functions that are very important to being alive, what I can do?”*

5. The future

Participants were keen to know **how they were progressing and what the future might bring**. They talked about the importance of continuity of care and of being able to build a relationship with their health care provider so as to facilitate an answer to the important questions: **have I made an improvement?** and, **what else can be done?**

F2: *“You go back and then you tell them and you have this dialogue. It is working, my pain’s less, I can move my arm more, so this progression, this dialogue, this relationship, of seeing the same person when you go back, is so important.”*

M2: *“... if you go back and it’s totally different people and you have to reiterate what you said the first time and go through it all over again. If you’ve tried you want to know have I done it properly, can you see an improvement and they could show you where you’ve gone wrong.”*

WHAT MAKES A GOOD FIRST CONTACT PRACTITIONER

Participants were also asked what makes a good first contact health care provider. They came up with a range of skills, knowledge and attitudes which are described in the 6 themes below:

1. Good communication skills:

Participants spoke at length of the importance of first contact health practitioners being able to listen, to put people at ease and to make the patient feel comfortable to ask questions.

F11: "Bedside manner is really important, warm, friendly, open, listening. That's what you need, not to feel like a number."

M5: "Yeah, it's a big one listening. They really need to be able to take on board what you're saying ...You want to feel you can talk to them like your closest friends sort of thing. Obviously you'll never get to that point, but you'll want to feel as comfortable."

2. Appreciation of impact

Participants emphasised the importance of health care providers being empathic and able to appreciate the impact of the MSK condition on their lives. This was particularly true for those with long term conditions.

M1: "... it's the approach. The fact they should have some sort of appreciation of how debilitating it [IA] can be on normal existence. "

3. Being supportive of patients

Participants spoke of the importance of health care providers being supportive of patients and re-enforcing their feelings of self-efficacy.

F7: "With exercises you've got to find time to do them which isn't always easy. Perhaps the only thing I would suggest is more encouraging you and motivating you... Believing in you, so that you can believe in yourself."

4. A willingness to discuss alternative and complementary therapies

For some of the participants it was important that the first contact provider was open to recognising and discussing the patient's use of alternative and complementary medicines.

F 11: "The alternative route, herbal, doctors don't like that. I'm on medication for other things and if I say can I take Echinacea, will that affect my medication?, the doctor says don't ask me I'm a doctor not a herbalist. That's not helpful when you are trying to make a sensible decision. "

F6: "I feel that doctors dismiss alternative options here. It's such a different picture in XX, they advised me to go to yoga, looked at all the options. I think that's very good if they can do that. "

5. Shared decision -making

Participants felt that first contact health care providers should be willing and able to learn from their patients, especially those with long term conditions. They should be open to working with patients to make decisions and to provide the patients with sufficient and accessible information to help them in this process.

F2: "... so the idea of responsibility of yourself ... we have dual responsibility, you're the doctor, I'm the patient. I come and I know a bit more than I used to. You know sometimes more, sometimes less."

F8: "Be person centred, if recommending something explain what it is and why."

6. Awareness of own limitations and when to refer

Following on from this participants felt it was important that first contact health practitioners have sufficient knowledge to be able to know their own limitations and when to refer on. Where health care providers do not know the answer they should be honest and open about it.

M1: "It would be nice if they get someone who doesn't know exactly what they are up against, to admit that they weren't sure however, get them [the patient] in the right place instead of just fumbling away in the dark. ... to say I don't know that but I'll find out."

M5: "It's if they have a baseline knowledge, enough to know roughly the problem and who I should refer you to. As long as they get the next stage right and they are referring you to the right people, giving you the right advice about what you should be doing..."

Discussion

This research was conducted to support the development of the MSK Health Capabilities Framework so as to ensure the framework reflected patients' priorities. It explored what questions patients want answered when they first seek help for their MSK condition and the values and behaviours they expect and value from a first contact health practitioner.

Identifying what questions patients with MSK health problems want answered in the early phases of their condition is challenging because of the varied nature of MSK conditions and of the patients' diverse journeys to care. Some conditions may be acute such as a sports injury, some may be recurrent such as back pain and others may be long term progressive conditions such as rheumatoid arthritis. Depending on the condition and the nature of their patient journey, patients may have different expectations of their first contact health practitioner informed by previous experience. Patients agreed with the majority of the patient questions posited in the draft framework but in addition wanted answers to questions about how they could practically manage their problem and advice on where to obtain information and support.

Patients want first contact health practitioners to be knowledgeable, to be honest and open about when they don't know the answer and to seek expert advice including referral if the problem is not within their capabilities. Evidence suggests that getting the right destination for MSK referrals can be challenging for GPs, with a lack of clarity over whether patients are best sent to physiotherapy, orthopaedics, rheumatology or elsewhere (11). There is also evidence that some GPs are unclear what allied health professionals such as physiotherapists and occupational therapists have to offer (12).

In terms of professional behaviours and values patients emphasised the importance of the practitioner having the ability and inclination to communicate well with the patient, taking the time to explain and discuss options. They also emphasised the importance of continuity of care and of

being treated holistically as an individual, supported and motivated to make the most of their capabilities. A willingness to engage in shared decision making was valued. This supports National Institute for Health and Care Excellence (NICE) guidelines (13) and the emphasis placed on shared decision making by NHS England (14-15).

The findings from the focus groups reinforce the strong messages appearing in other professional frameworks (17-19) that health and social care professionals must work collaboratively with people who use health and community services. For those with IA and other long term conditions there was a wish for the consultation to be a meeting between experts where patients and clinicians can learn from each other. They want to be supported to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health. This echoes the four principles of person-centred care put forward by the Health Foundation (16).

There are several strengths of our study; the focus groups participants included a range of people with differing conditions, health care experience and age; participants came from locations across England and were recruited through a wide variety of methods. JE, the lead facilitator, emphasised to the groups that she is not a medical professional, encouraging participants to be open about their views even if critical of these professionals. In addition the authors have explored an area that to date appears to be have been little researched. A limitation was that the majority of participants had long term conditions and so the views of those with acute conditions were less well represented. In addition, no young women (aged under 25) took part in the groups. The authors are unsure why were unable to recruit any young women to the study. A speculative explanation for this disparity is the possibility that, given young men are more likely to take part in sports and physical activities than young women (20), they are more aware of MSK health and therefore more interested in to take part in the study. Future work must ensure that the voices of young women are heard.

Conclusion

The MSK core capabilities framework for first point of contact clinicians aims to ensure a person-centred approach in the first stages of managing any MSK problem a person may present with. For this to be achieved, first contact health practitioners must meet the expectations and needs of people with a MSK problem, address the concerns they have and foster shared decision-making. The focus groups enabled the developers of the framework to achieve a greater understanding of patient priorities, expectations and needs when first contacting a health practitioner about a MSK problem and allowed the patient perspective to be included in this national framework.

References

1. GBD 2017 Disease and Injury Incidence and Prevalence Collaborators. Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet* 2018; 392(10159):1789-1858.
2. Department of Health. Programme Budgeting Data 2009-10. [Internet] 2011 [cited 11/04/2019} Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216588/dh_119175.pdf
3. Health Education England. Framework to promote person-centred approaches in health and care. [Internet] 2017 [cited 11/04/2019]. Available from <https://hee.nhs.uk/news-blogs-events/hee-news/new-frameworkpromote-person-centred-approaches-healthcare>.
4. Skills for Health. MSK Core Capabilities Framework. [Internet] 2018 [cited 11/04/2019] . Available from <http://www.skillsforhealth.org.uk/services/item/574-musculoskeletal-core-skills-framework> .
5. Erwin J, Edwards K, Woolf AD, Whitcombe S, Kilty S. Better arthritis care: Patient's expectations and priorities. *Musculoskeletal Care* 2018; 16(1): 60-66.
6. Hill S, Dziedzic KS, Nio B. Patients' perceptions of the treatment and management of hand osteoarthritis: a focus group enquiry. *Disabil Rehabil* 2011; 33(19–20):1866–1872.
7. Mann C, Gooberman-Hill R. Health care provision for osteoarthritis: concordance between what patients would like and what health professionals think they should have. *Arthritis Care Res* 2011; 63(7):963–972.
8. Ryan S, Lillie K, Thwaites C, Adams J. 'What I want clinicians to know'-experiences of people with arthritis. *Br J Nurs* 2013; 22(14):808-12.
9. Thomas MJ, Moore A, Roddy E, Peat G. "Somebody to say 'come on we can sort this'": a qualitative study of primary care consultation among older adults with symptomatic foot osteoarthritis. *Arthritis Care Res* 2013; 65(12):2051-5.
10. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology* 2006; 3(2):77-101.
11. Speed CA, Crisp AJ. Referrals to hospital-based rheumatology and orthopaedic services: seeking direction. *Rheumatology* 2005;44(4): 469-71.
12. Erwin J, Edwards K, Woolf AD, Whitcombe S, Kilty S. Better arthritis care: What training do community-based health professionals need to improve their care of people with arthritis? A Delphi study. *Musculoskeletal Care* 2018; 16(1): 48-59.
13. NICE. Shared decision making consensus statement. [Internet] 2016 [cited 11/04/2019] Available from <https://www.nice.org.uk/Media/Default/About/what-we-do/SDM-consensus-statement.pdf>
14. NHS England. Why is shared decision making important. [Internet] 2017 [cited 11/04/2019]. Available from <https://www.england.nhs.uk/shared-decision-making/why-is-shared-decision-making-important/>
15. Coulter, A. and Collins, A., 2011. Making shared decision-making a reality: no decision about me, without me. Kings Fund, London.
16. Health Foundation. Person Centred Care Made Simple. London: Health Foundation 2014.

17. GPC. Standards for pharmacy professionals. [Internet] General Pharmaceutical Council 2017.[cited 11/04/2019]. Available from https://www.pharmacyregulation.org/sites/default/files/standards_for_pharmacy_professionals_may_2017.pdf
18. NMC. Standards for competence for registered nurses. [Internet] Nursing & Midwifery Council 2014. [cited 11/04/2019]. Available from <https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf>
19. CSP. Physiotherapy Framework: putting physiotherapy behaviours, values, knowledge & skills into practice. [Internet]. Chartered Society of Physiotherapy 2011. [updated 2013, cited 11/04/2019]. Available from https://www.csp.org.uk/system/files/documents/2018-16/csp_physiotherapy_framework_condensed_2013.pdf
European Commission. Special Eurobarometer 472 - December 2017 “Sport and physical activity”.

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Table 1: Patient focus group topic guide

Intro:

There are a number of different people you can go and see if you have a MSK problem – for instance you might go and see your GP, your practice nurse, a physiotherapist, an occupational therapist, a podiatrist, an osteopath, a chiropractor or a pharmacist. In this project we are interested in finding out what questions people want answered when they **first** go to see someone about a MSK problem. So we're interested in what you want from so called "**first contact providers**" such as GPs and others that work in your community rather than the **hospital** doctors, physios or OTs that your GP might refer you to.

Could you please take a minute to think about a MSK problem that you had in the past year that you went to see a doctor, nurse or other health professional about (remember we are not including hospital visits here) .

Q.1. What made you decide to seek health care for your MSK problem?

Q.2. What questions did you want answered when you very first went to see a health professional about this MSK problem?

Q.3. How about if you had to have a follow-up appointment? How did the questions differ?

Q.4. What affects how satisfied you feel with a consultation?

Q.5. How would you describe a good first contact health provider?