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LITERATURE REVIEW

Access to first contact physiotherapy appointments in primary care: A scoping review

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Abstract

Background: First Contact Physiotherapy (FCP) is part of the drive to increase General Practice (GP) capacity by providing access to expert musculoskeletal (MSK) Physiotherapists in GP surgeries. For the FCP model to provide effective MSK care at the start of the patient's journey, it is essential that patients are directed to FCP appointments in a timely manner. It is therefore important to know how patients are accessing FCP appointments.

Objective: To provide an overview of the literature regarding patient access to FCP appointments.

Design: Scoping review.

Methods: We reviewed studies published from January 2016 to May 2023 that focused on FCP and made a mention of patient access to FCP appointments. A search was performed using six databases as well as grey literature sources. Study selection and data extraction were independently conducted by two reviewers. Extracted data were tabulated and analysed according to our research questions.

Results: From 186 records identified, 24 studies and other materials were included in the review. A variety of terms were used to describe access routes to FCP appointments, the most common being 'signposting'. These studies suggest the importance of the role of GP reception/administrative staff in enabling efficient patient access to FCP appointments.

Conclusion: There is a clear gap in the literature concerning how patients access FCP appointments. Since the importance of appropriate access is acknowledged as an essential feature of the expansion of FCP in Primary Care, future research is needed to refine and implement optimal FCP access models by identifying the key components needed to ensure timely and appropriate access to FCP.

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1 | INTRODUCTION

Nicola Walsh is an author on the following papers included in the review: Halls et al. (2020), Jagosh et al., 2022, Morris et al., 2021.

In the UK, the rising workload in primary care and difficulties maintaining the General Practitioner (GP) workforce (Hobbs et al., 2016) has led to the need for diversification of the primary care team. First Contact Physiotherapists (autonomous practitioners with musculoskeletal (MSK) expertise) are part of this diversification and provide patients with quick access to specialist MSK input in GP surgeries and increase capacity in Primary Care (Health Education England (HEE), n.d.).

MSK disorders are the leading cause of years lived with disability (YLD) in the UK (Vos et al., 2017) and globally MSK disorders are second only to mental and behavioural problems for YLD (March et al., 2014). The economic impact is substantial, with MSK disorders accounting for half of all European absences from work and for 60% of permanent work incapacity, leading to considerable economic burden (Bevan, 2015). As Foster et al. (2012) point out, early intervention for MSK disorders such as back pain can help prevent acute problems becoming chronic and reduce time off work. MSK disorders account for over 20% of all GP consultations (Jordan et al., 2010), and their burden globally has increased from 1990 to 2017 (Safiri et al., 2021). In the UK, consultation rates for MSK pain have increased by 19% over a 5-year period (Hill et al., 2020). In addition, there is a recognised GP workforce crisis in England, with a deficit of at least 1300 full-time equivalent GPs, due to falling recruitment and increasing numbers of GPs leaving (Owen et al., 2019), although the shortfall in GPs has been estimated recently to be as large as 4200 (Health Foundation, n.d.). Alongside the falling numbers of fully qualified, full-time equivalent GPs, public satisfaction with general practice is also reported to be at record lows (Beech et al., 2023). The implementation of First Contact Physiotherapy (FCP) to address this growing demand and meet the need for timely access to care for MSK disorders has been endorsed by HEE (2020).

The Additional Roles Reimbursement Scheme (ARRS) was established in 2019 to allow Primary Care Networks to access funding to grow additional General Practice capacity with new roles, such as FCPs (Network Contract Directed Enhanced Service Additional Roles Reimbursement Scheme Guidance, 2019). The requirement for GP practices to provide FCP input for patients has been incorporated in The NHS Long Term Plan, which includes a commitment to ensure that all adults in England with a musculoskeletal condition will have direct access to MSK FCPs by 2023/24 (NHS Long Term Plan, 2019).

For the FCP model to provide effective MSK care at the very start of the patient's journey, when they first present to Primary Care for assessment, it is essential that the right patients are directed to FCP appointments in a timely manner. Anecdotal evidence from conversations with FCPs known to the authors of this study as well as posts on the Chartered Society of Physiotherapy (CSP) online forum iCSP suggest that patients with MSK problems often consult with an FCP only after they have already had a consultation with a GP. Data from an unpublished service evaluation in Leeds highlighted that only 40% of FCP new patient appointments were true first contact, that is, 60% of patients had already seen a GP and been assessed for the problem for which they subsequently attended an FCP appointment, and in their qualitative study Greenhalgh et al. (2020) interviewed an FCP who stated that 90% of their appointments were second contact. This may lead to a delay in patient access to specialist MSK advice and care, and inefficient use of healthcare resources. Therefore, there is a need to investigate how patients are accessing FCP appointments. Different appointment booking processes including 'triage at reception' and 'self-booking' were identified through a survey exploring FCP provision across the UK (Halls et al., 2020), suggesting that there may be multiple and varied models in practice for accessing FCP care.

A clear understanding of the extent and range of evidence about how patients access FCP appointments will help inform future work around efficient and timely patient access to this important and rapidly evolving role in primary care. Since FCP is a relatively new model of care, a scoping review is an appropriate method to investigate the range of evidence currently available.

A preliminary search of MEDLINE, the Cochrane Database of Systematic Reviews, PROSPERO and *Joanna Briggs Institute (JBI) Evidence Synthesis* was conducted in November 2022, and no current or in progress systematic reviews or scoping reviews on this topic were identified.

The objective of this scoping review is to provide a comprehensive overview of the literature focused on patient access into FCP appointments and provide insight into areas of interest, identify gaps in the literature and the implications for future studies. Based on issues raised in online discussion forums, and informed by discussions with general practice staff, FCP clinicians, and researchers, the following research questions were identified as priorities:

1.1 | Primary question

What FCP appointment access models are described in the current literature and how well are they described?

1.2 | Secondary questions:

- Is terminology relating to FCP appointment access consistent across the literature?
- Has acceptability for patients of different access processes been explored?
- Has the clinical and cost-effectiveness of different access processes been explored?
- Is evidence available from the literature about consistency/variability in FCP access processes across different settings/geographical locations?

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2 | METHOD

The scoping review was conducted in accordance with the JBI methodology for scoping reviews (Peters et al., 2021), which aligns with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping review guidelines (PRISMA-ScR) (Tricco et al., 2018). The JBI methodology is built upon the Arksey and O'Malley (2005) framework and subsequent enhancements proposed by Levac et al. (2010), and consists of nine stages;

1. Defining and aligning the objective/s and question/s (protocol development)
2. Developing and aligning the inclusion criteria with the objective/s and question/s (protocol development)
3. Describing the planned approach to evidence searching, selection, extraction, analysis, and presentation (protocol development)
4. Searching for the evidence
5. Selecting the evidence
6. Extracting the evidence
7. Analysis of the results
8. Presentation of the results
9. Summarising the evidence in relation to the purpose of the review, making conclusions, and noting any implications of the findings.

A protocol for this review was developed by all four authors (KL, CC, NW, GM) in accordance with the JBI methodology.

2.1 | Development of search strategy

An initial preliminary search of MEDLINE was undertaken to identify articles on the topic and find relevant index terms relating to the concept of first contact practice and the concept of access models. The terms 'First Contact Physiotherapist' and 'First Contact Practitioner' were most commonly used, with 'First Point of Care Physiotherapist' being used in two articles. After consultation with the specialist healthcare librarian assisting with the searches, it was decided not to add terms for the concept of appointment access models because defining and capturing the multiple terms used for this concept was challenging, and because the numbers of relevant articles retrieved without adding these terms were relatively low. It was decided, therefore, to run the search based solely on the terms "First Contact Physiotherapist/therapy" and "First Contact Practitioner/Practice".

2.2 | Eligibility criteria

To be included in the review, published studies and grey literature needed to be:

- focused on adults seeking care for MSK disorders in GP/Primary Care settings via FCPs and detailing patient access to FCP appointments
- published between January 2016 and May 2023
- published in the English language

The date range was chosen since FCP as a term referring to the current UK NHS model first came into use in published articles in 2016 (Millet, 2016), and in a peer-reviewed journal in 2017 (Salmon et al., 2017). Only English language documents were included because no funding was available for the translation of any other languages.

Since not all the materials relevant to this subject were in the form of academic studies published in peer reviewed journals, the term 'materials' is used to describe the articles, guidance documents, and online posts which were considered, screened, and included/excluded.

2.3 | Information sources

The databases MEDLINE, Ovid Emcare, CINAHL, AMED, Cochrane and Physiotherapy Evidence Database were searched. Assistance was sought from a specialist healthcare librarian to ensure that the searches were conducted as effectively as possible.

Once the database search was completed, further hand-searching was undertaken by scrutinising the reference lists of relevant articles from the completed search. In addition, sources of unpublished studies and grey literature were searched, including the CSP website, The Kings Fund, National Institute for Health and Care Excellence, Department of Health and Social Care (UK), The Nuffield Trust, Electronic Theses Online Service, Google scholar, and the UK Government website publications.

2.4 | Study selection process

Studies and other materials were retrieved from each database. Titles and abstracts were screened for eligibility by two reviewers (KL, CC); an Excel spreadsheet of the studies and other materials was created to record those retained for full text review and those excluded. For materials where it was unclear from the abstract whether they met the eligibility criteria, the material was retained for full text review. The full text reviews were performed by two reviewers independently (KL, CC). Any disagreements between reviewers were discussed until final inclusion/exclusion was agreed upon by both. During the screening and selection process, exclusion reasons for any materials that were not eligible were tabulated in an Excel spreadsheet. The reasons for the exclusion of materials at each stage are presented in the PRISMA flow chart (Figure 1).

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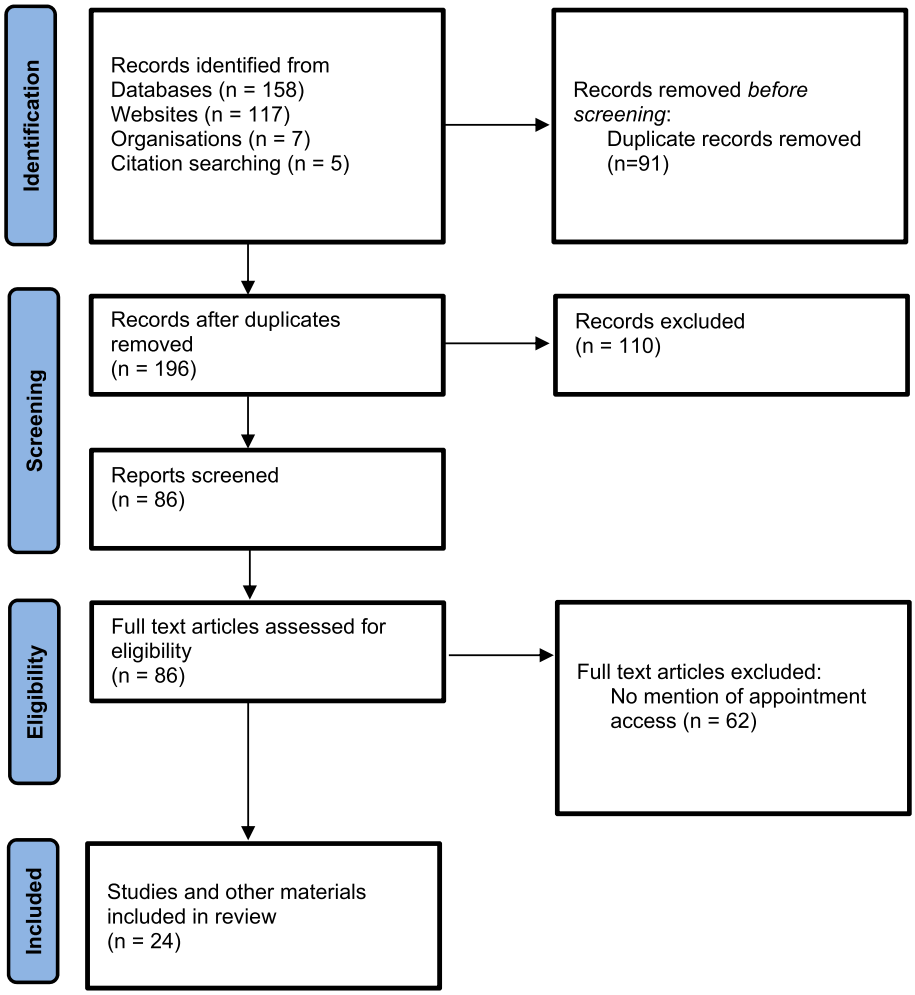

FIGURE 1 Preferred Reporting Items for Systematic reviews and Meta Analyses extension for Scoping Reviews flow diagram (Tricco et al., 2018).

2.5 | Data extraction process

Data relevant to each research question were extracted and added to a data extraction form created on an Excel spreadsheet. Data extracted included details about the material, such as the date of publication, the area of the UK the material was based in, the type of publication, the design/aims/purpose, and the context of the material. To address the primary research question of what methods of access are described in the literature, headings of 'Process involved', 'Personnel involved', and 'Digital/phone methods' were used. Headings reflecting the secondary research questions were also used, such as whether clinical or cost-effectiveness of access methods were explored in the material, and whether acceptability for patients was explored in the material.

We used an iterative approach to data extraction and data charting, creating additional categories of data extraction as required. For example, we extracted data relating to barriers/facilitators to FCP appointment access, which we felt was relevant although not directly answering one of our research questions. In a similar way, any other information felt to be pertinent to the aims of this review was extracted and entered into a column on the spreadsheet labelled 'Other'. In addition to extracting specific data fitting the extraction form headings, any mention of access to FCP appointments was copied verbatim into a separate column of the Excel spreadsheet and pertinent details, phrases, or words highlighted.

The data were extracted by one reviewer initially (KL), and then checked by and added to as felt necessary by a second reviewer (CC). In any case of disagreements, these two reviewers (KL, CC) discussed the data extraction process and came to an agreement about what data was relevant to the research questions and should be extracted.

2.6 | Data analysis

A table of key descriptive data was created to report the characteristics of each of the studies and other materials included (Table 1).

To tabulate data describing access methods, each piece of extracted verbatim data was read through and discussed by two reviewers (KL, CC). Codes were created iteratively to summarise and sort the data in relation to the research questions. These codes were

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TABLE 1 Included studies and other materials.

Author/year/location	Type of study/ material	Study/material design	Access method terms used	Personnel involved	Digital features
Goodwin et al., 2020 Nottingham	Journal article	Qualitative study. Interviews and focus groups with patients. GPs, administration staff, commissioners and physiotherapists	"Signposting"	"Healthcare staff" "Reception staff" "Reception administration staff"	N
Goodwin et al., 2021 England	Journal article	Mixed methods service evaluation. Qualitative findings from the FCP national evaluation (Phase 3). Individual interviews and focus groups	"Signposting" "GP triage"	"GPs" "Reception/administration staff"	N
Goodwin n.d. Scotland and Northern Ireland	Journal article	Qualitative interviews study. Part of the national evaluation of the FCP model. Interviews with FCPs, GPs and GP practice administration staff	"Signposting" "Care navigation"	"Frontline general practice administration staff"	N
Greenhalgh et al., 2020 North West England	Journal article	Semi-structured face to face interviews. Qualitative interviews with 10 FCPs recruited into full time posts.	GP triage	GPs as first contact, FCPs as second contact	N
Halls et al., 2020 UK	Journal article	Cross sectional online survey of FCPs.	"Self-booking" "Triage at reception" "Involvement of GPs/ANPs" "Telephone-based triage" "Walk in appointments"	"Reception staff, GPs/ANPs"	N
Ingram et al., 2023 England	Journal article	Qualitative interviews study with eight FCPs	GP referral	"Reception staff"	N
McDermott et al., 2022 England	Journal article	Analysis of NHS digital workforce data, a survey of practice managers, and an in-depth case studies of five general practices to examine how staff and patients experience a broad range of practitioners	"Categorisation" "Matching patients problems with the skills of a practitioner" "Triage" "Online triage systems" "Care navigation" "Signpost"	"Receptionists" "Doctors or other practitioners" "Operational manager"	Y - "online triage systems"
Morris et al., 2021 South West and North of England	Journal article	Realist evaluation. Two GP practices as case study sites - interviews with patients, GPs, FCPs, receptionists and practice managers	"Signposting"	"Receptionists"	N

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TABLE 1 (Continued)

Author/year/location	Type of study/ material	Study/material design	Access method terms used	Personnel involved	Digital features
Jagosh et al., 2022 UK	Journal article	A reflection on the methods used in the FRONTIER study of FCPs	"Self-refer" "Book via reception"	-	N
Wood et al., 2022 England	Journal article	Thematic analysis of free text responses. Part of the national evaluation of the FCP model.	"Signposting"	-	N
Akehurst et al., 2019 London	Abstract/poster presentation	Service evaluation of a project involving spinal specialist APPs working within a GP practice as FCPs to manage the patient pathway and decrease demand from back pain patients on GP time	"Self-refer"	-	Y - "telephone or video consultation as a first point of triage"
Bater 2022 UK	Abstract/poster presentation	Cross sectional descriptive survey	"Triage"	"Reception staff"	N
Davies et al., 2021; South West of England	Abstract/poster presentation	Service evaluation of FCP pilot. Questionnaire including quantitative and free text questions	"Signposted to FCP"	"Reception"	N
Doran 2021a North East Wales	Abstract/poster presentation	Service evaluation of FCP service. Retrospective analysis of quantitative and qualitative data.	"Reception triage"	"GP"	N
Doran 2021b North East Wales	Abstract/poster presentation	Service evaluation of the impact of using a single or dual hub model of FCP care.	"Patient self-referral""GP referral"	"GP administrators"	N
Pain 2022 Middlesex	Abstract/poster presentation	Mixed methods service evaluation of a pilot FCP service, hub and co-location models used.	-	"Reception"	N
Hensman-Crook 2019 UK	Guidance published by professional organisation	Document produced as part of NHS England's evaluation of FCP	"Direct from reception"	"Primary care team"	Y - "online booking systems"
CSP FCP GP support guide UK	Guidance published by professional organisation	Document produced by the CSP to guide general practices when introducing FCP roles	"Care navigation""GP (online and telephone) booking systems"	"Care navigators" "Receptionists"	N
HEE n.d. England	Guidance published by professional organisation	National guidance document	Care navigation	"Reception team" "GP" "ANP"	Y - "booked in online"

(Continues)

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TABLE 1 (Continued)

Author/year/location	Type of study/material	Study/material design	Access method terms used	Personnel involved	Digital features
iCSP post 1 2021 UK	Discussion on iCSP forum	Online discussion question/response	"Booked in via reception team or online" "Referred in after seeing the GP" "Triage"	"Admin" "GP"	Y - "e-consult"
iCSP post 2 2021 Scotland	Discussion on iCSP forum	Online discussion question	"triage" "Signposting"	"Admin team" "GP" "Care navigators"	N
iCSP post 3 2021 UK	Discussion on iCSP forum	Online discussion question/response	"triage" "GP referral"	"Reception staff" "GPs"	N
Pike 2020 Surrey	News article in journal	Report on an FCP pilot project in surrey	Via "reception staff and GPs"	"Reception staff"	N
Wise 2019 South Lincolnshire	News article in journal	A report on the teams shortlisted for the primary care team of the year BMJ award 2019	"Reception staff were trained to direct patients to [the physiotherapist]"	"Reception staff"	N

systematically applied to each piece of data, with new codes being created as necessary. The codes were then grouped into categories containing similar codes, and the categories were linked into overarching themes. This was done using Excel spreadsheets and continued discussion between two reviewers (KL, CC). Once the themes and categories had been agreed, and the key processes in FCP access determined, a flow diagram was created to visually depict them (see Results section, Figure 2). This type of basic descriptive qualitative coding is endorsed for scoping reviews by Peters et al. (2020).

The studies and other materials were not appraised for quality since the purpose of the scoping review is to examine what evidence is available in the area studied rather than to seek and synthesise "best available" evidence to guide practice, and Khalil et al. (2021) advise against quality or risk of bias assessment.

3 | RESULTS

There were 24 studies and other materials included for analysis (see Table 1); 16 were journal articles (n = 10) or abstracts of poster presentations (n = 6) in peer-reviewed journals and eight were grey literature, ranging from online forum posts (n = 3), to news articles (n = 2), to guidance documents produced by the CSP and HEE (n = 3). The findings from the analysis of the data are presented in relation to the review's primary and secondary research questions. The types of access models in the literature are described, and then data related to terminology, consistency, acceptability and clinical/cost-effectiveness as well as personnel and digital aspects of FCP access are described.

3.1 | Access models

With regard to the primary research question of what FCP access models are described in the current literature and how well are they described?, there was relatively little information contained within the included studies and other materials. Nine had just a single line mentioning access to FCP appointments, and in those with more detailed information, there was generally limited explanation of the exact methods used. Although there was a paucity of detail regarding access models, it was determined from the overall data that patients appear to access FCP appointments via a relatively simple route, with some variations according to individual areas/practices. Patients requiring care for MSK problems make contact with their GP surgery, are directed to an appointment via a GP staff decision-making process, and then attend for an appointment. These main areas are discussed in further detail below.

3.1.1 | Referral routes

Patients with MSK problems may contact their GP practice by phone, using an online system (such as e-consult), or by attending in person. Non-clinical and/or clinical staff may be involved in dealing with this

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contact and facilitating patient access to FCP appointments. It appears that reception/administration staff are the most likely to deal with patient contacts, but other staff members such as GPs and Advanced Nurse Practitioners (ANPs) were also mentioned.

3.1.2 | Decision making processes

The GP staff, usually a Receptionist, dealing with the patients calls, online submissions and attendances goes through a process of decision-making to ensure that the patient is booked an appointment with an appropriate clinician (ie patients with MSK problems are booked an FCP appointment). This process of decision-making was labelled with various terms in some of the studies and other materials: signposting, care navigation, triage, matching a patients problems with a practitioner, and categorisation. The use of this terminology was variable; one study used all five of these terms (McDermott et al., 2022), and others used at least two interchangeably (Goodwin, n.d). There are various factors which feed into the decision-making process, including the Receptionists knowledge

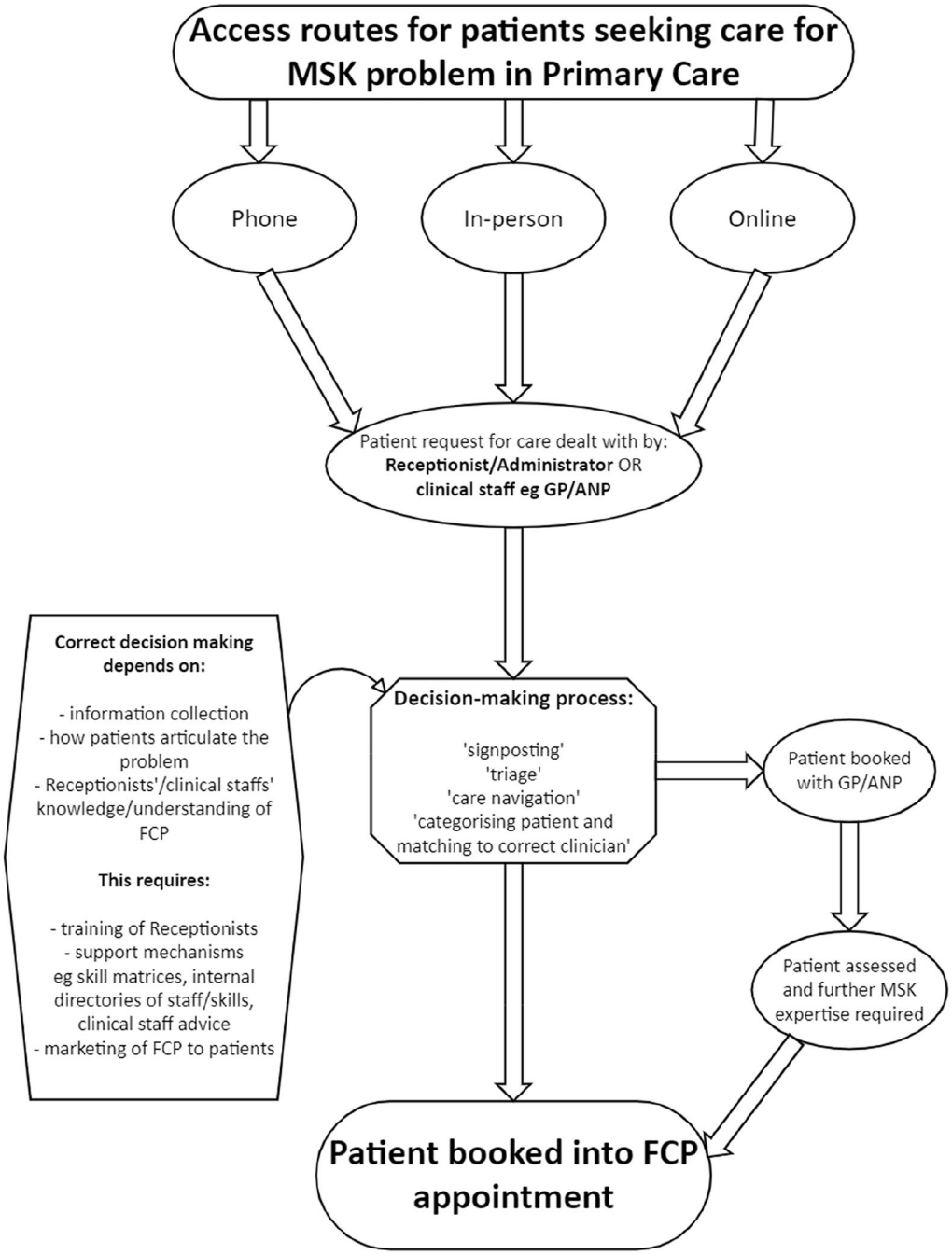

FIGURE 2 Access routes to First Contact Physiotherapy (FCP) appointments.

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and understanding of FCP, how the patients articulate their problem, and the information which is collected. To aid effective decision-making by Receptionists or Administrators, support mechanisms, training for reception/administration staff, and marketing of FCP to patients were suggested. However, barriers to Receptionists effectiveness at facilitating patient access to FCP were also noted in some studies, such as patient perception of the Receptionist role, and limited time to explain the concept of FCP to patients.

3.1.3 | Booking processes

The patient may be booked directly into an FCP appointment or may be booked an appointment with a different clinician, such as a GP. If this clinician feels that the patient would benefit from further MSK expertise, they may then be booked into an FCP appointment as a second appointment.

3.2 | Consistency of terminology

Terminology about how patients access FCP appointments was not consistent; eight sources used the term 'signposting' (Davies et al., 2021; Goodwin, n.d.; R. Goodwin et al., 2020; iCSP 2, 2021; McDermott et al., 2022; Morris et al., 2021; Wood et al., 2022), four used the term 'care navigation' (CSP, n.d.; Goodwin, n.d; HEE, 2020; McDermott et al., 2022), and one used the term 'walk-in appointments' (Halls et al., 2020). The term 'triage' was used by nine sources, five of which used the term on its own (Bater & Sellars, 2022; iCSP 1-3, 2021; McDermott et al., 2022), two of which used the term 'reception triage' (Doran, 2021a; Halls et al., 2020), and two of which used the term 'GP triage' (R. Goodwin et al., 2021; Greenhalgh et al., 2020). 'Patient self-referral' or 'self-booking' was used by four sources (Akehurst et al., 2019; Doran, 2021b; Halls et al., 2020; Jagosh et al., 2022), and 'GP referral' or GP involvement in the patient accessing an FCP appointment was referred to in seven sources (Doran, 2021a; R. Goodwin et al., 2021; Greenhalgh et al., 2020; Halls et al., 2020; iCSP 1-3, 2021; Pike, 2020). Involvement of Reception was stated as an access method in five of the sources (Hensman-Crook, 2019; iCSP 1, 2021; Jagosh et al., 2022; Pike, 2020; Wise, 2019), for example, direct from reception and booked via reception. Most of the terminology involving the process of patients accessing FCP appointments was not explained or defined by the sources authors; the only source which had a detailed explanation of how staff interacted with patients to match the 'right' patients to the 'right' clinicians was McDermott et al. (2022).

3.3 | Acceptability for patients

There was very little evidence of the acceptability for patients of different access processes; Goodwin et al. (2021) found that speed and ease of access contributed to patient satisfaction with FCP services, and McDermott et al. (2022) reported that some patients had difficulties managing new online or telephone triage systems introduced to manage patients access to FCP appointments, but none of the other sources mentioned how acceptable patients found appointment access processes.

3.4 | Consistency/variability across settings and locations

Since there were relatively few studies and other materials with limited information about how patients access FCP appointments, there was not enough evidence to determine how variable FCP access methods are across different settings or geographical locations.

3.5 | Clinical/cost effectiveness of access processes

None of the included studies or other materials explored the clinical or cost-effectiveness of different access processes, which was not unexpected, given the nature of the studies. However, several studies have discussed the fact that some patients seen by FCPs were not always 'first contact', and this undermining of the first contact principle may have a negative effect on the impact of FCP and increase unnecessary steps in the healthcare system (R. Goodwin et al., 2021; Greenhalgh et al., 2020; Hensman-Crook, 2019). Alternatively, it may improve overall use of the healthcare system if patients receive appropriate MSK care as a second appointment in Primary Care, rather than using several GP appointments or being referred to Secondary Care. However, this has not been explored in the literature to date.

3.6 | Personnel

Personnel involved in patients accessing FCP appointments were described as 'reception/receptionists' or 'admin/administration/administrators' in 17 of the sources (Bater & Sellars, 2022; CSP, n.d.; Davies et al., 2021; Doran, 2021a, 2021b; Goodwin, n.d.; R. Goodwin et al., 2020; Halls et al., 2020; HEE, 2020; Hensman-Crook, 2019; Jagosh et al., 2022; McDermott et al., 2022; Morris et al., 2021; Pain, 2022; Pike, 2020; Wise, 2019; Ingram et al., 2023), GPs in 10 of the studies and other materials (Doran, 2021b; R. Goodwin et al., 2021; Greenhalgh et al., 2020; Halls et al., 2020; iCSP 1-3, 2021; McDermott et al., 2022; Pike, 2020), 'ANPs' in three (R. Goodwin et al., 2020; Halls et al., 2020; iCSP 1, 2021), 'primary care team' in one (CSP, n.d.), and 'healthcare staff' in one (R. Goodwin et al., 2020). Three of the studies did not provide any information regarding personnel involved (Akehurst et al., 2019; Bater & Sellars, 2022; Wood et al., 2022).

3.7 | Digital features

Digital features to access routes such as 'e-consult' (iCSP 2, 2021), 'online triage'(McDermott et al., 2022), and 'video consultation as the

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first point of triage' (Bater & Sellars, 2022) were mentioned, and the term 'online booking' was used in two of the materials (CSP, n.d.; iCSP 1, 2021). Appointment booking systems involving telephones were mentioned by six of the studies and other materials, two of which used the term 'telephone booking systems' (CSP, n.d.; HEE, n.d.), and four of which used the term 'telephone triage' (Bater & Sellars, 2022; Doran, 2021a; Halls et al., 2020; McDermott et al., 2022).

4 | DISCUSSION

The aim of this scoping review was to investigate the literature around how patients access FCP appointments. From the 24 studies and other materials reviewed, there was little evidence investigating this area, demonstrating a clear gap in the research base, and likely reflective of the relative infancy of FCP services. Of the included sources, many had very brief mentions of FCP appointment access methods; nine had only one line regarding access (Akehurst et al., 2019; Bater & Sellars, 2022; Doran, 2021a, 2021b; Hensman-Crook, 2019; Jagosh et al., 2022; Pain, 2022; Pike, 2020; Wise, 2019). Only one study, the UK-wide online survey of FCP provision (Halls et al., 2020), specifically asked participants about the variety of access options available. Despite the paucity of evidence, we were able to determine some key processes and themes related to patient access to FCP appointments, as described in the Results section.

This scoping review has revealed a variety of routes by which patients access FCP appointment, one of the key methods being via GP Reception. This was most commonly termed 'signposting', but in only one study (McDermott et al., 2022), the term was defined or the processes involved explained. Several sources in the review did not use the term 'signposting', but the brief descriptions given suggested a comparable process; "booked via reception" (Wise, 2019), "direct from reception" (Hensman-Crook, 2019). 'Triage' and 'care navigation' were other terms that appeared to indicate a process similar to that of 'signposting'—that of determining a patient's need and directing them to the most suitable member of the GP team (Bater & Sellars, 2022; CSP, n.d.; Doran, 2021a; Wood et al., 2022). There seems to be agreement between many of the studies and other materials that signposting by reception or administrative staff is fundamental in ensuring appropriate access to FCP (Doran, 2021a; D. R. Goodwin, n. d.; R. Goodwin et al., 2020; Goodwin, 2021; Health Education England, 2020; McDermott et al., 2022; Morris et al., 2021; Pain, 2022; Wood et al., 2022). The central role of signposting may be due to a finding of two of the qualitative studies (R. Goodwin et al., 2020; Goodwin, 2021); that there is a lack of patient awareness of FCP, and confusion about what FCPs do, and how and where they do it, therefore explanations and guidance from GP Reception staff ensure patients are made aware of FCP. However, the importance of GP reception staff acting as gatekeepers has long been acknowledged in the literature, with Gallagher et al. (2001) reporting the complex nature of the work and stating the value of receptionists in managing patient demand. More recently, Litchfield et al. (2022) reported that receptionist roles routinely involve triage, but few receptionists describe receiving training for this. Therefore, signposting is likely to be a central feature of all Reception/patient interactions, not solely related to how patients access FCP.

A qualitative study of FCPs found that there appeared to be a lack of understanding of the FCP role among GPs and reception staff as well as among patients (Greenhalgh et al., 2020). This may contribute to the fact that some patients access FCP after being assessed by a GP or ANP, suggesting that without efficient signposting from Reception FCP services may not be used effectively; FCP service having a very low first point of contact rate is clearly contrary to the objective of shifting GP MSK workload and providing immediate expert care for MSK patients. As Goodwin and Hendrick (2016) and Langridge (2019) point out, it is not economically viable if FCP services are not providing the first point of contact, since if patients are seeing the GP before the FCP there is a doubling up of appointments and therefore costs. However, there is also an argument that a second appointment with an FCP may be more efficient than multiple appointments with a GP or referral to Secondary Care, and multiple studies have confirmed that FCPs reduce referrals for both investigations and to Secondary Care (Horne et al., 2019; McColl et al., 2022; Salmon et al., 2017). Goodwin et al. (2021) reported that GPs found the presence of FCPs in the practice a valuable resource, not just for patients but also for supporting and up-skilling GPs and other practice staff with MSK knowledge. Therefore, the 'first contact' principle may be less important than previously thought. Added to this is the fact that the National Evaluation of FCP (Stynes et al., n.d) found that although one of the aims evaluated was FCP services should reduce the workload of GPs, current models of FCP do not provide enough capacity to reduce GP burden.

In terms of the secondary research questions of this review, there was little evidence on the clinical and cost effectiveness of different access processes, the acceptability for patients of different access processes, or the variability in access processes across different settings/locations. This is likely to be due to a combination of several factors. FCP is a relatively new model of care, and the research base is therefore fairly limited. Early studies have mainly focused on the feasibility of Physiotherapists working as first contact practitioners, and on evaluation of services (Horne et al., 2019; McColl et al., 2022; Salmon et al., 2017; Stynes et al., n.d). Therefore, how patients access FCP has not been explored in detail, and the finer points of effectiveness, acceptability and variability of access processes have not been specifically addressed in the literature.

The uncertainty and unfamiliarity around FCP services means that 'patient pathways need clear articulation to patients' (Wood et al., 2022), and that 'communication is crucial' (Pain, 2022). Communication was felt to be an important facet of ensuring effective utilisation of FCP; communication between clinical and non-clinical GP staff, and communication between GP staff and patients. With better awareness about what FCP is, there may be more efficient or effective use of appointments, as was found by Jones (2022) who interviewed a number of ARRS clinicians, including clinical pharmacists and paramedics, and found that good communication was highly prized. One clinician in this study said: "I was able to meet with the

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reception team and talk to them personally about my role and the types of referrals I can take, this improved the type of referrals I was receiving"(Pg. 16). Indeed, in the literature relating to other ARRS roles, there is a repeated theme of a lack of understanding of newer non-medical roles amongst patients and GP surgery staff (Nabhani Gebara et al., 2020; Nelson, 2019; Ryan et al., 2018), so the issue of role awareness and subsequent uncertainty is not limited to FCPs.

In order to achieve improved understanding of FCP and to ensure efficient decision-making and signposting by reception and administrative staff, several materials suggested that training for practice staff is essential (CSP, n.d.; R. Goodwin et al., 2020; McDermott et al., 2022; Pain, 2022; Wood et al., 2022). A mixed methods service evaluation suggested that 'optimisation of GP administration training should be explored for FCP services' (Pain, 2022), and a study utilising results from the national evaluation of FCP pointed out the importance of 'investing in training of staff to signpost effectively' (Wood et al., 2022). Goodwin et al. (2020) point out that the content and effectiveness of signposting training should be evaluated in future research since this will ensure the most effective use of FCP appointments.

5 | LIMITATIONS AND STRENGTHS

The strength of this review was that the JBI framework, and the PRISMA-ScR checklist were used to ensure that a high-quality scoping review was produced. This involved two reviewers performing the screening and data extraction/analysis, and rigorous reporting of the methods and results. It could be considered a strength that several grey literature materials were included in this review, since this demonstrates a comprehensive overview of all potential data sources. Another strength is that the data extracted were not merely tabulated and reported, but were analysed and descriptively coded in order to enhance understanding of the key points and processes relevant to patient access to FCP. This scoping review only considered articles published in English since 2016, which could be considered a limitation as some relevant studies may have been excluded. However, since FCP is a relatively recent UK-based innovation, it is unlikely that significant literature was omitted. The paucity of research/data in this area is probably the biggest limitation since there were few sources that mentioned FCP appointment access methods, and those that did mostly contain very little detail. Several of the sources included in this review were not peer-reviewed journal articles, for example, the iCSP discussions, and CSP/HEE guidance documents, and could therefore be considered to be less robust sources of data. However, since a scoping review is intended to summarise and identify gaps in the evidence, the inclusion of all possible sources was considered appropriate.

5.1 | Implications for research and practice

This scoping review has revealed a lack of literature specifically about how patients access FCP appointments and have exposed the minimal detail within the small amount of literature that mentions access. There is a clear need to investigate the variety of appointment access methods that patients with MSK problems are currently using to access FCP appointments and to examine the most effective and efficient methods so that access to FCP is optimised in practice. With regards to further research, it may be helpful to define terms such as 'signposting', 'care navigation' and 'triage' with regards to how patients access appointments since these terms were often used interchangeably and in the majority of cases the exact methods used for patient access were not described, although this would not necessarily affect practice value.

6 | CONCLUSION

Whilst the importance of efficient and effective access to FCP appointments is acknowledged repeatedly in the small amount of literature found mentioning this subject, the fact that no published studies have so far focussed on access methods suggests a need for further research into this area.

AUTHOR CONTRIBUTION

Kirsten Lamb: Conceptulisation, methodology, investigation, analysis, writing – original draft; Christine Comer: Conceptulisation, methodology, investigation, analysis, writing – review and editing; Nicola Walsh: Conceptulisation, methodology, writing – review and editing; Gretl McHugh: Conceptulisation, methodology, writing – review and editing.

KEYWORDS

access, physiotherapy, primary health care

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CONFLICT OF INTEREST STATEMENT

Kirsten Lamb, Christine Comer and Gretl McHugh declare that we have no conflicts of interest.

ETHICS STATEMENT

Ethical approval was not sought since this was a scoping review and all information was freely available in the public domain.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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