



# First point of contact physiotherapy; a qualitative study

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## Abstract

**Objectives** First point of contact physiotherapy (FPCP) provides patients direct access to a physiotherapist. Literature demonstrates efficacy of FPCP. Evidence has highlighted the need for cultural shifts from both patient and professional perspectives to optimise FPCP. This study explored stakeholder perceptions of patient awareness and understanding of FPCP to better inform FPCP implementation.

**Design, setting, participants** A qualitative methodology utilised semi-structured interviews and focus groups. Findings from a previous realist review were used to generate a priori topic guides. Participants included patients, physiotherapists, GPs, administration staff, and commissioners. A thematic analysis was undertaken.

**Results** Four themes emerged that are described: level of patient awareness of the FPCP role situated against the GP as first contact practitioner, patients attain an awareness of FPCP from a variety of sources, patient understanding of physiotherapy arises from several sources and is poorly aligned with the FPCP model, characteristics and behaviours of patients influence access to FPCP services. Patient awareness and understanding was poor. Patients tended to view the GP as the default first contact practitioner. Traditional advertising approaches appeared on the whole invisible to patients and there was a reliance on signposting to facilitate patient access.

**Conclusion** Findings from this study can inform implementation of FPCP. Several obstacles to the optimisation of FPCP were highlighted. Improved marketing of physiotherapy generally and FPCP specifically may increase patient awareness and understanding. However, it is likely further time will be required to bring about the cultural shift in public perception required to optimise the potential of FPCP.

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**Keywords:** Musculoskeletal physiotherapy first contact practitioner

## Introduction

The first contact practitioner (FCP) initiative has gathered considerable momentum over the last three years. Evidence of this momentum is demonstrated in the advocacy of the FCP role in the NHS long term plan [1] and the 2019 GP contract [2]. Both documents refer to the contribution that FCP can make to the alleviation of the growing pressures experienced in general practice and primary care.

First point of contact physiotherapy (FPCP) provides patients with direct access to physiotherapists, most commonly for the assessment and management of musculoskeletal disorders (MSD), without recourse to prior assessment by, or referral from, a GP. The GP contract pledges central government funding to primary care networks throughout the UK for the implementation of FPCP services. Interestingly, this commitment to FPCP has been made despite an apparent paucity of supporting evidence.

A small body of literature demonstrates efficacy of FPCP in the UK [3–5]. This is supported by several pragmatic service evaluations which all demonstrate similar findings [1,6]. A service evaluation was completed in 2017 of a FPCP

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service and found that the physiotherapists were able to manage most patients and appeared acceptable to patients and GPs [4]. Most patients were managed utilising a tailored self-management strategy within two appointments [3,4]. In addition, staff and patients described satisfaction with FPCP services [3,5]. The only published economic evaluation was pragmatic but demonstrated considerable potential savings for the health economy [3].

Nevertheless, several more nuanced issues were highlighted in a qualitative evaluation undertaken by Moffatt *et al.* [7]. The authors suggested the successful implementation of FPCP necessitated a number of cultural shifts both from a patient and professional perspective. From a patient perspective there was evidence to suggest an intransigent patient belief that the GP was the default first point of contact practitioner.

It has been suggested that FPCP could alleviate some of the growing patient demand experienced in general practice. The redistribution of patients experiencing MSDs from GPs to physiotherapists could lessen GP burden. However, to date this potentiality has not been demonstrated. It would seem pertinent to explore the more hidden complexities highlighted [7] if the full potential of the FPCP initiative is to be achieved. This current study sought to investigate these issues by exploring stakeholders' perceptions of patient awareness and understanding of FPCP and in doing so highlight issues that might impact the realisation of the full potential of FPCP.

The aim of this study was to:

Explore factors that affect public awareness and understanding of FPCP in the management of MSDs.

## Methods

### Design

Researchers used a qualitative methodology which consisted of semi-structured interviews and focus groups. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [8] was used throughout to ensure necessary components of study design were reported. Ethical approval was granted by Haydock-North West Research Ethics Committee (REC reference: 16/NW/0618).

This study formed one piece of a wider PhD project [9] that applied realist research methodology. Realist methodology is theory driven and seeks to 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 [10,11]. The 'unit of analysis' in realist research is programme theory – the proposed theory, or theories, about what makes an intervention work [12,13]. If the programme theory is the unit of analysis 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 [13] these explanations are context, mechanism,

outcome configurations – CMO configurations. An example of a CMO configuration from this study follows; where there was poor public awareness (Context) of FPCP, physiotherapists used advocacy strategies (M-Resource) to disseminate information, targeting the public to improve public awareness (Reasoning) and of FPCP and increase utilisation of FPCP (Outcome). This qualitative study was preceded by a realist review that generated several CMO configurations. These configurations provided a priori theories that informed this current investigation and in doing so also provided an empirical framework around which interview, and focus group, topic guides were developed.

### Participant recruitment and data collection process

Participants were recruited from a FPCP service in Nottingham, UK. Participant groups included patients who had attended the FPCP service, physiotherapists, GPs, administration staff, and commissioners. Recruitment was purposive [14] with individuals and focus groups identified and selected based on their engagement with the service. Recruitment of the administration staff, GP and commissioner participants was influenced by convenience, practicality, availability and previously established relationships with GP practices. All physiotherapists involved in the delivery of the FPCP service 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 to ensure they 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. A nominated code was given to each participant in order to preserve confidentiality and anonymity.

Interviews are a commonly used method of data collection [15,16]. Focus groups, on the surface, may appear similar to a semi-structured interview but involve 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 [17]. Conversely, it also requires considerable researcher skill and flexibility to manage the group and there is the possibility that some voices may not be heard within the group. As such, the decision was made to interview the patient participants individually to ensure each participant was allowed the opportunity to contribute fully. The physiotherapists and administration staff were interviewed in focus groups. Practi-

cality 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. A topic guide was devised for each participant group which the interviewer (RG) used to probe the a priori programme theory; ‘patient awareness and understanding of FPCP’.

The interviews and focus groups were recorded using digital voice recorders with the duration of each interview ranging between 25 and 75 minutes. A copy of the audio-file was saved in a secure study file. Each of the interviews and focus groups were transcribed verbatim. The transcriptions were uploaded into QSR International’s qualitative data analysis NVivo 11 Software.

### Data analysis

This evaluation interrogated *an priori* theory and, as such, a deductive, theory driven, method was necessary. However, the 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 [18,19]. Braun and Clarke [19] described the flexibility inherent in a hybrid thematic analysis as allowing for either ‘bottom up’ inductive analysis or ‘top down’ deductive analysis. A template was created in a ‘code book’ in NVivo, providing initial codes against which to interrogate the data. At the same time, evidence of new theories was coded via an inductive approach [19]. In accordance with COREQ guidelines [8] transparency in data coding is described. All transcripts were coded by RG with co-investigators (PH, FM, PL) coding 10% each of the transcripts. As such a total of 30% of the transcripts were joint coded. Previous research has shown this method is adequate to demonstrate consistency in coding, interpretations and inferences made by the lead researcher [21]. Indeed, this method demonstrated excellent agreement in coding and analysis of the data. As such no further joint coding was deemed necessary.

### Participants

The patient population recruited to this study had a mean age of fifty-three (range 35–73). This was representative of a typical MSK physiotherapy caseload [22,23]. 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.

### Results

Four themes emerged and are presented sequentially with discussion. [coding; P=patient, A=administrator, Phy=physiotherapist, GP=general practitioner].

#### *Theme 1; level of patient awareness of the FPCP role situated against the GP as first contact practitioner*

Most participants were aware of physiotherapy as a profession and it appeared that, as a profession in the NHS, physiotherapy was well established; “*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. . . .*” (P5). However, most felt that the general population would only be aware of physiotherapy generally and not FPCP specifically.

The lack of awareness of FPCP is articulated in this frank patient exclamation. When the public’s view of FPCP was explored they suggested “*I don’t think they’d know what you was talking about*” (P7). This impression of a lack of awareness of FPCP was repeated frequently and as a result of this lack of awareness participants anticipated that patients would default to their GP as the FCP.

Participants repeatedly situated FPCP against this apparent intransigent position of the GP as the default FCP. Indeed, the most frequent cited cause of patient resistance to attending FPCP was attributed to their preference to access a GP appointment. It was clear that FPCP stood against the established primacy of the GP in general practice:

*“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”* (P5).

One GP reported that this tendency was more likely in older people; “*I think that some of the older generation, you know, they were brought up that the doctor is everything, the fountain of knowledge . . . . they wait for five weeks to get an appointment, and that’s so stupid of them. Because there’s loads of really competent people out there they could see the same day”* (GP1), while others reported that the issue spanned generations and appeared to be resistant to change.

Evidence also highlighted some concern about patient perception of comparative clinical competence of the physiotherapist, relative to the GP. The data suggested this anxiety could be alleviated by reassurance from a GP prior to attending FPCP. However, this propensity clearly undermined the FCP principle. The evidence inferred that FPCP challenged the socio-historically situated GP: patient relationship and one physiotherapy focus group voiced the need for wider cultural change. At the same time they described their frustration when it appeared that certain systems reinforced the status quo rather than challenging it.

*“It’s a culture shift, isn’t it, with people. Because I think, again, if you look at media . . . . 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”* (Phy2).

All participant groups described the public’s perception of the GP, as the default FPC, providing an obstacle to the

FPCP initiative. As highlighted in this administrator quote; *“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” (A1).*

*Theme 2; patients attain an awareness of FPCP from a variety of sources*

Participants hypothesised that when people were exposed to information pertaining to FPCP it led to an increased patient awareness and greater FPCP attendance. A number of methods by which information relating to FPCP was disseminated to the public were described. The main methods were; signposting by healthcare staff, as a result of the embedding of services and via traditional advertising strategies.

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 associated with the process of embedding (information disseminated via word of mouth, or as a result of previous attendance) and traditional advertising strategies. Participants spoke of traditional advertising strategies such as posters, pamphlets, life-sized mannequin adverts, and the use of TV screens in practice waiting areas. The data repeatedly suggested that these more traditional methods of advertising were not successful. Furthermore, participants spoke of a lack of resource investment if these advertising approaches. The implication appeared to be that providers of FPCP services relied on time and good fortune for information to be disseminated via these methods. There appeared to be more certainty with regards to information provided by reception staff, which was described as ‘critical’.

*“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” (Phy2).*

*Theme 3; patient understanding of physiotherapy arises from several sources and is poorly aligned with the FPCP model*

There was a commitment to differentiate between ‘awareness of FPCP’ and ‘understanding of the role of FPCP’. From the physiotherapists’ perspective it was clear that FPCP sat within a more general adoption of the contemporary biopsychosocial (BPS) model of 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” (Phy2).* 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. One GP described the generally elevated expectations of the public generalising into healthcare; *“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” (GP2).* The impression was that this tension in patient expectations immediately positioned the FCP initiative on the back foot.

It was clear that patient understanding of the clinical application of physiotherapy came from several sources and, overall, this aligned poorly with the model of FPCP. For example, there was considerable data referencing the media, and in particular television, as providing an understanding of physiotherapy practice.

In addition, there was an impression of widespread confusion between different MSK healthcare professionals (Physiotherapist, osteopath, chiropractor). This resulted in uncertainty about who was, or wasn’t, a physiotherapist and appeared to reinforce the confusion pertaining to the application of ‘hands-on’, or manual, therapies which clearly stood against the contemporary BPS, FPCP model. The following quote from an administrator emphasised this.

*“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” (A3).*

The confusion about what it was that physiotherapists did, how they did it and where they did it (NHS services vs private practice services), resulted in patient confusion and there was a consensus in the data that participants from all groups felt that this lessened the likelihood of patients accessing FPCP. The confusion and misaligned expectations meant that patient disappointment was frequently reported in the data, and it would seem reasonable to imagine that this would adversely affect utilisation. The following patient quotation articulated this sentiment as they described their experience of accessing physiotherapy; *“Just usually cheesed off, and it’s a waste of time as usual. Which is what, you know, is what I’ve found” (P5).*

*Theme 4; characteristics and behaviours of patients influence access to FPCP services*

The features of patients who attended FPCP were discussed with participants and are presented as two sub-themes; patient characteristics and autonomous health seeking behaviours.

*Sub-Theme 1; patient characteristics influence access to FPCP services*

Previous research had ascribed particular characteristics to those patients accessing physiotherapy through their own volition [24–26]. These characteristics were explored with all participant groups. There was an initial sense from partici-

pants that age did not appear to influence those who attended (“I wouldn’t have picked a certain type of person, or group of people to be honest” (A2)). However, there was an impression that there might be specific considerations when it came to the older population accessing FPCP:

*“With the elderly. . .they might want to see the doctor rather than physiotherapist, kind of just to make sure that sort of thing is there”.* (GP1) (emphasis added).

This was a frequent finding in the data and appeared related to the pre-eminence of the GP for the older population and particularly those with multi-morbidities. The impact of the age of the patient and the existence of multi-morbidities highlighted the challenge in disentangling the proportion of patients with MSDs from the wider GP caseload. This was an issue highlighted previously [7] and challenged one of the fundamental justifications for FPCP, that of lessening GP workload. A further issue identified in the data that related to older people was the methods used to communicate to this population group. The approaches commonly used were thought, by all participant groups, to potentially inhibit older people accessing FPCP with concerns ranging from the application of internet-based methods of information dissemination to the language used in the materials distributed. There was also the perception that the isolation and lack of advocacy that frequently accompanied ageing might add a barrier. It is likely that this could extend to other socially isolated groups. So, although the descriptive data for these participants did not demonstrate a predominance of younger people attending FPCP there was evidence to suggest that the older population might require greater reassurance or experience greater obstacles.

There was a consistent finding in the data from all participant groups that obstacles to accessing FPCP could be additionally attributed to different cultural beliefs and expectations. These cultural sensitivities ranged from a preference to see a doctor, the clinician’s gender, a concern over undressing and an expectation for a more traditional medical model of ‘curative’ healthcare. One example of this cultural specificity is articulated in the following GP quote; *“More so from our overseas patients, I would say. 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”* (GP1).

#### *Sub-theme 2; autonomous health seeking behaviours influence access to FPCP services*

The previous sub-theme made a distinction between those people who might and those who might not access FPCP based on certain characteristics and this was not straightforward. Previous literature [25,26] has suggested the characteristic of autonomous health seeking behaviour 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 all participant groups, was that the association

between autonomous health seeking 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”* (A1).

However, the data suggested that autonomous health seeking behaviour, in the general population, remained the exception: *“I don’t think a lot of patients want to take the responsibility on themselves”* (A2). Furthermore, it was apparent that there were socioeconomic characteristics influencing the adoption of autonomous health seeking behaviours. One GP described their experience:

*“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 (inner city, deprived area), 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”* (GP2).

There was a consistent sense among participants, from both patient and staff groups, that these socioeconomic determinants influenced patient health seeking behaviour and subsequently access to FPCP and this clearly challenged the FPCP initiative.

## Discussion

This qualitative study synthesised new and important findings. The primacy of the GP in general practice is long established and FPCP stands against this positionality. As such, beyond the straightforward question of efficacy, it is important to understand the more nuanced issues associated with implementing FPCP.

Participants described physiotherapy as an established profession. However, the study highlighted poor public understanding of the clinical application of physiotherapy. Webster *et al.* [26] described a survey reporting 88% of the public supported self-referral to physiotherapy. However, it was not clear whether they were expressing their support for the concept or had knowledge that allowed them to make an informed decision [26]. There is little other previous research exploring public understanding of physiotherapy and none pertaining to FPCP. Evidence derived from high school age students was consistent with this research in that understanding of the clinical application of physiotherapy practice is poor [27,28].

Patient participant understanding derived from varied sources and was generally inaccurate. 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.

There was acknowledgement of the need to disseminate information about FPCP to stakeholder groups. The most common marketing strategies reported were traditional in approach (posters, pamphlets, life-sized mannequin adverts) and were largely invisible to patients and consequently deemed ineffective. Zadro *et al.* [29] suggested that “*marketing is new in physiotherapy*”, but evidence-based marketing ought to be considered a component of service developments. The study data suggested that any information disseminated should include information about the nature of the service and what patients might expect if they attended. Planning of marketing approaches should extend to specificity in terms of tailoring to clinical conditions and socioeconomic determinants. This aligns 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 [30,31].

Because of the ineffectiveness of marketing strategies, most patients who accessed FPCP were signposted by general practice reception staff. 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 [32,33]. Evidence has suggested potential patient resistance to the signposting [34] and the role had been shown to increase receptionist emotional burden [34]. Brant *et al.* [33] 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. They went on to report that training for this new, potentially burdensome, role was patchy. As such, it would appear important that the content and effectiveness of signposting training is evaluated in the future.

It was also clear that the FPCP initiative stood against the intransigent position where GPs are regarded as the legitimate default first point of contact practitioner. The dominance of the medical profession has been described at length [38,39]. Within this context it was felt that older people would be more likely to adhere to 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 equity of access to FPCP. There was the perception from healthcare professionals that the isolation and lack of advocacy that frequently accompanied ageing might add a barrier. However, it was likely that this could extend to other socially isolated, or minority, groups. It would appear extremely important to consider these features in future research if access to FPCP is to be equitable.

Previous work had suggested autonomous health-seeking behaviour was more evident in people accessing physiotherapy directly [25,26]. Despite this study corroborating this view the impression was that health autonomy in the population remained the exception. It appeared that there were

several cultural, demographic and economic determinants that influenced health autonomy.

### Strengths and weaknesses

The principle strength of this study is the highlighting of new and important evidence that can be subsequently considered in the implementation of FPCP. This study has looked beyond the efficacy of FPCP and considered more nuanced cultural issues that could undoubtedly influence the FPCP initiative. It is also of considerable strength that participants from every stakeholder group were represented. It could be considered a weakness that this study included participants from a discreet geographical region, so some caution needs to be exercised in generalising the results. The results have been articulated at a level that hopefully allows wider transferability.

### Conclusion

The evidence that is available would point towards the safety, acceptability and efficacy of FPCP [3–5,7]. However, as is often the case the success, or otherwise, of innovative interventions can rest on more nuanced issues. This study has provided novel evidence of how some of these issues might affect the FPCP initiative.

As an established health profession there may be an assumption of widespread population level understanding of physiotherapy, and by association FPCP. This appears not to be the case with widespread lack of awareness of FPCP and lack of understanding of FPCP specifically, and physiotherapy generally.

The evidence generated in this study suggested that traditional advertising approaches were, on the whole, ineffective in increasing awareness. It appeared that these advertising strategies were inadequately planned and resourced. This was exaggerated where initiatives were implemented in a geographically piecemeal way with unequal population coverage. The national commitment to the FPCP initiative [1,2] might result in a more comprehensive advertising strategy.

As well as addressing the apparent lack of awareness and understanding that was highlighted this more systematic, comprehensive approach to the dissemination of information pertaining to FPCP may also address the other potential barriers to FPCP. By providing reassurance about the safety and efficacy of FPCP it may start to place physiotherapists as a genuine alternative default first point of contact practitioner to the GP. Nevertheless, the FPCP initiative stood against the intransigent position with GPs regarded as the legitimate default first point of contact practitioner. The societal changes necessary to alter this default position are not going to happen overnight and will require time, patience and commitment. As one patient stated; “*[the default position of the GP] is a brick wall they’ve [Physiotherapy] 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" (P5).

Despite this new and important evidence arising from this study further work in the area is required. The success, or otherwise, of the FPCP initiative is dependent on the next steps taken in the national agenda. For example, questions remain with regards to models of FPCP and scope of practice of physiotherapists. More importantly, the question of models of implementation and issues around demand vs capacity still require considerable research. These are undoubtedly challenges for the next five years.

### Key messages

- There is general public awareness of physiotherapy as a profession.
- There is a lack of awareness of first point of contact physiotherapy.
- There is poor understanding of physiotherapy and first point of contact physiotherapy.
- Traditional methods of advertising first point of contact physiotherapy are ineffective and poorly planned.
- Signposting was fundamental in ensuring access to first point of contact physiotherapy.

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