Department of Health

Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services

Report

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Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services

Report

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Foreword

One of the key elements of Lord Darzi's *High Quality Care for All: NHS Next Stage Review Final Report*, which was launched in June, was services that are locally led, patient-centred and clinically driven. Every local vision articulated the need to improve access as a priority. Empowering patients to self-care/self-manage and enabling choice for patients were other key themes. Self-referral is a patient-centred approach that can help make local visions a reality.

It is important that we maximise the talents of all healthcare professions, including the allied health professions, to deliver services that are innovative and adapt to the needs of patients. Allied health professionals are autonomous, first-contact practitioners able to respond to a rapidly changing environment with new roles and new ways of working to improve the patient experience.

Self-referral is not a new concept. This report demonstrates how self-referral is being used by allied health professionals to improve services for children, vulnerable groups and individuals with long-term conditions.

The process of developing this work has been an example of co-production between health services, the Department of Health and the professional organisations, in particular the Chartered Society of Physiotherapy.

Feedback from patients, GPs and physiotherapists involved in the pilots is very positive. 'It's simple, it works and it's a win-win for everyone' is a comment that sums up the benefits for patients, staff and the health system.

I commend the report to you when considering local service redesign.

Ann Keen MP
Parliamentary Under-Secretary
of State for Health
October 2008

Introduction

This report signals a significant step towards making allied health professions services more accessible to the public and patients and towards providing more choice. It also signals the recognition that allied health professionals, as autonomous practitioners, can and should be the first point of contact for many patients.

The self-referral pilots to musculoskeletal physiotherapy build on extensive research in Scotland and highlight the many benefits of switching to self-referral.

This report documents the findings from six pilot sites. Significant benefits were identified for patients and local populations. There were also benefits for GPs, physiotherapists and the health and social care system as a whole, but I have been particularly interested in the unintended consequences of these pilots.

The physiotherapists and, crucially, their support staff worked hard to understand the needs of their local populations, including how they wanted to access services. They also worked to assess the demand for their services and to understand how best to manage supply. As a result, the sites are now data-rich and have an excellent basis for continued improvement.

The pilot sites were already planning to introduce self-referral. The pilots enabled them to do so, and have also given us the valuable information that is provided in this report. I know that all the pilot sites plan to continue and extend their work in opening up access.

I would like to take this opportunity to thank all those involved in this work.

I hope that this report will give other commissioners and services the confidence to trial self-referral in order to reap the rewards for their local populations and staff.

Karen Middleton
Chief Health Professions Officer

1. Executive summary

Policy context

1.1 The national 'Your health, your care, your say' public listening exercise in 2005 indicated support for self-referral to allied health professions AHP services, and the resulting White Paper[1] included the following commitment:

'…in order to provide better access to a wider range of services, we will pilot and evaluate self-referral to physiotherapy. We will consider the potential benefits of offering self-referral for additional direct access for other therapy services.'

The Department of Health (DH) has worked in partnership with six sites and the Chartered Society of Physiotherapy (CSP) to pilot self-referral to musculoskeletal physiotherapy. Demographic and clinical data relating to the population from the pilot sites was collected and analysed.

1.2 The vision and strategy set out in the *NHS Next Stage Review: Our vision for primary and community care*[2] promote personal and responsive services that listen to and act on patient views, delivered within a culture of high-quality care and continuous improvement. Patients should expect to be able to access services at times and in places that are convenient to them, make appointments easily and be seen by helpful and courteous staff who will listen to their needs.

1.3 Self-referral to AHP services is not a new concept. Physiotherapists (and other AHPs) have been able to act as first-contact practitioners since 1978.[3] Self-referral is well established in the independent sector. It is used in the NHS but is not 'universal', so there is inconsistency in the system.

1.4 At the beginning of the pilots the AHP professional bodies agreed a definition of self-referral. This was that '*Patients are able to refer themselves to a therapist without having to see anyone else first, or without being told to refer themselves by a health professional. This can relate to telephone, IT or face-to-face services.*'

The self-referral project

1.5 The aim of the pilots was to evaluate the impact of introducing self-referral to musculoskeletal physiotherapy, and in particular to:

- evaluate the widening of patients' access to musculoskeletal physiotherapy, which would include seeking the views of patients, GPs and physiotherapists;
- establish whether the significant number of users of private physiotherapy services in England would return to the NHS as a result of widening access;
- identify any changes to waiting times;
- understand any differences there might be in accessing self-referral by ethnic background (where English is not the first language);
- gauge the difference that self-referral makes to GP workload; and
- build on rather than replicate published work.

1.6 Patients with musculoskeletal problems or injury from 20 participating GP practices (total population 160,000) were able to self-refer to physiotherapy in addition to existing referral mechanisms. At no time were patients who self-referred given preferential treatment in terms of waiting times.

Results of the self-referral pilots

1.7 The results of the analysis from the pilot sites indicate that patient self-referral to musculoskeletal physiotherapy services has the following benefits:

Patient benefits

- High levels of service-user satisfaction and confidence.
- A more responsive and attractive service to patients with acute conditions, affording them wider access.
- Empowering of patients to self-care/ self-manage to meet their needs.
- Lower levels of work absence.

Service benefits

- No increase in demand for services.
- Accessed by males and females of all ages.
- No evidence that BME groups use self-referral less than white groups.
- Greater levels of attendance and completion of treatment.
- No return to the NHS by patients traditionally seen within the private sector.
- Well accepted and supported by physiotherapists and GPs.
- Associated with lower NHS costs.
- 75% of patients who self-referred did not require a prescription for medicines.

Implications for other allied health professions' services

1.8 A workshop attended by the AHP professional bodies and AHP leads within Strategic Health Authorities in March 2008 concluded that self-referral is just as relevant to the majority of AHP services as it is for physiotherapy to improve the patient experience via expert assessment, diagnosis, treatment, management and education.

1.9 Participants recognised that self-referral is not a new concept. Examples of how self-referral is already being used across other AHP services and clinical specialities can be found in Appendix 1.

2. Policy context

2.1 The national 'Your health, your care, your say' public listening exercise in 2005 indicated support for self-referral to AHP services, and the resulting White Paper[1] included the following commitment:

'…in order to provide better access to a wider range of services, we will pilot and evaluate self-referral to physiotherapy. We will consider the potential benefits of offering self-referral for additional direct access for other therapy services.'

DH has worked in partnership with six pilot sites and the CSP to pilot self-referral to musculoskeletal physiotherapy.

2.2 The vision and strategy set out in the report *NHS Next Stage Review: Our vision for primary and community care*[2] promote personal and responsive services that listen to and act on patient views, delivered within a culture of high-quality care and continuous improvement. Patients should expect to be able to access services at times and in places that are convenient to them, make appointments easily and be seen by helpful and courteous staff who will listen to their needs.

2.3 Dame Carol Black's Review of the health of Britain's working age population, *Working for a healthier tomorrow*,[4] was published in March 2008. It identifies three principal objectives:

- prevention of illness and promotion of health and wellbeing;
- early intervention for those who develop a health condition; and
- an improvement in the health of those who are out of work, so that everyone with the potential to work has the support they need to do so.

Self-referral has the potential to be a cornerstone for all three areas, contributing to a new approach to health and work.

2.4 Self-referral is in line with a number of current healthcare policies – choice, access, self-care/self-management. It also focuses on shifting the paradigm from secondary to primary care. Furthermore, self-referral has the potential to prevent acute problems becoming long-term conditions; if people with long-term conditions are allowed to self-refer, they can receive individual advice and education about their condition and are enabled to manage their condition more effectively, avoiding unplanned admissions to hospital.

2.5 As a greater range of providers of NHS services come into the system, the options for people seeking AHP services and other services should increase. Self-referral offers a powerful mechanism for rewarding quality, convenience and positive patient experiences through choice.

2.6 Self-referral has the potential to support achievement of the 18-week target in orthopaedics, by limiting the number of patients who have to go through that pathway to those who really need to see an orthopaedic consultant.

3. Background to self-referral

3.1 Patients and the public have made it clear that they would like to have wider access to more convenient health and care services.

There are a number of reasons for this:

- increasing desire for services closer to where people live and work, and at times beyond nine-to-five;
- growing convenience in other areas of people's lives, fuelling higher expectations of health and care services;
- the strong downward trend over the past decade in waiting times for many health and care services which has increased expectations of wider access across the system as a whole; and
- a shift among service users towards a greater willingness to embrace self-care and self-management.

3.2 Self-referral to AHP services is not a new concept. Physiotherapists (and other allied health professionals) have been able to act as first contact practitioners since 1978.[3] Self-referral is well established in the independent sector. It is used in the NHS but is not 'universal', so there is inconsistency across the country in accessing AHP services. Self-referral has the potential to support Primary Care Trusts (PCTs) in their achievement of the ambitions of world class commissioning. With the shift from secondary to primary care services, including both prevention of ill health and promotion of health and wellbeing, PCTs and increasingly practice-based commissioners will be looking for new ways of delivering services to meet these challenges. Examples of self-referral to AHP services are provided in Appendix 1.

3.3 At the beginning of the pilots the AHP professional bodies agreed a definition of self-referral. This was that *'Patients are able to refer themselves to a therapist without having to see anyone else first, or without being told to refer themselves by a health professional. This can relate to telephone, IT or face-to-face services.'*

3.4 Research conducted between 2003 and 2005 in Scotland[5,6,7,8] studied self-referral within NHS settings. The aim was to determine levels of effectiveness and efficiency on which to base future service provision, and to determine the impact of differences in geographical settings or deprivation on the rate of self-referral to physiotherapy. The research was a multi-centred trial involving 26 general practices throughout Scotland. Over 3,000 patients participated in the research.

3.5 The published findings included the following:

- patients referring themselves unprompted accounted for 22% of all referrals, those referring themselves at the suggestion of their GP accounted for 18%, and the remaining 60% were referred by their GP using the traditional referral route;
- introducing self-referral did not lead to an increase in the overall referral rate, except in areas with a history of under-provision;
- patients of all ages, genders and levels of deprivation used self-referral to access services;
- 76% of self-referring patients completed their course of

physiotherapy, compared with 69% of GP-suggested referrals and 72% of GP referrals;

- average costs per episode were lower for self-referring patients, owing to less GP use of prescribing and diagnostic tests; and
- levels of patient satisfaction and confidence were higher.

3.6 A year-long study[9] in Tower Hamlets, east London in 2006 reported a self-referral rate among the Bengali ethnic population of 30%, almost as high as the 36% representation of Bengalis within the practice population – despite all the advertising material being available only in English.

4. The project and the pilot sites

4.1 The aim of the project was to evaluate the impact of introducing self-referral to musculoskeletal physiotherapy, and in particular to:

- evaluate the widening of patients' access to musculoskeletal physiotherapy, which would include seeking the views of patients, GPs and physiotherapists;
- establish whether the significant number of users of private physiotherapy services in England would return to the NHS as a result of widening access;
- identify any changes to waiting times;
- understand any differences there might be in accessing self-referral by ethnic background (where English was not the first language);
- gauge the difference that self-referral made to GP workload; and
- build on rather than replicate published work.

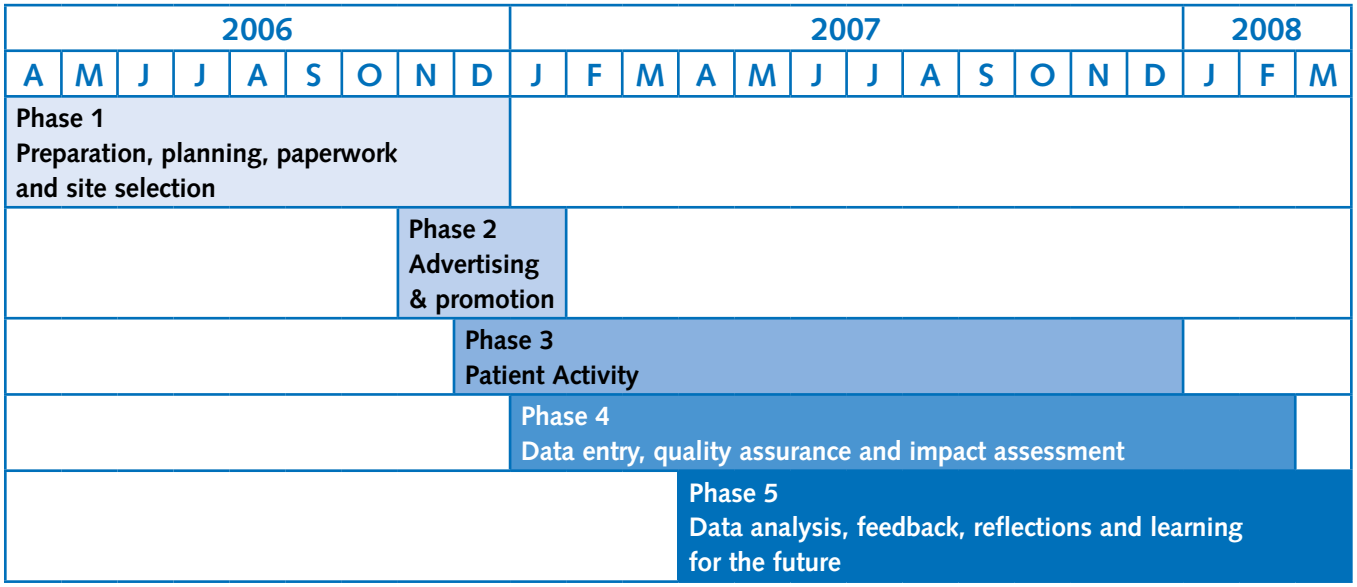
4.2 Six pilot sites participated, all of which were intending to introduce self-referral:

- Barnet Hospital – Barnet and Chase Farm Hospitals NHS Trust;
- Bridgwater and Burnham-on-Sea Hospitals – Somerset PCT;
- Darent Valley Hospital – Dartford and Gravesham NHS Trust;
- King's College Hospital NHS Foundation Trust;
- Melksham Community Hospital – Wiltshire PCT; and
- Solihull Hospital – Heart of England NHS Foundation Trust.

Appendix 3 details the main characteristics of the sites.

4.3 The sites covered a range of populations, trust types, physiotherapy services and degrees of integration with other musculoskeletal services such as Integrated Clinical Assessment and Treatment Services (ICATS). All sites had to show evidence of collecting baseline data for their services for the previous three years, and had to have the full support of their organisation. Pilot site status meant that support from DH was provided for the added evaluation required for the White Paper commitment.

4.4 The work had five phases, illustrated in the following table.



4.5 A joint DH and CSP self-referral working group was established to provide oversight of the project.

4.6 Patients with musculoskeletal (MSK) problems or injury from 20 participating GP practices (total population 160,000) were able to self-refer to physiotherapy in addition to existing referral mechanisms. At no time were patients who self-referred given preferential treatment in terms of waiting times.

4.7 Referrals to physiotherapy during the pilot year were classified as 'self-referral', 'GP referral' or 'GP-suggested' (where the GP had suggested that the patient refer themselves to physiotherapy).

4.8 Questionnaires were sent to all patients, GPs and physiotherapists participating in the project, and were analysed using Pinpoint Questionnaire Software.

4.9 Demographic and clinical data relating to the population from the pilot sites was collected over a year. A specifically designed data collection sheet was adapted from the Scottish study; a copy of this is provided in Appendix 4.

4.10 The comparative dataset was made up of anonymised data for 2,835 patients.

The data entered was analysed using SPSS[(a)]. The data was subjected to non-parametric testing, with the level of significance set at 5%. The specific tests used were the chi-squared test for nominal and categorical data and the Kruskal-Wallis test for continuous data.

4.11 More detail of the methodology for the self-referral pilots to physiotherapy is provided in Appendix 4.

(a) SPSS (Statistical Product and Service Solutions) is a computer program for managing and analysing social scientific data.

5. Findings

5.1 Analysis of the data from the pilot was undertaken by Dr Lesley Holdsworth, one of the authors of the self-referral research in Scotland.[5,6,7,8] An outline of the methodology used is provided in Appendix 4.

Patient experience

5.2 Among patients who self-referred during the pilots:

- 77% were satisfied or very satisfied with being able to self-refer;
- 59% preferred a community setting as the location for assessment/treatment;
- 65% preferred to be able to make an appointment to see the physiotherapist without having to see their GP first;
- 72% were confident that they knew when they needed to consult a physiotherapist;
- 74% thought that patients can learn a lot about how to manage their conditions themselves;
- 89% would use the service again; and
- fewer than 1% regularly used private providers, and fewer than 24% had ever used a private provider.

Quotes from patient feedback:

'I have been very impressed by the service with the self-referral system and the help and advice I received from the physiotherapist. The trial avoids the 14-day wait to see a doctor before being referred for treatment, which means the patient receives treatment and advice that much earlier.'

'I know I can contact my physio when I need to, and that in itself is a comfort. I always feel I am wasting my GP's time when I know the treatment I need, and it cuts out the waiting time for referral. Hope it continues.'

'Being able to discuss what one is concerned about – regarding medicine, exercise, activities, causes of pain, causes of symptoms and what is safe to ignore – were all very important regarding my peace of mind.'

'Self-referral is an exceptional way of getting treatment. It cuts down the waiting time. The system should be used for other kinds of treatment.'

Demand

5.3 The impact of introducing self-referral was explored by comparing the total number of referrals reported for two six-month periods (1 February to 31 July in both 2006 and 2007). Total referral numbers for these periods were similar (2,061 in 2006 and 1,883 in 2007), indicating that there was no increase in demand as a consequence of introducing self-referral. The research in Scotland had yielded similar findings in relation to demand. Anecdotal evidence from physiotherapy services in England that do not currently include self-referral suggests similar referral patterns for 2006 and 2007.

5.4 Referrals per referral type were as follows:

23.6%	Self-referrals
35.4%	GP-suggested referrals
41.0%	GP referrals

Gender, age and ethnicity

5.5 There was no significant association between referral type and gender – the 'p-statistic' produced by analysis of the data had a value of 0.684, well above the 0.05 level below which an association may be thought probable. Similarly, no significant association was found between referral type and age ($p=0.253$) or ethnicity ($p=0.055$). The research in Scotland had demonstrated no relationship between gender or age group and route of referral.[7]

5.6 A number of ethnic minorities were represented only in small numbers, and it was not possible to determine whether certain ethnic minorities used one form of access over another.

Physiotherapy waiting times

5.7 There were significant differences in the waiting times for physiotherapy ($p<0.001$) and the duration of presenting symptoms ($p<0.001$) across the sites. All sites offered urgent appointments within two weeks. More self-referring patients and patients referred at the suggestion of their GP were seen within two weeks than those referred by GPs.

5.8 Waiting times in all sites fell from an average of 14.2 weeks to 8.4 weeks. Throughout the study period, the pilot sites were also dealing with significant changes to MSK services as a result of publication of the MSK strategy, the 18-week patient pathway and the development of ICATS. These may have been contributory factors in the fall in waiting times.

Employment and absence from work

5.9 There were no significant differences between the employment status of patients of each referral type ($p=0.258$). However of those in paid employment, the proportions absent from work did differ between referral types ($p<0.001$), as did the average number of days absent from work (self-referral – 4.1 days, GP-suggested – 6.5 days, GP referral – 7.0 days). The proportions who had been absent from work for longer than one month were 8.7% for self-referrals, 16.9% for GP-suggested referrals and 17.2% for GP referrals. These results indicate self-referrers were less likely to be absent from work.

Impact on private physiotherapy providers

5.10 Fewer than 1% of patients reported that they regularly used private providers, and fewer than 24% had ever used a private provider. The majority of patients in all three referral groups said they would have gone to their GP if self-referral had not been available. (See also 5.23.)

Presenting conditions, severity and duration of treatment

5.11 While the majority of patients of all three referral types had had symptoms for over three months, significantly more self-referring patients reported symptoms of less than two weeks' duration (6.5% of self-referrals, 4.4% of GP-suggested and 2.7% of GP referrals).

5.12 In terms of presenting conditions there were significant differences between the groups ($p<0.001$). For example the lowest proportion of referrals for low back and neck problems were from GPs (30.3%), compared with 37.0% of GP-suggested referrals and 35.6% of self-referrals.

5.13 There were no significant differences between referral types in condition severity reported by either the patient or the physiotherapist ($p=0.946$). The majority of all referrals were classified as moderate.

5.14 Self-referring patients completed their treatment in greater proportions (89.6% compared with 87.7% of GP-suggested referrals and 85.5% of GP referrals; $p<0.001$).

5.15 There was no difference between the groups in the number of physiotherapy contacts.

Use of other NHS services

5.16 There were significant differences in use of NHS services up to three months prior to or during the physiotherapy episode of care ($p=0.023$). 78.5% of self-referring patients did not undergo X-ray, MRI or referral to secondary care compared with 70.6% of GP referred patients and 69.9% of GP suggested referrals. There were also significant differences in terms of level of prescribing ($p<0.001$), with 75.7% of self-referring patients receiving no prescription compared with 62.9% of GP-suggested referrals and 61.2% of GP-referred patients.

Clinical outcomes

5.17 In terms of clinical outcome, there were no significant differences between the initial and final numerical rating scores across the referral types. All groups reported significant improvement over the course of their treatment.

Costs

5.18 The research methodology in Scotland had included detailed economic modelling which was not transferable to the English pilots.

5.19 Findings from the research in Scotland indicated 17% lower costs for self-referral compared with GP-suggested referral, and 26% lower costs compared with GP referral.

5.20 A number of the findings from the English pilots support the idea that self-referral is associated with lower costs – for example less use of GP time, less use of prescriptions and earlier presentation resulting in less contacts per episode of physiotherapy care.

GP views

5.21 GPs indicated a high level of confidence in physiotherapists acting as first-point-of-contact practitioners, and 91% of GPs wanted the self-referral facility to continue. The primary reasons cited were:

- savings in GP consultation and administrative time;
- convenience for patients;
- encouraging patient autonomy; and
- positive impact on waiting times.

5.22 A majority (60%) of GPs considered that choice of access had improved as a consequence of introducing self-referral.

5.23 Almost three-quarters (73%) of GPs reported that they commonly recommended private providers to MSK patients, and 45% thought self-referral to physiotherapy within the NHS could attract patients from the private sector. However, many of these responses came with additional comments which consistently reported that the main factors influencing use of private providers over NHS services were ease of access, waiting times and convenience of appointments.

5.24 GPs consistently saw benefits for patients in physiotherapists being able to monitor the use of non-steroidal anti-inflammatory drugs (NSAIDs), request routine X-rays, and monitor and issue sickness certification. GPs were less sure of the benefit for patients in physiotherapists being able to issue prescriptions for NSAIDs.

Typical GP comments:

'It has been very successful, has saved GPs considerable time and saved patients unnecessary trips to the surgery.'

'It gives more autonomy to the patient to have their own part in helping themselves get well. It reduces the paperwork for doctors.'

'Saves time for GP practices. No disadvantages as long as communication with GP practice continues.'

'They [physiotherapists] are more skilled than us in certain musculoskeletal areas and I value their diagnostic skills as well as management of the actual physiotherapy session.'

'I feel they have more time to assess patients with musculoskeletal problems and better experience.'

'The patients refer themselves. If the physiotherapist is uncomfortable they send them back with a clear, concise clinical finding – most helpful.'

Physiotherapy feedback

5.25 Among physiotherapists, 96% considered referrals via the three access routes appropriate.

5.26 Some 80% of physiotherapists considered that choice of access had improved as a consequence of introducing self-referral.

5.27 Only 34% of physiotherapists felt that the general public understood what physiotherapy could do for them. Numerous suggestions were made as to how this situation could be remedied:

- increased marketing initiatives at professional and local levels, including better use of the media;
- patient leaflets;
- healthcare professional education and advertising; and
- school-based education programmes for children.

Physiotherapist comments:

'You need to understand your population and what demand there is out there. It's good for patients and staff.'

'It's simple, it works and it's a win-win for everyone.'

5.28 Physiotherapists consistently saw benefits for patients in physiotherapists being able to monitor the use of NSAIDs, request routine X-rays, and monitor and issue sickness certification.

5.29 One of the benefits recognised by all the sites was the greater knowledge of population demographics gained through the pilots. This was particularly relevant for the sites in considering how they made information on self-referral available to seldom-heard and BME groups within the pilot practice populations.

Current status

5.30 All the pilot sites are continuing with self-referral to MSK physiotherapy services, and some are extending it to other GP practices.

6. Implications for access to other AHP services

6.1 The White Paper[1] stated:

'*We will consider the potential benefits of offering self-referral for additional direct access for other therapy services*.'

AHP workshop

6.2 A workshop attended by the AHP professional bodies and AHP leads within Strategic Health Authorities in March 2008 explored four questions:

- Can benefits of self-referral for patients be identified?
- Does self-referral meet clinical governance requirements to ensure patient safety?
- Can cost-effectiveness of self-referral be demonstrated?
- Is self-referral easy for staff to introduce?

6.3 A number of examples were provided to illustrate how self-referral is already being used across a number of AHP services and clinical specialities.

6.4 There was some initial caution in respect of introducing self-referral. However, the representatives from the pilot sites reported that:

- confidence in using self-referral to improve service delivery and outcomes for patients had developed throughout the pilot period; and
- investment in time was needed, particularly to plan for implementation. The sites emphasised that working with commissioners, GP practices and all physiotherapy staff – e.g. using marketing to ensure appropriate self-referrals through the leaflet/referral form, and working with practice managers – was essential to build confidence and overcome any barriers to implementation.

6.5 Participants recognised that self-referral is not a new concept, and examples were provided to illustrate how self-referral is already being used across a number of AHP services and clinical specialities (see Appendix 1).

6.6 Participants thought that self-referral:

- should be considered in the context of the patient journey/care pathway rather than by profession;
- can improve access to primary care;
- can be an enabler – reducing waiting lists, improving self-care and choice, and shifting diagnostics and care into the community;
- can alter patient expectations – providers will need to consider service redesign to reduce waiting times;
- may identify unmet need;
- increases patient choice rather than being limited by the knowledge of the gatekeeper to choose;
- has the potential, where it takes place to multi-professional AHP teams, to reinforce AHPs as integrators of care; and
- can deliver safe, effective and timely interventions.

6.7 The workshop concluded that self-referral is just as relevant for the majority of AHP services as it is for physiotherapy, and has the potential to be used in services for children, adults and older people and across all clinical specialities.

Conclusions

7.1 The aim of the self-referral pilots to musculoskeletal physiotherapy was to explore the impact of opening up access to physiotherapy through self-referral where it had not previously been part of usual musculoskeletal service provision.

7.2 Analysis of the data from the self-referral pilots to physiotherapy in England supports the finding from the research in Scotland that self-referral does not increase demand except where there has previously been under-provision.

7.3 The wider access that self-referral gives is valued by patients, GPs and allied health professionals, is in line with current health policy and gives value for money to the NHS.

7.4 Self-referral can increase access to primary care services by enabling GPs to spend more time with patients who have more complex health problems.

7.5 Self-referral can help reduce waiting times across a pathway – for example, physiotherapy services within orthopaedics, orthoptic services in eye care, occupational therapy in neurological services.

7.6 Self-referral supports self-care/self-management, particularly of long-term conditions, by empowering patients to be more actively involved in managing their condition. Patients can access AHP services easily, receive advice and treatment and prevent an acute problem from becoming a long-term condition.

7.7 A number of additional benefits were identified, with self-referral found to:

- widen access to AHP services
- reduce the number of associated NHS costs, particularly for investigations and prescribing; and
- reduce work absence

7.8 The results of the analysis from the pilot sites and from the workshop indicate that patient self-referral to AHP services can improve the patient experience and make better use of resources.

Patient benefits

- High levels of service-user satisfaction and confidence.
- A more responsive and attractive service to patients with acute conditions, affording them wider access.
- Empowering of patients to self-care/self-manage to meet their needs.
- Lower levels of work absence.

Service benefits

- No increase in demand for services.
- Accessed by males and females of all ages.
- No evidence that BME groups use self-referral less than white groups.
- Greater levels of attendance and completion of treatment.
- No return to the NHS by patients traditionally seen within the private sector.
- Well accepted and supported by physiotherapists and GPs.
- Associated with lower NHS costs.
- 75% of patients who self-referred did not require a prescription for medicines.

Appendix 1

Examples of self-referral to AHP services

I. The Portsmouth City Teaching PCT **podiatry** service is commissioned to enable the most vulnerable groups within Portsmouth and south-east Hampshire to have self-referral access to professional staff for assessment and advice. These groups are specifically:

- those with a long-term condition that has a known impact on foot health and mobility, e.g. diabetes or rheumatoid disease;
- children and adults with a registered disability; and
- people aged over 65.

Approximately 35% of all initial contacts to the service are self-referred. On completion of an application form, an appointment for assessment is made, reducing the need for an appointment with a GP and avoiding an additional step in the process. Many patients benefit from a single appointment, having discussed their foot health issues with a health professional for the first time. At this appointment patients can be signposted to other NHS services or other foot care services provided locally, for example by social services or by other organisations such as Age Concern. Treatment plans will be agreed for those requiring specific interventions.

A review of referrals based on risk factors demonstrated that self-referral did not overload the service.

II. The Early Years **speech and language therapy** service for children under the age of five operates 'Talking Walk-in' sessions as the first point of contact in Hackney (City and Hackney Teaching PCT). This self-referral method means that parents come when they are concerned and they can be seen straight away. Previous audits of non-attendance at initial appointments showed that the longer the wait for the service or the lower the level of parental concern, the less likely families are to turn up. Self-referral drop-ins have been found to be more time-efficient for the therapists and there are now no waiting lists for initial appointments. Written referrals are also accepted and the majority are invited to a 'Talking Walk-in', which are held in a number of locations across Hackney.

III. Community services in the East Riding of Yorkshire and City of Hull:

- Access to all adult community services includes self-referral.
- Access to the children's service is by referral from consultants, community medical officers (paediatrics), GPs and school doctors. Referral by a medical practitioner provides the **occupational therapist** with all the relevant information needed to care for children with a complex physical disability. Open access to the service

is provided for all children following this initial referral. A re-referral can be made for a child by any health/social service/education professional and by parents/carers.

IV. The Wandsworth PCT Community Neuro Team has been established for over 10 years and operates an open referral system, which includes self-referral. Self-referral is usually from patients who are seeking further input from the team as their needs change. Referral is to the **multi-disciplinary team,** which includes a speech and language therapist, an occupational therapist, a physiotherapist and a dietitian.

V. Self-referral to **dietetic services** at Bradford Hospital falls into two main categories:

- Firstly, direct access self-referral where patients are able to independently contact the dietetic service and book a place on a supermarket tour, or simply turn up to one of the diabetes drop-in sessions.
- Secondly, in a number of the clinical settings dietitians work as an integral part of the multi-disciplinary team (i.e. attend clinics on the same day/time as the GP/nurse/diabetes specialist, and often work alongside these other healthcare professionals in the same clinical consultation), and in these circumstances patients are able to self-refer.

Appendix 2

AHP professional bodies

Association of Professional Music Therapists www.apmt.org

British and Irish Orthoptic Society www.orthoptics.org.uk

British Association of Art Therapists www.baat.org

British Association of Dramatherapists www.badth.org.uk

British Association of Prosthetists and Orthotists www.bapo.org

British Dietetic Association www.bda.uk.com

British Paramedic Association www.britishparamedic.org

Chartered Society of Physiotherapy www.csp.org.uk

College of Occupational Therapists www.cot.org.uk

Royal College of Speech and Language Therapists www.rcslt.org

Society of Chiropodists and Podiatrists www.members.feetforlife.org

Society of Radiographers www.sor.org

Appendix 3

Characteristics of pilot sites

Site a) Geographical profile b) Deprivation# c) Percentage white (persons)*	Trust	Pilot practice population	GP practices participating in pilot
Darent Valley Hospital a) Urban b) 170/354 c) 91%	Dartford and Gravesham NHS Trust	16,300	2
King's College Hospital a) Urban b) 23/354 c) 50%	King's College Hospital NHS Foundation Trust	25,280	4
Bridgwater and Burnham-on-Sea Hospitals a) Semi-rural/rural b) 234/354 c) 96%	Somerset PCT	28,425	2
Melksham Community Hospital a) Semi-rural/rural b) 261/354 c) 96%	Wiltshire PCT	26,103	3
Solihull Hospital a) Urban b) 15/354 c) 89%	Heart of England NHS Foundation Trust	18,400	2
Barnet Hospital a) Urban b) 193/354 c) 60%	Barnet and Chase Farm Hospitals NHS Trust	47,831	6

The English Indices of Deprivation 2004, Department for Communities and Local Government. (Note these have now been replaced by Indices of Deprivation 2007).

* Neighbourhood statistics, 2001 Census, Ethnic Group (UV09), Office for National Statistics.

Appendix 4
Outline methodology

Pilot sites

I. A notice was placed in *Frontline* (the CSP newsletter) seeking providers of physiotherapy services that may be interested in being involved in a national pilot.

II. Six pilot sites were selected:
- Barnet Hospital – Barnet and Chase Farm Hospitals NHS Trust
- Bridgwater and Burnham-on-Sea Hospitals – Somerset PCT
- Darent Valley Hospital – Dartford and Gravesham NHS Trust
- King's College Hospital NHS Foundation Trust
- Melksham Community Hospital – Wiltshire PCT
- Solihull Hospital – Heart of England NHS Foundation Trust.

III. All sites had to show evidence of collecting baseline data for their services for the previous three years, and of having the full support of their organisation.

IV. The sites were selected on the basis that self-referral was already a planned development. Pilot site status provided support and the added evaluation required for the White Paper commitment. The sites also covered a range of populations, trust types, physiotherapy services and degrees of integration with other musculoskeletal services, e.g. ICATS.

V. Support was provided to the pilot sites by a site co-ordinator. Initial visits to the sites and subsequent workshops assisted them in their preparation for introducing self-referral. This included the marketing of self-referral, the development of patient self-referral forms and posters, and the finalising of the data collection form. The site co-ordinator provided regular contact throughout the one-year pilot by telephone and email support, and site visits took place at the midway point.

Project

VI. The project started on 1 December 2006, with all patients referred or referring themselves to physiotherapy services over a one-year period (the pilot finished on 31 December 2007). Due to the varied waiting lists at each of the pilot sites, the first three months of the pilot (up to 28 February 2007) were treated as a 'run-in' period and not included in the final analysis of clinical and demographic data. The only exclusions were children under the age of 16 and those not able to give consent.

VII. Each participating physiotherapy service had received approval from the chair of their local ethics committee to undertake this service evaluation.

VIII. Marketing of the self-referral process used a variety of methods. Posters and leaflets were placed in all the participating GP practices and in supermarkets, pharmacies

and libraries. A number of sites made presentations to the participating GP practices.

IX. Each of the sites also created additional initiatives to raise awareness and facilitate self-referral. Examples of these include a presentation developed for screens in the Somerset practices' waiting areas, two sites (Barnet and King's College) placing the referral form on their trusts' websites, and Solihull working with the practice manager to attach leaflets to repeat prescriptions and letters sent out to patients. A number of sites also placed items in practice newsletters where these were available, and King's had an item in the local press.

X. Three categories of referral were used:

- GP referral – patient seen by GP who refers them to the physiotherapy service;
- GP-suggested referral – GP sees patient and suggests to them that they use the self-referral facility; and
- self-referral – patient completes the self-referral form without seeing the GP first.

Data collection

XI. Data collection focused on two main areas – baseline data and study data. The baseline data included demographic and practice data, plus information on historic demand, activity and waiting times. The study data included patient data at first contact and at discharge. It also included feedback from patients, GPs and physiotherapists who took part in the pilots. The final patient dataset was made up of anonymised data for 2,835 patients.

XII. Data collection included:

- a data form completed for each patient and an anonymised copy forwarded to the CSP;
- a patient feedback form sent to all patients four weeks after discharge;
- a monthly update from the sites, which recorded any changes such as staffing; and
- GP and physiotherapist feedback forms at the end of the pilot.

XIII. Demographic and clinical data relating to the patients from the six sites was collected over a full year. This included:

- **at initial contact:**
  referral date
  assessment date
  age
  sex
  ethnicity
  disability
  alternative private providers
  condition category
  severity of presenting condition
  duration of symptoms
  initial patient perception of severity of condition
  employment status and number of days absent from paid employment.

- **at final contact:**
  discharge data
  reason for discharge
  final patient perception of severity of condition
  total number of contacts.

XIV. A specifically designed data collection sheet was adapted from the Scottish study[5,6,7,8] to record all of the required information on one side of A4. Carbonised sheets meant that physiotherapists only had to record this information once, and this became part of the physiotherapy record. After discharge, one copy was retained and the carbon duplicate returned to the CSP for entering onto a database. Following this, the database was forwarded to the Department of Health for analysis, which was undertaken by Dr Lesley Holdsworth, one of the authors of the research in Scotland.

Statistical analysis

XV. The data entered was analysed using SPSS, and was subjected to non-parametric testing with the level of significance set at 5%. The specific tests used were the chi-squared test (for nominal and categorical data) and the Kruskal-Wallis test (for continuous data).

XVI. Data collection and evaluation complied with the Data Protection Act, the NHS confidentiality code of practice and the Caldicott Guidelines. All sites had board-level agreement and support for their participation.

XVII. However, there are some limitations to the study that need to be taken into account:

- The project was undertaken as a service evaluation, to build on the existing evidence from Scotland, not as a research study.
- Data from one site was excluded as it was incomplete and unreliable.
- The small number of patients from BME groups meant that firm conclusions regarding use of any of the referral mechanisms were not reached.

Data Form – National (NHS England) Self-Referral to Physiotherapy Pilots

Patient name

Serial Number: [1]

Patient postcode Date of Birth / /

Please tear and send off part below

Patient practice/GP Serial Number: [1]

Date of 1st GP consult (GP refs ONLY) / / Referral date / /

Date form received / / Initial assessment date / /

Working days from referral/form received to assessment weeks ☐ days ☐

Referral type Self ☐ GP ☐ GP suggested ☐ Other *(please state)*

Pat. gender Male ☐ Female ☐ Age Years ☐ Months ☐

Do they consider themselves disabled Yes ☐ No ☐

Ethnic origin Refused to say ☐

If you had not come here, where would you have gone? Private sector ☐ GP ☐

Have you gone to the private sector in the past for this or previous problems Yes ☐ No ☐

On a regular basis ☐ please specify

Duration of symptoms < = 2 weeks ☐ 2-6 weeks ☐ 7-12 weeks ☐ >12 weeks ☐

Employment status Paid employment ☐ Student ☐ Retired ☐ House person ☐ Unemployed ☐

If in paid employment, total number of days off work as a days consequence of this condition ☐☐☐

(put in 000 if not applicaable)

Condition category LBP ☐ Neck ☐ Thoracic ☐ Knee ☐ LL ☐ Multi ☐ UL ☐ Shld ☐

Neuro ☐ Urology ☐ Other ☐ *(please state)*

Previous physio Yes ☐ No ☐ No. referrals ☐☐☐ Severity Mild ☐ Moderate ☐ Severe ☐

Patients initial score: Pain VAS – Score (0-10) ☐☐☐ Affecting daily life VAS – Score (0-10) ☐☐☐

Discharge date

Time from referral to discharge Weeks ☐ Days ☐ Total number of contacts ☐

Discharge reason Rx completed ☐ Failed to complete ☐ Condition resolved 1st appoint ☐

DNA ☐ Re-referred to GP (why?) ☐ Other

Patients final score: Pain VAS – Score (0-10) ☐☐☐ Affecting daily life VAS – Score (0-10) ☐☐☐

Was the patient prescribed any of the following by their GP before or during this Physiotherapy intervention?

	Yes	No
NSAIDs	☐	☐
Painkillers	☐	☐

Other *(please state)*

Did the patient undergo any of the following related to this condition up to 3 months prior to or during the physiotherapy episode of care

X-Ray ☐ MRI scan ☐ Referral to secondary care ☐ Other *(please state)*

Additional comments for the patient record can be made on the reverse of the carbonised copy beneath

Appendix 5

References

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9 **Howarth, B. (2006)** *Physiotherapy self-referral – final evaluation*, **Tower Hamlets PCT (unpublished)**

Further sources of information

Self-referral to physiotherapy pilots

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Department of Health (2008) *Physiotherapy Pathway Improvement Tool*, **London, Department of Health (www.18weeks.nhs.uk)**

Appendix 6

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