Self-referral to physiotherapy

Chris Salisbury on behalf of the 'Making the Most of Evaluation' research group

Background

The concept of self-referral (without referral from a GP) for NHS services gained momentum during the 1990s. The White Paper 'Our Health our care our say'[1] noted that there were good examples from around the country of how this approach had increased the accessibility of services. An example highlighted in the White Paper was the PhysioDirect service in Huntingdon, in which patients can contact a physiotherapist by telephone and then be seen in person if necessary.

Providing timely access to physiotherapy has long been a problem in the NHS, so physiotherapy is a good example of the need for simpler, quicker and more convenient routes to care. The concept of self-referral to physiotherapy began to gather momentum in the 1990s, reflecting many other initiatives to promote a more patient-focused NHS.[2-5] In addition, there has a strong push from the profession, represented by the Chartered Society of Physiotherapists, to allow patient self-referral. To some extent this reflects a long term trend of allied health professional groups seeking to strengthen their right and ability to manage their own patients, without referral from doctors.

An international perspective shows that models of care based on direct access by patients have been developed since the 1970s in several developed countries, often couched in the rhetoric of promoting professional identity. In Australia, for example, a seminal publication in 1977[6] pioneered the 'professional advance' of direct access in physiotherapy. In the United States, since the early 1980s individual states have been 'fighting for the right of patients to see physical therapists without having to obtain a physician referral'.[7] Direct access was introduced in the Netherlands in 2006.[8]

In the late 1990s, self-referral to physiotherapy began to be implemented and studied in the UK. A pioneering study found that patients used a self-referral service appropriately and that GPs wanted the service to continue.[9] Fears of being inundated with referrals and missing important diagnoses were not realised. A series of observational studies by Holdsworth et al have expanded the evidence base, including an observational study of self-referral by patients from 29 general practices throughout Scotland.[10-13] These studies have suggested that self-referral is feasible, acceptable to users and providers, and leads to reductions in GP workload. Referral rates differ according to geographical setting, with rural areas experiencing the highest rates of referral.[13] Less than 20% of areas experienced an increase in referrals following the introduction of a self-referral system, but it is notable that most of the areas studied had a much higher level of provision at baseline (53/1000) than is the norm in England (GP referral rate 23/1000).[14] It is also worth noting that the Scottish studies only studied the impact on demand for physiotherapy over a short period of time. Only about 22% of patients did in fact refer themselves,[13] with most patients being referred by GPs as usual, so it is difficult to assess the long term impact on demand as patients become more aware of the possibility of self-referral.

Holdsworth et al also showed that, compared with patients referred by GPs, those who referred themselves tended to have had their condition for less time, and had been absent from work in lower proportions and for less time,[10;11]suggesting that self referral may increase access for people with less severe problems. Experience in the Netherlands suggested that those who self-referred were younger, better educated and had their problems for a shorter period than those referred by doctors.[8] If self-referral does increase demand on physiotherapists this is beneficial if it represents meeting previously unmet need, but may not be cost-effective if it involves diverting resources to treating people who are less in need.

In 2004 the Chartered Society for physiotherapists called for self-referral for all primary care patients by 2007, and leadership by senior physiotherapists to deliver the changes.[15] The intended benefits are described below:

Aims

The aims of self-referral can be identified from the CSP briefing document[15] as well as in the White Paper itself.

The main intended benefits are:

- Improved clinical outcomes, particularly with a faster return to work
- Reductions in waiting times for patients
- Improved patient choice
- Reduced costs
- Reduced workload for GPs and other help-professionals.

In terms of wider NHS goals, this is consistent with the goals of improving access to services, increasing patient choice and putting patients in control of how their care is delivered, improving public health and improving the quality and consistency of health care.

The ways in which these benefits would be achieved are also clearly articulated in the CSP briefing document. Self-referral would mean that patients did not have to go through the step of visiting the GP acting in their role as gate-keeper. Since musculoskeletal problems are one of the most common reasons for consulting a GP, and physiotherapy is the treatment of choice for many of these problems, this would have a substantial impact on GP workload, reduce costs, reduce one step in the access chain for patients and enable them to see a more appropriate health professional more rapidly, therefore improving patient outcomes.

The initiative

The DH worked with the CSP to identify six pilot sites, which would test the impact of self-referral to physiotherapy in England. Three of these sites were in or around London, two were in the Southwest of England and one was in Birmingham. From December 2006 these sites would accept patients who self-referred for physiotherapy. Patients had to complete a self-referral form, and the remainder of the care pathway was not dissimilar from previous systems – there was no PhysioDirect type telephone assessment or email access. Self-referral was introduced in addition to patients being referred by GPs in the usual way. All referrals were prioritised and treated in the same way, irrespective of the source of referral.

The evaluation

Aims and objectives

The aim was to evaluate the impact of introducing self-referral to musculoskeletal physiotherapy,[16] and in particular to:

- Seek the views of patients, GPs and physiotherapists
- Establish whether significant numbers of users of private physiotherapy services would return to the NHS
- Identify changes in waiting times
- Understand differences in accessing self-referral according to ethnic background
- Gauge the difference that self-referral made to GP workload
- Build on rather than duplicate existing work

Design

Patients at the six pilot sites were able to refer themselves, as described above. From December 2006 patients were allowed to self-refer. Data were collected about referrals (self-referrals, GP referrals, and 'GP-suggested' referrals) over a one year period from December 2006 to December 2007. The sites received no extra funding apart from initial costs of advertising and relevant paperwork. Data were collected as follows:

- Historical data about demand, activity levels and waiting times
- Anonymised data about 2835 patients. This data included details at baseline about socio-demographic status, severity of condition, duration or symptoms, employment status, use of alternative providers. At discharge, data

were only collected about reason for discharge, patient perception of condition severity and total number of contacts.

- Feedback forms sent to GPs and physiotherapists

Data were subsequently analysed by Dr Lesley Holdsworth, who had conducted the original research in Scotland. Analysis was mainly descriptive, but some comparisons are made between the groups (self-referred, GP referred, GP-suggested). Data from one site were omitted because of concerns about data reliability.

Evaluation team's findings and conclusions

The headline findings reported[16] were that the service led to:

- High-levels of user satisfaction
- A more responsive service
- Patients were empowered to self-care
- Lower levels of work absence
- No increase in demand for services
- No evidence that black and ethnic minority groups used self-referral less than white groups
- No return to the NHS by patients traditionally seen by private physiotherapists
- Well accepted by physiotherapists and GPs
- Lower NHS costs

Comments on the evaluation

It is important to note that this is a simple observational comparison of patients who chose to self-refer or had a referral made by or suggested by their GP. It can provide evidence about differences between the types of people who chose different routes of referral. But in the absence of any control group it does not provide any evidence about whether offering self-referral leads to the benefits intended for the service e.g. improved patient satisfaction, reduced costs, shorter waiting times, faster return to work or improvements in other outcomes. To make this type of comparison it would be necessary to compare patients who were self-referred or GP referred in terms of their outcomes after they accessed physiotherapy, after adjusting for any differences between the patients at baseline (and it is evident that people who use self-referral have different characteristics from those referred by GPs).

The design of the evaluation means that it could not address many of its aims (aims 2, 3, or 5). Nor could it test whether the intended benefits of self-referral to physiotherapy are achieved (e.g. reductions in waiting times or costs). This would require a trial comparing patients in areas which do or do not offer self-referral (ideally but not necessarily randomised).

The findings from the evaluation appear to have been over-stated in the evaluation report in some cases. For example, it is claimed that self-referral led to less work absence. However, no data about work absence was collected at follow-up, so it is not possible to demonstrate an impact of self-referral. The data show that those people who chose to self-refer had had their symptoms for a shorter period and had been off work for less time *before* they accessed physiotherapy compared with those who were referred by GPs. This suggests that the group who self-referred were less severe and/or accessed physiotherapy at an earlier point in the illness episode, but it does not provide any evidence that this resulted in them getting back to work any more quickly. Similarly, the headline findings claim that self-referral was associated with reduced costs but no robust evidence is provided in the report to demonstrate this. Instead, reference is made to the earlier Scottish research, which has the same limitations as this evaluation since it was an observational study with no control group.

Our interpretation of the findings

This evaluation suggests that self-referral is appreciated by patients (although no details are given about response rates to the patient survey, or comparison with patients who were GP referred), and is also popular with GPs and physiotherapists.

Comparison with historical, routinely collected data shows no evidence of an increase in demand following self-referral. It is important to note that routinely collected data are often of doubtful reliability and may not be comparable between areas or services.

There is a suggestion that self-referral may be accessed differently by different ethnic groups and this requires further investigation (even though there were only small numbers of BME patients in the study, the association between referral type and ethnicity was of borderline statistical significance ($p=0.055$)).

There is no robust evidence from this evaluation about the impact of self-referral on the important outcomes of patient clinical outcome, return to work, waiting times, GP workload or NHS costs.

Other relevant evaluation work

Three local evaluations of self-referral were identified in this overview. These were conducted by physiotherapy services within PCTs. One of these was examined in detail as a case study. All three local evaluations were based on an audit of performance against standards and included patient feedback using questionnaires. Two of the three local evaluations described ambitious aims, such as to determine whether self-referral reduces GP workload or increases demand on the physiotherapy service, and involved collecting considerable amounts of data. However the design of the evaluations, which included no control group or before-and-after data, meant that it was not possible to answer these questions. It was encouraging to observe the willingness of local services to assess their activities against performance standards, but there was a lack of clarity about how the data collected would answer the evaluation questions.

Conclusions about the evidence that the initiative achieved its objectives and delivered policy goals

The main aims of self-referral are listed again below, with comments about the evidence so far available:

Improved clinical outcomes, particularly with a faster return to work. There is currently no evidence about the impact of self-referral on clinical outcomes or return to work. This is an important priority for further research.

Reductions in waiting times for patients. It might be predicted that self-referral would lead to increased demand which would increase rather than reduce waiting times. Assessing the impact of service change on waiting times is difficult, because so many other factors and concurrent initiatives affect waiting times and it is difficult to attribute changes to any one factor. Overall, the evidence from the White Paper self-referral pilots and the Scottish data suggest that, in itself, self-referral does not increase demand on physiotherapy services compared with GP referral when the supply of physiotherapy services is sufficient to offer services to 50/1000 patients per year. However this level of supply is much higher than currently provided in some areas of England, so self-referral may expose the service to increased demand due to previously unmet need.

Improved patient choice. It is self-evident that self-referral achieves this aim, so evaluation may not be necessary. However, it would be worthwhile to consider whether self-referral increases choice for all groups of patients e.g. those with language or literacy difficulties.

Reduced costs. Although patients who self-refer have lower GP consultation costs and other NHS costs than those who are referred by GPs, these patients also have less severe illness than those referred by GPs.[12] In the absence of a self-referral option it is possible that these patients would not have consulted either a GP or a physiotherapist. Therefore there is an *a priori* reason to think that self-referral may increase rather than decrease costs, both within physiotherapy services and in the wider NHS. There is at present no robust evidence that self-referral is associated with reduced or increased costs.

Reduced workload for GPs and other help-professionals. For the same reason as the above, there is no robust evidence about this issue.

White Paper goals. In terms of the White Paper goals, it is evident that self-referral improves patient choice in how they access services and it also is consistent with ensuring that patients are in control and services are responsive to patients' wishes. However further evidence is needed before it can be concluded that self-referral is associated with improvements in the quality of care or health outcomes.

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Address for correspondence

Professor Chris Salisbury, MD.
Professor of Primary Health Care
Academic Unit of Primary Health Care, School of Social and Community Medicine
University of Bristol
c.salisbury@bristol.ac.uk

Disclaimer

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