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Information paper

Project to evaluate patient self-referral to women's health physiotherapy pilot sites

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Project to evaluate patient self-referral to women's health physiotherapy pilot sites

Table of tables

Table of figures

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Introduction

This report is another step towards making women's health physiotherapy services more accessible to the public and patients and also to providing more choice. Physiotherapists are autonomous practitioners, able to accept referrals from any source including the patient themselves.

The success of the Department of Health musculoskeletal self-referral project prompted the Chartered Society of Physiotherapy (CSP) to identify other client groups and populations that might benefit from patient self-referral. We were pleased that in 2010 the CSP agreed to work with the Association of Chartered Physiotherapists in Women's Health (ACPWH) to extend patient self-referral to women's health physiotherapy services, particularly continence and pelvic floor rehabilitation.

Incontinence is highly prevalent in the general population but under-diagnosed and under-treated. Due to the highly sensitive nature of this health care issue, women may take up to 10 years before seeking help. They may be too embarrassed to ask for advice and may not wish to bother their general practitioner (GP). Patient self-referral as an additional route of access to effective treatment is beneficial to this population.

This report documents the findings from seven pilot sites. The physiotherapists and their support and admin staff worked hard to understand the needs of their local populations. They were asked to gather a wide range of data, including Patient Reported Outcome Measures (PROMs), via a web-based tool. This helped them to assess the demand and impact of their service and as a result they now have an excellent basis for continued improvement.

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

Ruth Hawkes FCSP
Chair, Association of Chartered Physiotherapists in Women's Health

Executive summary

Policy context

In recent years health policy has placed an increasing emphasis on patient choice and experience. The vision and strategy set out in the report *NHS Next Stage Review: Our vision for primary and community care*[1] promoted personal and responsive services that listen to and act on patient views, delivered within a culture of high-quality care and continuous improvement. Patient self-referral accords with the principles of the Next Stage Review.

The Chartered Society of Physiotherapy (CSP) has worked in partnership with seven sites to pilot self-referral to women's health physiotherapy. Patient self-referral has been extended to women with urinary or other pelvic floor problems who could expect to access services at times and in places convenient to them. Demographic and clinical data relating to the population from the pilot sites was collected and analysed.

Patient self-referral is not a new concept. For more than 30 years, physiotherapists have been able to practise autonomously and accept referrals from any source, including the patient themselves. Since the publication of the Department of Health patient self-referral guidance in 2008, approximately 50 per cent of NHS musculoskeletal physiotherapy services now offer patient self-referral or a prompted route into the service.[2]

Patient self-referral is not a fast track access to services; it is simply an additional way of accessing NHS physiotherapy services, which some patients may prefer. There is no change to either the delivery of physiotherapy or the waiting time for assessment/treatment.

The patient self-referral project

The aim of the project was to evaluate the impact of introducing patient self-referral to women's health physiotherapy services, particularly continence and pelvic floor rehabilitation, and in particular the impact on:

- demand/waiting times
- access for patients
- effectiveness
- clinical outcomes

Additional aims included:

- evaluation of the impact of widening of access to the service for women with urinary incontinence and pelvic floor dysfunction, by seeking the views of patients, physiotherapists and GPs;
- identification of changes in referral pattern

Patients with either continence or pelvic floor problems were able to self-refer to the seven pilot sites. The sites covered a range of populations, trust types, physiotherapy services, and degrees of integration with continence services.

Four of the pilot site services were based in secondary care (providing a service to primary care patients), the other three were primary care services. The pilot site physiotherapists were of mixed experience but had all completed postgraduate training in the assessment and rehabilitation of continence/pelvic floor dysfunction.

At no time were patients who self-referred given preferential treatment in terms of waiting times.

Results

The results of the analysis from the pilot sites indicate that patient self-referral to women's health physiotherapy has the following benefits:

Patient benefits

- Empowered patients to refer themselves
- Provided easier access to services and saved time
- High levels of patient satisfaction
- A more responsive service affording wider access
- As clinically effective as other referral options

Service benefits

- No overall increase in demand or waiting times
- Promoted equality of access
- Greater levels of attendance and completion of treatment
- Lower levels of Did Not Attends (DNAs)
- Well accepted by service users

Recommendations

The greater access that self-referral provides is in line with current health policy. It is valued by patients and supports self-management by allowing patients to choose when to opt in to services.

Whilst the self-referral route was used by women of all ages, the proportion of patients referring themselves to women's health physiotherapy was lower than was reported in the 'Patient self-referral to MSK physiotherapy' project. There was a reported lack of awareness and knowledge, within the patient group, that physiotherapy had a role to play in the treatment of incontinence and pelvic floor dysfunction.

The main recommendations from this project are:

- A national campaign to raise awareness within the general population that physiotherapy is an effective treatment for women with incontinence or pelvic floor dysfunction
- More robust analysis of referral and administrative processes to reduce both the Do Not Attend (DNA) and 'failed to complete treatment' rates
- For effective implementation of patient self-referral to women's health services across any population, the provider must ensure that services are designed, planned and delivered in such a way as to address the particular needs of that population. This will include consideration of the needs of specific ethnic and cultural groups.

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Policy context

In recent years health policy has placed an increasing emphasis on patient choice and experience. The *Your health, your care, your say* national public listening exercise in 2005 indicated support for patient self-referral to Allied Health Professions (AHP) services, and the resulting White Paper[3] 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.' (3 p. 94)

The vision and strategy set out in the report *NHS Next Stage Review: Our vision for primary and community care* promoted personal and responsive services that listen to and act on patient views, delivered within a culture of high-quality care and continuous improvement.[1] This includes:

> '…a NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart.'(4 p. 7)

Patient self-referral accords with the principles of the Next Stage Review.

Subsequent to the publication of the Department of Health report on *Self referral pilots to MSK physiotherapy*[2], the *Operating Framework for the NHS 2009/10*[5] set out that from April 2009, Primary Care Trusts (PCTs) should be commissioning self-referral services:

> '…new service models including self-referral to Allied Health Professional (AHP) services such as musculoskeletal (MSK) physiotherapy have improved patient outcomes and satisfaction and reduced demand elsewhere in the system'.(5 p. 13)

It advised that PCTs

> 'will want to consider such alternative models for other AHP and community services, where clinically appropriate and promote their use to their local population'.(5 p. 13)

The Any Qualified Provider (AQP) policy, which is aimed at extending patients' choice, is one of the new procurement models for the NHS. Continence

services are included in the first wave of implementation of AQP, and patient self-referral is included in the service specification.[6]

Background to self-referral and the project population

Patient self-referral is a system of access that allows patients to refer themselves directly to a physiotherapist without having to see anyone else first or without being prompted to refer themselves by a health professional. This can relate to telephone, IT or face-to-face services.[2]

This is not a new way of accepting referrals; for more than 30 years physiotherapists have been able to practise autonomously and accept referrals from any source, including the patient themselves. It is common for patients to self-refer in the independent sector, but until relatively recently it has not been available in the NHS. Since the publication of the Department of Health patient self-referral guidance in 2008[2] approximately 50 per cent of NHS MSK physiotherapy services offer patient self-referral or a prompted route into the service. The benefits are well documented[2] and include:

- Puts the individual in control of their care
- Supports the individual in developing skills in self care and self management
- Promotes health focused behaviour
- Champions a whole service ethos of 'treat to manage not treat for life'
- Provides a simple route in and out of services for people with complex and long term conditions
- Gives patients an easy route back into the service.

Patient self-referral is not a fast track access to services; it is simply an additional way of accessing NHS physiotherapy services, which some patients may prefer. There is no change to either the delivery of physiotherapy or the waiting time for assessment/treatment.

The success of the MSK pilot project led the CSP to identify other client groups and populations that might benefit from patient self-referral. In 2010 the Association of Chartered Physiotherapists in Women's Health (ACPWH) approached the CSP to extend patient self-referral to women's health physiotherapy services, particularly continence and pelvic floor rehabilitation.

The case for patient self-referral for women with urinary problems

Urinary incontinence (UI) is the complaint of involuntary loss of urine. UI is distressing and socially disruptive and may be the cause of personal health and hygiene problems.(7) It may restrict employment and educational or leisure opportunities and lead to embarrassment and exclusion.(8)

The size of the problem

Incontinence is highly prevalent in the general population but under-diagnosed and under-treated. It has been estimated that UI affects 20.4 per cent of people aged 40 years and over, equivalent to five million people in the UK, although not all may need or want help. In women this figure increases to 35.6 per cent at age 80 and over.(9) Urinary incontinence is the second most common reason for admission of an individual to a nursing home.

The financial cost

Affecting people of all ages, the condition is largely treatable or preventable; however, in some cases poor continence care can lead to unnecessary catheterisation, associated urinary tract infections, and pressure ulcers which alone caused 51,000 hospital admissions in 2008-09 and are estimated to cost the NHS £1.4 - £2.1 billion each year.(10) In comparison, continence services cost the NHS £112 million in 2009/10 – a relatively small amount.(10)

The cost to the individual

Due to the highly sensitive nature of this health care issue, women may take up to 10 years before seeking help. They may be too embarrassed to seek advice and may not wish to bother their general practitioner (GP). Many believe UI to be a normal consequence of the ageing process or may not appreciate that effective treatments are available.(11)

A review, which aimed to summarise help-seeking behaviours for UI symptoms among non-institutionalised women of all ages with all types of UI, found that less than 38 per cent of women sought help for their UI symptoms. Factors affecting help-seeking included perceptions women had regarding the normalcy of UI and beliefs about treatment options available for the problem. Embarrassment was also found to be significantly related to help-seeking in most, but not all, of the reviewed studies.(12)

Physiotherapy is a clinically effective treatment

The National Institute for Health and Care Excellence (NICE) clinical guideline for the management of urinary incontinence in women recommends conservative treatment (pelvic floor muscle training and/or bladder retraining) as first-line treatment for women with stress, urge or mixed urinary incontinence.[13] Pelvic floor muscle training (PFMT) is also recognised as a preventive strategy within this guideline. In addition, NICE recognises that women are at risk of pelvic floor dysfunction during/following pregnancy, in that it advises that all pregnant women should be given specific information on pelvic floor muscle exercises at the booking appointment (ideally by 10 weeks gestation).[14]

As well as symptoms of urinary incontinence, another problem related to pelvic floor dysfunction is pelvic organ prolapse (POP). A recent multi-centre randomised controlled trial of PFMT for women with pelvic organ prolapse has demonstrated that the intervention is effective in reducing prolapse symptoms and recommends PFMT as first-line management of this problem.[15]

The project and the pilot sites

The pathway for self-referral to women's health physiotherapy was modelled on the national MSK Quality, Innovation, Productivity and Prevention (QIPP) endorsed pathway.[16] The aims of the project were to evaluate the impact of introducing self-referral to women's health physiotherapy, in terms of:

- demand/waiting times
- access for patients
- effectiveness
- clinical outcomes

Additional aims included:

- evaluation of the impact of widening of access to the service for women with urinary incontinence and pelvic floor dysfunction, by seeking the views of patients, physiotherapists and GPs;
- identification of changes in referral pattern

Identifying the pilot sites

A notice was placed on the Women's Health network of *interactiveCSP* (a web-based CSP member forum) seeking providers of women's health physiotherapy services who might be interested in being involved in a national pilot project.

Involvement as a pilot site was based on:

- Previous collection of baseline data
- An understanding of the local population, including demographics
- A clinician at each site being willing to take on a leadership role.

Seven pilot sites participated in the project:

- Bradford Royal Infirmary, Bradford Teaching Hospitals NHS Foundation Trust *
- Camborne Redruth Community Hospital, Cornwall & Isles of Scilly PCT (later Peninsula Community Health)
- City of Coventry Health Centre, Coventry & Warwickshire Partnership Trust
- Cheltenham General Hospital & Gloucester Royal Hospital, Gloucestershire Hospitals NHS Foundation Trust *
- Kettering General Hospital, Northamptonshire Teaching PCT
- Royal Free Hospital, Royal Free London NHS Foundation Trust *
- Bristol Royal Infirmary & St. Michael's Hospital, University Hospitals Bristol NHS Foundation Trust

The sites covered a range of populations, trust types, physiotherapy services, and degrees of integration with continence services.

Four of the pilot site services were based in secondary care (providing a service to primary care patients); the other three were primary care services. The pilot site physiotherapists were of mixed experience but had all completed postgraduate training in the assessment and rehabilitation of continence/pelvic floor dysfunction.

A specialist women's health physiotherapist was employed as a project co-ordinator and provided day-to-day support for the clinicians at the pilot sites. A link clinician, identified at each of the sites, was the main point of contact for the project co-ordinator.

The work had five phases, illustrated in the following table:

* These sites started the patient activity phase at month 3 – see later for more details.

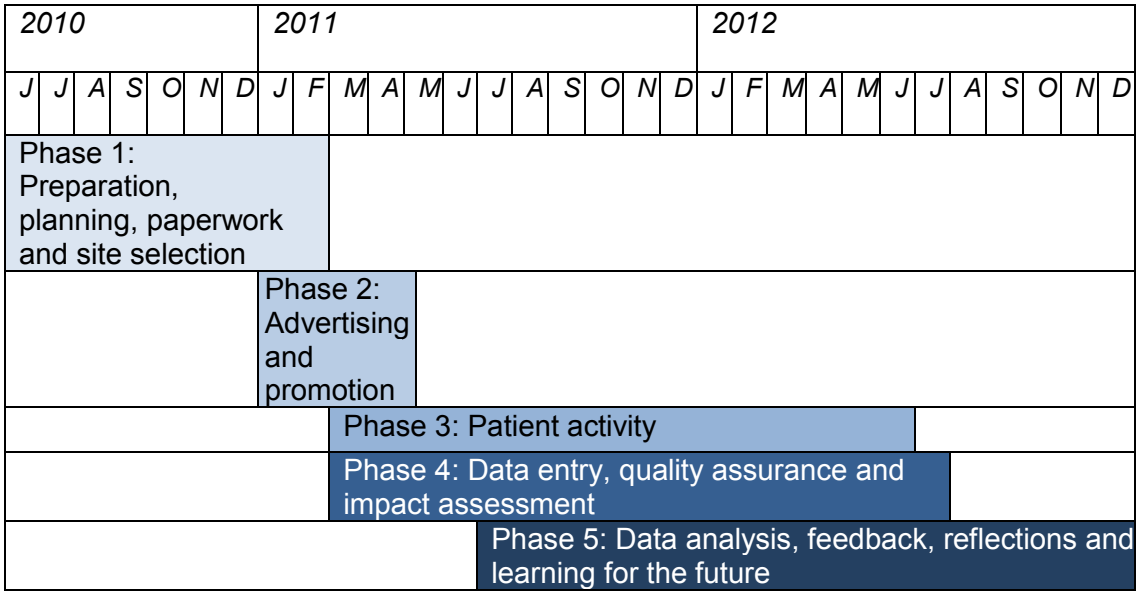

Table 1: Project plan

Eligible population

The population eligible for inclusion in the project was adult female primary care patients presenting with urinary or pelvic floor problems between 1 March 2011 and 29 February 2012. Three services joined the project on 1 May 2011, with the same end-point of 29th February 2012 (see *Identifying the pilot sites* above). All adult female patients with urinary symptoms or pelvic floor problems, including pelvic organ prolapse and pelvic floor muscle weakness, were able to self-refer to physiotherapy.

Patient information

Posters and leaflets were developed. These explained that leakage of urine is common (but not normal) and may be easily treated (see Appendix D).The promotional materials were aimed at women who had 'a problem with (their) bladder or pelvic floor'. The patient self-referral information leaflet included a referral form and details of the local service.

Referral source

The following five categories were used:

- Self-referral – patient completes the self-referral form without contact with any healthcare professional

- GP referral – patient seen by their GP who refers them to the physiotherapy service in the usual way
- GP-prompted referral – patient seen by their GP who suggests that they use the self-referral facility and prompts them to complete the self-referral form
- Other healthcare professional referral – patient seen by a healthcare professional other than their GP, who refers them to the physiotherapy service in the usual way
- Other healthcare professional-prompted referral – patient seen by a healthcare professional other than their GP, who suggests that they use the self-referral facility and prompts them to complete the self-referral form.

Screening

A physiotherapist screened all referrals.

Information given within the referral ensured that the offer/timing of an appointment was based on the clinical need of the patient. For some this was an urgent appointment, in other cases the patient was placed on the 'routine' waiting list.

The self-referral form was at the end of the patient information leaflet. It included a number of 'red flag' questions. If the responses provided by the patient raised any cause for concern, the patient would either be followed up immediately or referred directly to their GP without waiting for a physiotherapy appointment.

Data collection

Clinical and demographic data

This was collected via a web-based data collection form designed specifically for the project (see Appendix E). The data was inputted once the patient had been discharged. This database was closed on 6 July 2012 to allow data to be uploaded for any patient accepted as part of the project and discharged (following completion of their episode of care) by 30 June 2012.

Patient experience data

All patients who were discharged after 31 July 2011 were asked to complete an online questionnaire following discharge. The web link for the questionnaire was provided on a business card that was given to the patient by her physiotherapist at discharge. 523 women were eligible to complete the questionnaire, which asked a range of questions relating to knowledge and perceptions of physiotherapy.

Physiotherapist and GP feedback

Two further web-based questionnaires were developed, one for completion by the pilot site physiotherapists, and the other for completion by GPs working in the catchment area for each of the pilot sites. These were available during July 2012.

Project results

The final patient dataset was made up of anonymised data for 921 patients (see Table 2).

NHS Trust	*Count*	*Per cent*
Bradford Teaching Hospitals NHS Foundation Trust	289	31.4
Cornwall & Isles of Scilly PCT	74	8.0
Coventry and Warwickshire Partnership Trust	229	24.9
Gloucestershire Hospitals NHS Foundation Trust	117	12.7
Northamptonshire Teaching PCT	76	8.3
Royal Free London NHS Foundation Trust	25	2.7
University Hospitals Bristol NHS Foundation Trust	111	12.1
Total	**921**	**100.0**

Table 2: Valid patient records by NHS Trust

In addition 47 patients and 16 project physiotherapists completed the relevant online questionnaires. One GP completed the relevant online questionnaire. This response was positive but insufficient for inclusion in the report.

Analysis of the project data was undertaken using Microsoft Excel 2010 and IBM SPSS 18/19.

Demand

One in three referrals (66.6 per cent) were from GPs (see Figure 1). The self-referral rate was 15.5 per cent (slightly less than one in six referrals). The remaining referrals were either made by other health care professionals (12.8 per cent) or prompted/suggested by either a GP (2.9 per cent) or other health care professional (2.2 per cent).

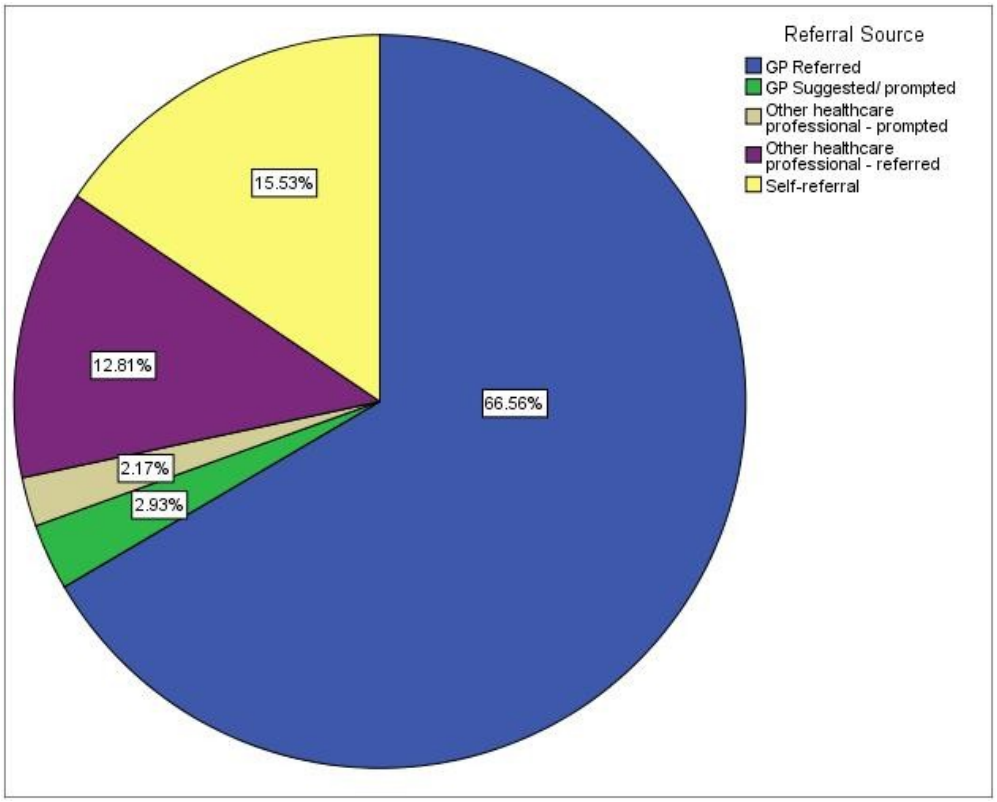

Figure 1: Percentage of valid patient records by referral type

There were significant variations in the proportion of self-referrals across sites (see Figure 2), with Coventry recording the lowest at 1.7 per cent and Gloucestershire the highest at 41 per cent. Gloucestershire has offered patient

self-referral to musculoskeletal patients since the early 1990s; the Gloucestershire findings are therefore likely to reflect a greater awareness of self-referral as a route of access to physiotherapy within the general population.

The referral pattern from the Cornwall site differed considerably from other sites in that the referral rate from other health professionals, at 34 per cent, was much higher than the average rate of 12.8 per cent. The specialist primary care nurse continence service is well established in Cornwall, with patients regularly being referred on to the physiotherapists involved in the project for specialist pelvic floor rehabilitation. This may account for the high rate of referrals in this category and the subsequent reduction in the rate of GP referrals (36.5 per cent). This site also recorded a higher than average rate of referrals prompted/suggested by a GP (13.5 per cent) and those prompted/suggested by other healthcare professionals (5.4 per cent).

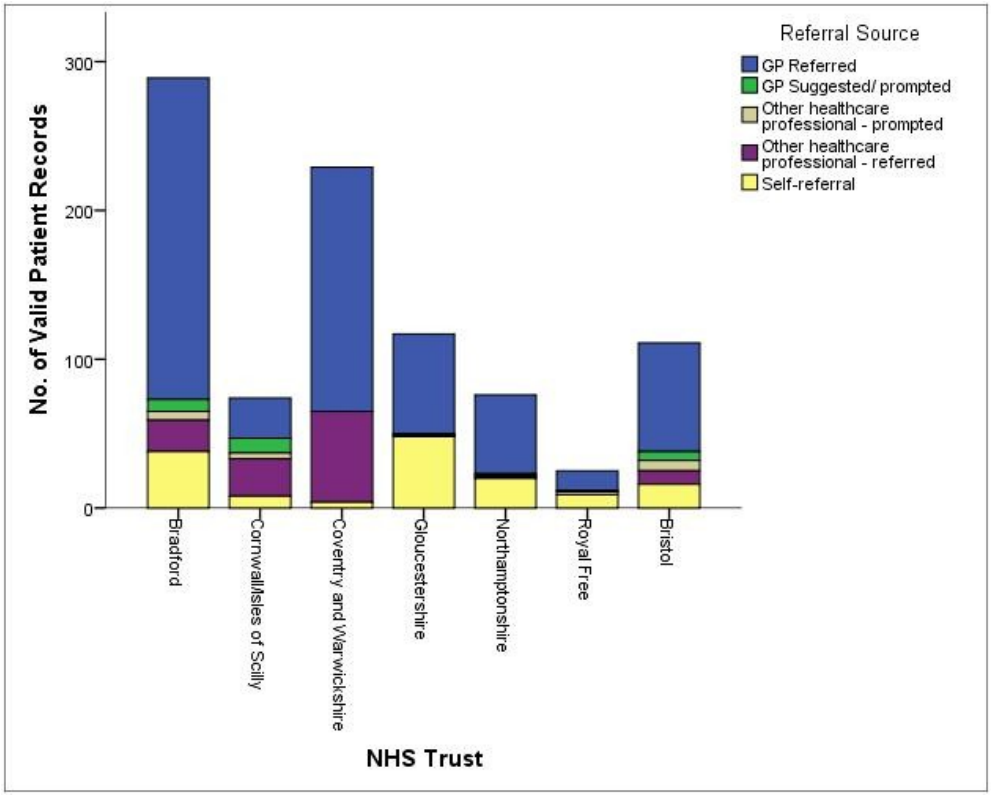

Figure 2: Referral source by site (NHS Trust)

The wide variation of rates and sources of referral across the sites means that referral effects may be confounded with other aspects of care.

There was no increase in the total number of referrals received at most of the sites (when compared with the estimated number of referrals received in the equivalent one-year period during 2010-11). The only exception to this was Coventry & Warwickshire Partnership Trust, which experienced a 22 per cent increase in referrals (compared with those estimated to have been received during the previous year).

Given that this service only reported receiving four self-referrals during the 12-month period of the project, it seems unlikely that the increase was due to the availability of patient self-referral.

Waiting times

There was no demonstrable difference in overall waiting times as a result of introducing patient self-referral. However, there was considerable variation in waiting time for each type of referral when sites were compared. This was due to a lack of consistency across sites in terms of staffing levels, referral patterns/pathways and waiting times.

The average waiting time for self-referred patients was lower than that for GP referrals. This was because most of the services received GP referrals by letter. The extended waiting time for GP referred patients is most likely to be related to:

- The time taken to produce the referral letter within the practice
- The time for it to be sent through the postal system
- The processing by the physiotherapy service.

If an earlier appointment was offered but declined by the patient, this would result in an extended waiting time being recorded. In many cases it was not possible to accurately identify from the database whether this had occurred. This may explain the maximum waiting time of 185 days for self-referrals (in comparison to a median of 28.5 days) and 140 days for GP referrals (in comparison to a median of 35 days).

Attendance rates

One of the key measures of efficiency of a physiotherapy service is attendance rate, both for new and follow-up appointments. When patients do not attend (DNA) there is a cost to the service, both in clinical and administrative resource. DNA rates can also have a negative effect on waiting times.

			Attendance		Total
			*Attended**	*DNA*	
Referral Source	*GP Referred*	Count	489	124	613
		% within Referral Source	79.8%	20.2%	100%
	GP Suggested/ prompted	Count	24	3	27
		% within Referral Source	88.9%	11.1%	100%
	Other healthcare professional - prompted	Count	18	2	20
		% within Referral Source	90.0%	10.0%	100%
	Other healthcare professional - referred	Count	98	20	118
		% within Referral Source	83.1%	16.9%	100%
	Self-referral	Count	136	7	143
		% within Referral Source	95.1%	4.9%	100%
Total		Count	765	156	921
		% within Referral Source	83.1%	16.9%	100%

*At least one attendance recorded

Table 3: Attendance rates by referral source

'DNA' was one of five options available as the 'discharge status' within the patient dataset. The DNA rates differed significantly between referral cohorts (see Table 3) with fewer than 5 per cent of self-referred patients not attending compared with an average non-attendance of almost 17 per cent (X^2, $p<0.001$). These results accord with those of the MSK self-referral project.

Access – Age

The average patient age was 47.7 years (SD 15.2 years) with a median age of 46 years. The highest numbers of patients were in the 30-50 age range (see Figure 3).

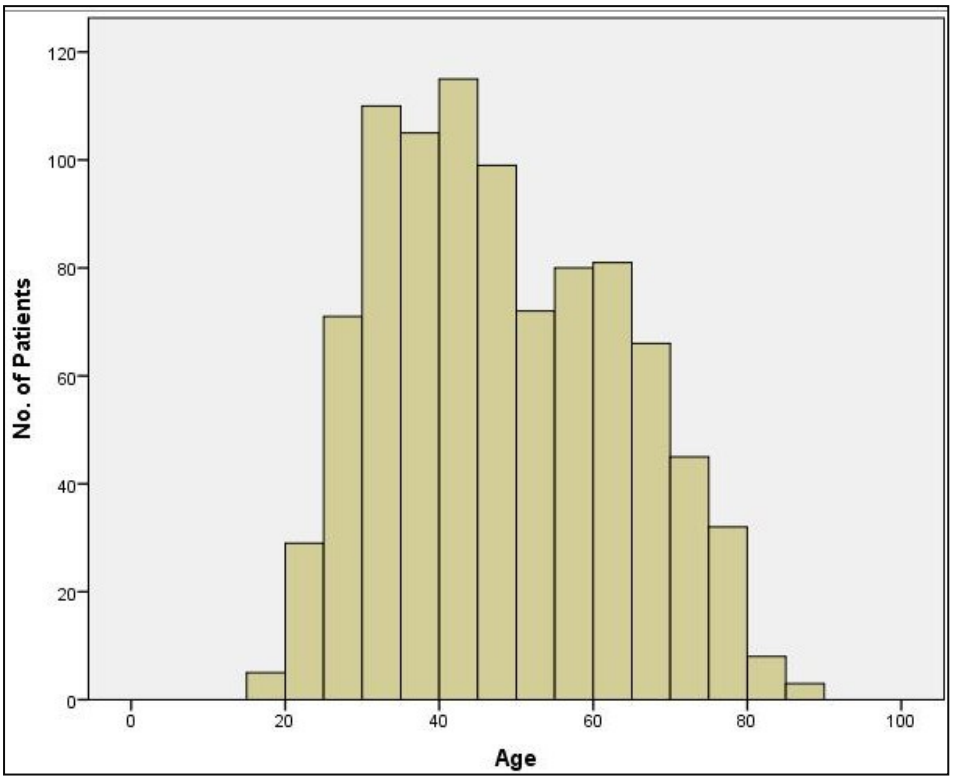

Figure 3: Age distribution of patients

The rate of self-referral in the different age groups is marginally non-significant (p=0.052).

There is an apparent tendency for higher self-referral rates in the middle age groups (45-64 years) with the proportion of self-referrals reducing towards the younger and older extremes (see Figure 4).

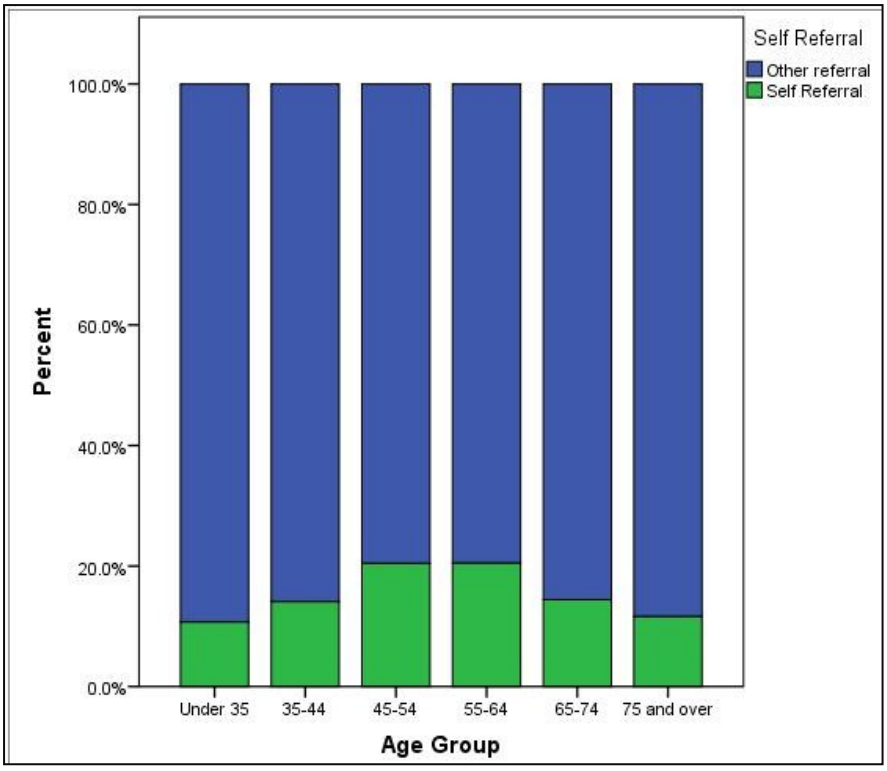

Figure 4: Self-referral rates by age group

Access – Ethnicity

The population was divided into four groups:

- White (72.1 per cent)
- Asian (13.1 per cent)
- Other (Black, Mixed, Chinese and other ethnicities; 2.2 per cent)
- Unknown (including those patients who did not wish to state their ethnicity and those for whom no data was recorded; 12.6 per cent).

The proportion of different ethnic groups varied widely between Trusts (see Figure 5). This was expected given the diverse locations, geography and demographics of the pilot sites.

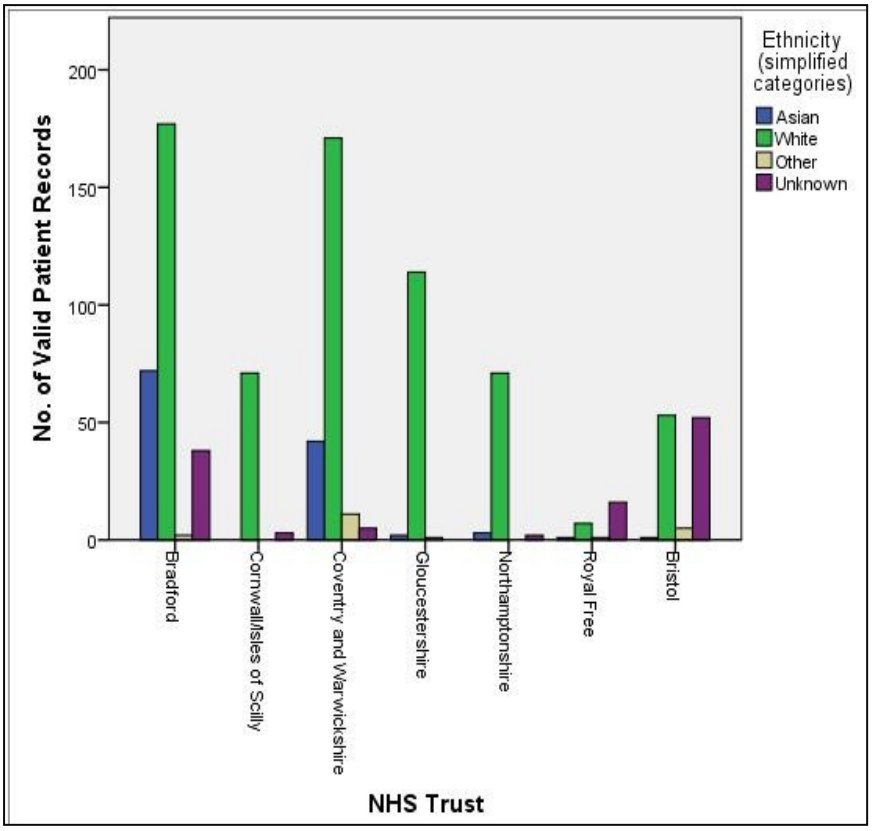

Figure 5: Ethnicity by site (NHS Trust)

The proportion of Asian patients who accessed physiotherapy at both Bradford (25 per cent) and Coventry (18 per cent) was not reflective of those populations as a whole (28 per cent and 33 per cent respectively, see Appendix B). However, project materials were only available in the English language. There was no specific promotion to any particular ethnic group, neither was there any investigation of cultural issues relating to help-seeking behaviour. This makes it difficult to draw reliable conclusions in relation to impact of ethnicity on access to services.

Two sites in particular have a significant proportion of patients assigned to the 'unknown' group. These are the Royal Free London (64 per cent) and Bristol (47 per cent).

			Ethnicity - reduced categories (derived)				
			Asian	*White*	*Other*	*Unknown*	*Total*
Referral Source (derived)	*GP referred*	Count	90	430	15	78	613
		% within Referral Source	14.7%	70.1%	2.4%	12.7%	100%
	GP suggested/ prompted	Count	3	19	0	5	27
		% within Referral Source	11.1%	70.4%	0%	18.5%	100%
	Other healthcare professional - prompted	Count	2	13	0	5	20
		% within Referral Source	10.0%	65.0%	0%	25.0%	100%
	Other healthcare professional - referred	Count	17	90	4	7	118
		% within Referral Source	14.4%	76.3%	3.4%	5.9%	100%
	Self-referral	Count	9	112	1	21	143
		% within Referral Source	6.3%	78.3%	0.7%	14.7%	100%
	Total	Count	121	664	20	116	921
		% within Referral Source	13.1%	72.1%	2.2%	12.6%	100%

Table 4: Attendance rates by ethnicity

The differences in access across ethnic groups could not be tested, due to the low numbers in several categories. However, whilst not significant, the difference in the level of self-referrals between those of Asian (7.4 per cent) and White (16.9 per cent) ethnicity requires further investigation.

Effectiveness

Prior to commencement of the project, none of the services was capturing detailed outcome data. Services were required to collect both generic and condition specific Patient Reported Outcome Measure (PROM) data.

Patient Reported Outcome Measures

Generic PROM

The EQ-5D-5L questionnaire is completed by the patient at the start and at the end of treatment. The data is converted to a score with the difference between pre- and post-treatment scores being recorded as the change score.

156 patients who never attended and 242 patients who failed to complete the course of treatment had no change score recorded.

There were small positive changes in mean EQ-5D score, which translated to small positive changes in quality of life.

Pairwise comparisons within the model suggest that mean improvement in score for self-referred patients was significantly greater than that for referrals made (p=0.011) or prompted (p=0.023) by another healthcare professional, but not for those made or prompted by a GP.

Also, the estimated mean change for both self-referred (95 per cent CI: 0.045-0.096) and GP referred patients (95 per cent CI: 0.039-0.067) is significantly greater than zero.

Small cohort sizes for the other referral types may mean there is insufficient power to detect this effect within these groups.

Condition-specific PROM

In addition to the generic outcome measure, each patient was asked to complete one of two symptom-specific outcome measures. These were the Incontinence Impact Questionnaire short-form (IIQ-7), and the Pelvic Organ Prolapse Symptom Score (POPSS). The choice of symptom-specific measure was made by the physiotherapist, determined by the predominant symptom described by the patient at assessment.

The symptom-specific measure was completed by the patient at the start and at the end of treatment.

Complete IIQ-7 data was recorded for 355/689 women who were identified as having solely or predominantly continence symptoms. This included those who never attended.

Complete POPSS data was recorded for 139/205 women who were identified as having solely or predominantly prolapse symptoms. Again, this included those who never attended.

All referral groups recorded an improvement in symptom-specific outcome measure scores. The overall average improvement in IIQ-7 score across all referral routes was 15.5 (95 per cent CI: 11.9-19.2). The overall average improvement in POPSS across all referral groups was 2.06 (95 per cent CI: 1.01-3.12).

Health status at discharge

The status of the patient at completion of her episode of care was selected from one of five options on the data collection form. These were:

- Discharged without symptoms
- Discharged with manageable symptoms
- Discharged for further investigations/surgery
- Failed to complete treatment
- Never attended (DNA)

Failed to complete treatment

There was wide variation across sites in the rates of patients who never attended and those who failed to complete treatment. For example, no DNAs were recorded at Bristol, but close to half of patients at that site (44 per cent) failed to complete treatment.

There is no facility within the women's health physiotherapy service at Bristol for patients to book their next appointment while at the hospital. Patients were asked to contact a central call centre to arrange their follow-up appointment. It was not known how many of those who failed to make a further appointment failed to do so because they were satisfied with the outcome, and how many simply did not get around to making the call or tried and failed to get through to the call centre. If the Bristol 'failed to complete' rates were excluded from the overall statistics, the proportion of patients in this category was 23.8 per cent.

NHS Trust		Health status at discharge (derived)					
		D/C without symptoms	D/C with manageable symptoms	D/C for further investigations/ surgery	Failed to complete	DNA (never attended)	Total
Bradford Teaching Hospitals NHS Foundation Trust	Count	10	71	57	54	97	289
	% within NHS Trust	3.5%	24.6%	19.7%	18.7%	33.6%	100%
Cornwall/Isles of Scilly PCT	Count	4	28	22	16	4	74
	% within NHS Trust	5.4%	37.8%	29.7%	21.6%	5.4%	100%
Coventry and Warwickshire Partnership Trust	Count	16	70	23	86	34	229
	% within NHS Trust	7.0%	30.6%	10.0%	37.6%	14.8%	100%
Gloucestershire Hospitals NHS Trust	Count	32	38	14	14	19	117
	% within NHS Trust	27.4%	32.5%	12.0%	12.0%	16.2%	100%
Northamptonshire PCT	Count	9	42	6	18	1	76
	% within NHS Trust	11.8%	55.3%	7.9%	23.7%	1.3%	100%
Royal Free Hampstead NHS Trust	Count	9	9	1	5	1	25
	% within NHS Trust	36.0%	36.0%	4.0%	20.0%	4.0%	100%
University Hospitals Bristol NHS Foundation Trust	Count	10	43	9	49	0	111
	% within NHS Trust	9.0%	38.7%	8.1%	44.1%	0%	100%
Total	Count	90	301	132	242	156	921
	% within NHS Trust	9.8%	32.7%	14.3%	26.3%	16.9%	100%

Table 5: Health status at discharge

Again, because of the differences in referral mix between Trusts, it was difficult to determine the true relationship between referral route and reason for discharge, especially given the small numbers in some categories. Nevertheless, the DNA rates for self-referred patients (4.9 per cent) was considerably lower than the average for all other referral sources (19.2 per cent). The rate of self-referred patients who failed to complete treatment was also at the lower end in comparison with all referral routes.

Patient experience

47/523 women completed the online questionnaire, nine per cent of eligible patients. Nine of the women completing the questionnaire (19 per cent) referred themselves to physiotherapy in comparison to 15.5 per cent of the total population.

Among the women who completed the questionnaire, 83 per cent agreed or strongly agreed that self-referral could save a lot of time.

An equal proportion disagreed or strongly disagreed that only GPs should be able to refer patients for physiotherapy.

36 per cent of women agreed or strongly agreed that they would feel happier consulting with both GP and physiotherapist, but an equivalent proportion disagreed or strongly disagreed with this.

The nine women who self-referred were asked what they would have done about their problem if they had not been able to refer themselves directly for physiotherapy.

Almost half of these women (four of the nine) said that they would have spoken to their GP. The same proportion (four of nine) said that they would have done nothing, and the remaining patient said that she might have opted for surgery. These figures are insufficient to draw any conclusions.

All the patients who completed the questionnaire (72 per cent) had previously discussed their problem with another healthcare professional. This was less likely to be the case with self-referrals, of whom only 43 per cent had previously discussed the problem with another healthcare professional. There were insufficient numbers of self-referral patients to draw any firm conclusions.

Patients' perceptions of physiotherapy

Of the 47 women who completed the online questionnaire just over a third (17/47; 36.2 per cent) were either very knowledgeable or quite knowledgeable of physiotherapy in general. Only 5/47 (10.6 per cent) had the equivalent level of knowledge of physiotherapy as a treatment for bladder/pelvic floor problems prior to their referral.

40.4 per cent of patients (19 of the 47) stated that they had no knowledge of physiotherapy as a treatment for bladder/pelvic floor problems prior to their referral, a further 48.9 per cent (23/47) of patients reported a limited knowledge of this role.

This accorded with the perception of the physiotherapists involved in the project, who felt there was a general lack of awareness amongst the general public as to what physiotherapy could do for women with bladder and pelvic floor problems. Just over half the physiotherapists (9/16) felt that the general public understood the role of physiotherapy for this client group 'to some extent'. The remaining seven physiotherapists (44 per cent) felt that the general public had no awareness or knowledge of the role of physiotherapy for this client group.

These findings accorded with those of a recent public opinion survey, undertaken by Opinium on behalf of the CSP. This showed that only 15 per cent of those questioned knew that physiotherapy had a role to play in the treatment of incontinence.[17]

Following completion of their physiotherapy treatment almost all patients were convinced of the efficacy of physiotherapy for women with bladder and/or pelvic floor problems. 98 per cent (46/47) either agreed or strongly agreed that physiotherapy offered effective treatment to women with bladder or pelvic floor problems. All patients said that they would use the service again and the majority (43/47; 92 per cent) were very satisfied with their experience.

Patient comments

Patients were able to make general or specific comments about the service or treatment they received. The following are a selection of comments received.

> 'I felt this was an excellent service. I saw it advertised in the local press and its easy access without having to go via a GP encouraged me to go

ahead. This has meant that I've had really useful self help advice at a time when my condition isn't so severe, enabling me to improve my control now and prevent or at least slow down any further deterioration.'

'I would have taken action a lot sooner if I could have made direct contact with the physio department. When first noticing I had a problem I delayed making an appointment with the GP as I felt it might be too trivial a problem when others might be in need of an appointment. Wider education of what physios can offer would be needed for self-referral to be a first route of choice.'

'I never knew of the women's health (physiotherapy) department before I had my problem, but I now know that they do invaluable good work. Thank you.'

'I was offered an appointment quickly and the advice I was given was very helpful. My physiotherapist explained fully the purpose of the exercises which helped my motivation in continuing to do them.'

'As the condition developed over a period of time I hadn't realised the impact it had on my life. I am so pleased I had the opportunity to access this service. It's a great relief to no longer suffer from this embarrassing and limiting condition.'

Physiotherapist feedback

16/18 physiotherapists in the project completed the online questionnaire.

The physiotherapists were asked a number of questions, including how appropriate they felt referrals were across the referral groups.

All physiotherapists completing the questionnaire (16/18) felt that no more than 10 per cent of referrals or prompted referrals were inappropriate. Slightly more therapists felt that self-referrals were more likely to be inappropriate than GP referrals (see Table 6), but the sample size was too small to draw any firm conclusion.

	How appropriate have GP referrals been during the pilot?		How appropriate have GP suggested referrals been during the pilot?		How appropriate have self-referrals been during the pilot?	
Valid	*Frequency*	*Percent*	*Frequency*	*Percent*	*Frequency*	*Percent*
All appropriate	13	81.3%	12	75.0%	9	56.3%
10 per cent inappropriate	3	18.8%	4	25.0%	6	37.5%
More than 30 per cent inappropriate	0	0%	0	0%	1	6.3%
Total	**16**	**100%**	**16**	**100%**	**16**	**100%**

Table 6: Physiotherapist assessment of patients' appropriateness for physiotherapy

Conclusions and recommendations

The aim of the project was to evaluate the impact of introducing the self-referral route of access to women's health physiotherapy services for women with urinary incontinence and pelvic floor dysfunction.

Patient benefits of patient self-referral:

- Empowered patients to refer themselves
- Provided easier access to services and saved time
- Reported high levels of patient satisfaction
- Reduced waiting times compared with other referral options
- As clinically effective as other referral options

Service benefits of patient self-referral:

- No overall increase in demand or waiting times
- Promoted equality of access
- Higher levels of attendance and completion of treatment
- Lower levels of DNAs
- Well accepted by service users

The greater access that self-referral provides is in line with current health policy. It is valued by patients and supports self-management by allowing patients to choose when to opt in to services.

The findings of this project suggest that more robust analysis of referral and administrative processes may be appropriate to reduce both the DNA and 'failed to complete treatment' rates. The use of alternative referral methods e.g. electronic referrals may also streamline the process for those patients who are referred for treatment.

For patient self-referral to women's health services to be implemented effectively across any population, the provider must ensure that services are designed, planned and delivered in such a way as to address the particular needs of that population. This will include consideration of the needs of specific ethnic and cultural groups, e.g. the development of leaflets and other promotional materials for non-English speaking populations and/or the use of community leaders or health advocates.

Whilst the self-referral route was used by women of all ages, there was a lack of awareness within the general population that physiotherapy has a role to play in the treatment of incontinence and pelvic floor dysfunction. This was confirmed both by the patients who completed the online questionnaire (Appendix E) and the recent public opinion survey.[17]

The main recommendation from this project must be for a campaign to raise awareness within the general population that physiotherapy is an effective treatment for women with incontinence or pelvic floor dysfunction.

Acknowledgements

The patients who participated in the project and provided valuable feedback as part of the evaluation process.

The physiotherapy staff at the pilot sites for their commitment and enthusiasm whilst undertaking the project.

The link clinicians at each of the pilot sites who played a key role through sharing their experience for the benefit of patients:

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- Karen Whitehouse, Peninsula Community Health
- Jacqui Knight, Coventry & Warwickshire Partnership Trust
- Rebecca Mallin-Jones, Gloucestershire Hospitals NHS Foundation Trust
- Lynne Reddyhough and Margie Critchley, Northamptonshire Teaching PCT
- Bronwyn Dunn and Amanda Holder, Royal Free London NHS Foundation Trust
- Jess Butterly, University Hospitals Bristol NHS Foundation Trust

The Chartered Society of Physiotherapy, and in particular:

- Ruth ten Hove, Professional Adviser
- Teresa Cook, Project worker

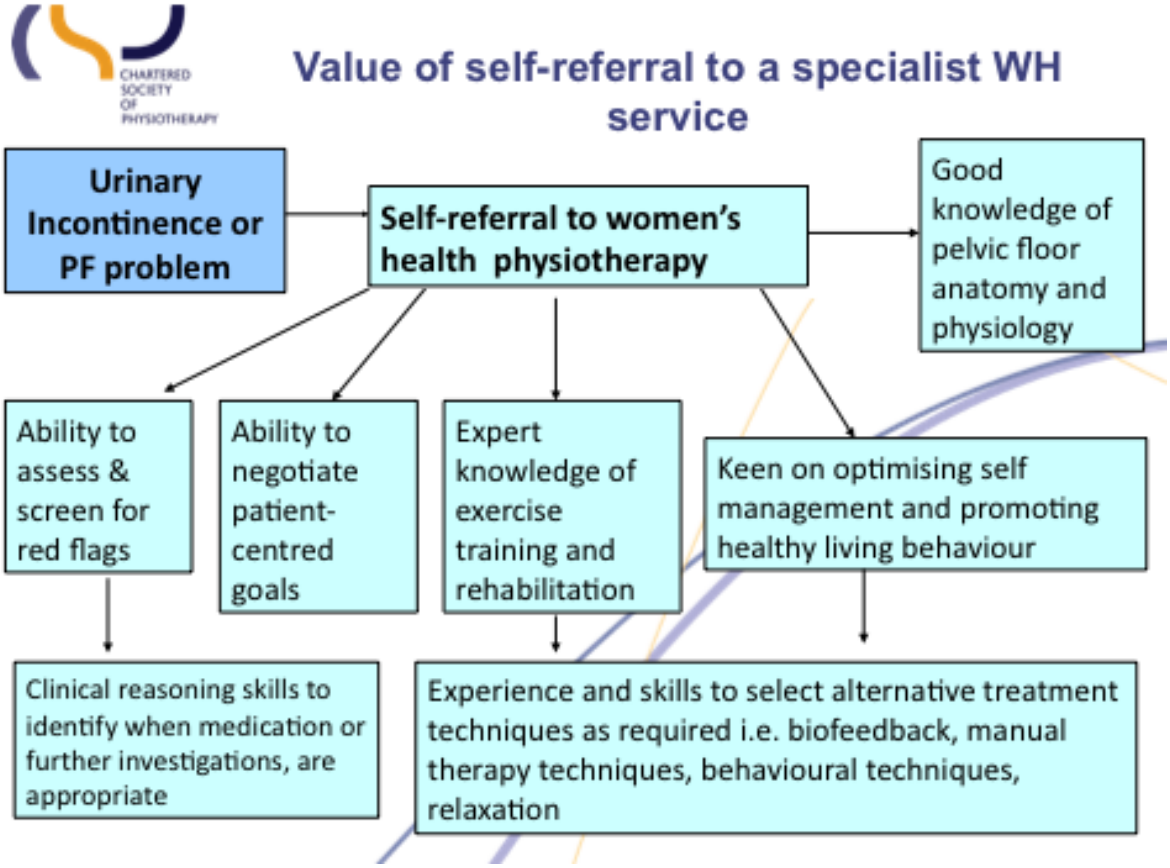
The Association of Chartered Physiotherapists in Women's Health, and in particular:

- Ruth Hawkes, Chair of ACPWH
- Doreen McClurg, Chair of the ACPWH Education Subcommittee

Karen Kilner, statistician at Sheffield Hallam University

Also Jane Brazendale and Louise Huber, women's health physiotherapists, Central Lancashire PCT, who provided valuable support to the project team, particularly at the start of the project.

Appendix A: Value of self-referral to a specialist women's health service

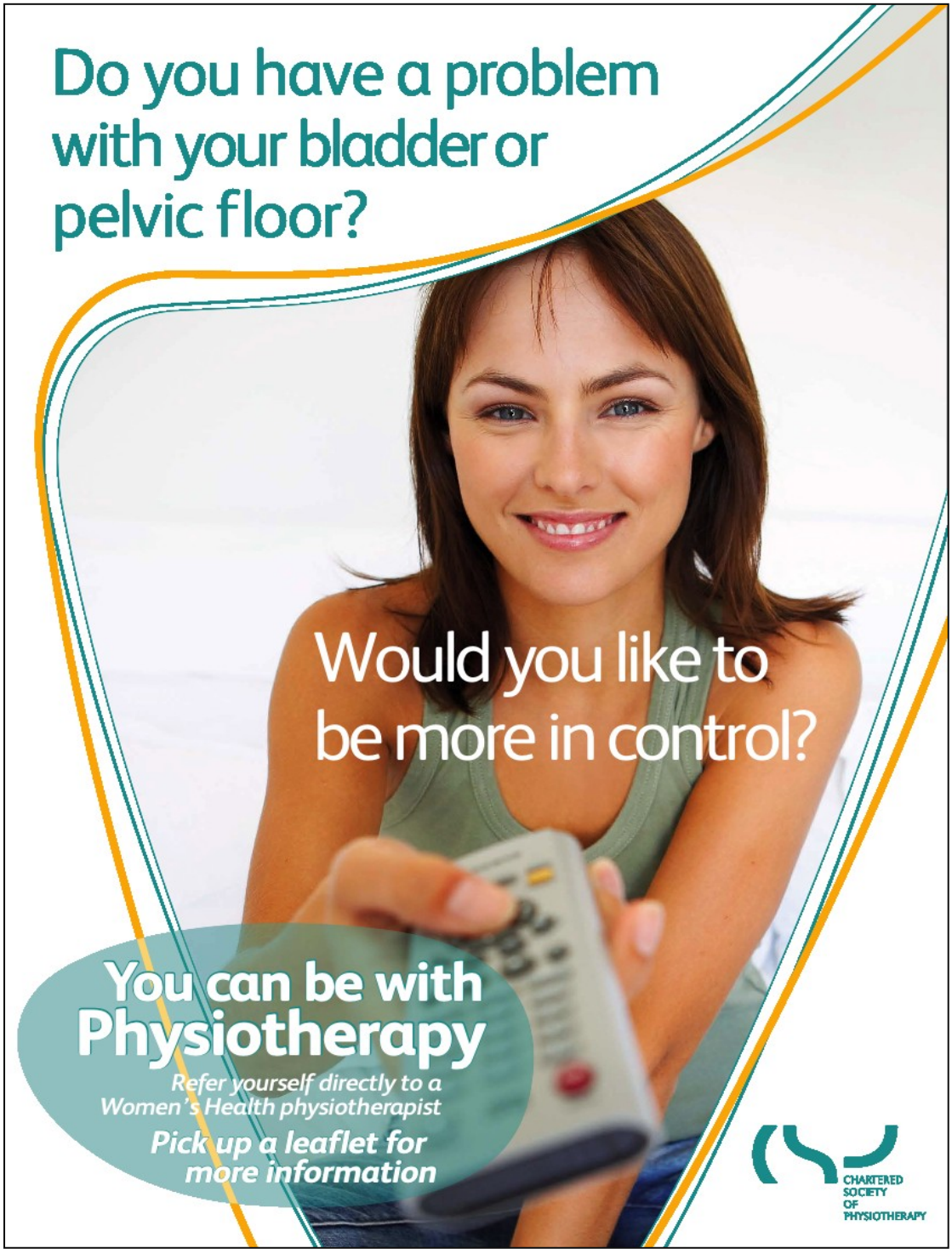


Appendix B: Characteristics of pilot sites

Trust	***Site characteristics*** *a) Geographical profile b) Deprivation*[†] *c) Percentage white (persons)*[‡]
Bradford Teaching Hospitals NHS Foundation Trust	Bradford Royal Infirmary a) Urban b) High c) 72 per cent
Cornwall & Isles of Scilly PCT, later Peninsula Community Health	Camborne Redruth Community Hospital a) Rural b) Mixed c) 99 per cent
Coventry & Warwickshire Partnership Trust	City of Coventry Health Centre a) Urban b) High c) 67 per cent
Gloucestershire Hospitals NHS Foundation Trust	Cheltenham General Hospital & Gloucester Royal Hospital a) Urban b) Low c) 95 per cent
Northamptonshire Teaching PCT	Kettering General Hospital a) Urban/Rural b) Mixed c) 90 per cent
Royal Free London NHS Foundation Trust	Royal Free Hospital a) Urban b) Mixed c) 60 per cent
University Hospitals Bristol NHS Foundation Trust	Bristol Royal Infirmary & St. Michael's Hospital a) Urban b) Mixed c) 84 per cent

[†] The English Indices of Deprivation 2010, Department for Communities and Local Government.
[‡] Neighbourhood statistics, 2001 Census, Ethnic Group (UV09), Office for National Statistics.

Appendix C: Promotional poster



Appendix D: Promotional leaflet, including self-referral form

Who suggested physiotherapy? ☐ GP ☐ Friend ☐ Healthcare professional

Or was it your own idea? ☐ Yes ☐ No

How long have you had this complaint?
☐ Days ☐ Weeks ☐ Months ☐ Years

Is the problem... ☐ New ☐ Return of old problem

Are your symptoms worsening? ☐ Yes ☐ No

Do you feel a stinging or burning sensation when you pass urine or have you noticed any blood in your urine?
☐ Yes ☐ No
If yes, please give details

Have you ever had an abnormal cervical smear test?
☐ Yes ☐ No
If yes, please give details

Have you had any unusual/unexpected bleeding or staining from the vagina?
☐ Yes ☐ No
If yes, please give details

Do you have persistent abdominal pain?
☐ Yes ☐ No

Do you have persistent bloating that doesn't come and go?
☐ Yes ☐ No

Do you have difficulty eating or find that you eat less but feel fuller?
☐ Yes ☐ No
If yes, please give details

Have you suddenly lost any weight without trying?
☐ Yes ☐ No
If yes, please give details

Do you have any numbness, tingling or muscle weakness?
☐ Yes ☐ No
If yes, please give details

CHARTERED SOCIETY OF PHYSIOTHERAPY

14 Bedford Row
London, WC1R 4ED
Tel: 020 7306 6662
Web: www.csp.org.uk

Please return this form to:

www.csp.org.uk

Do you have a problem with your bladder or pelvic floor?

Would you like to be more in control?

Project to evaluate patient self-referral to women's health physiotherapy pilot sites – PD105 – April 2013

CHARTERED SOCIETY OF PHYSIOTHERAPY

Physiotherapy may be beneficial

if you are having problems with your bladder or pelvic floor muscles

Is physiotherapy right for me?

Physiotherapy can be particularly helpful if you suffer from leakage of urine during exercise or when you cough or sneeze. It can also help if you suddenly need to go to the toilet but can't get there in time. These are common problems which affect 1 in 3 women at some time during life. Physiotherapy can also help you if your pelvic floor muscles are weak.

What is self referral and what do I need to do?

Self referral is just another way of getting to see a physiotherapist. It means that you don't have to see your GP and wait for her/him to contact the physiotherapist.

This service is available if you are female, over the age of 16 and have a bladder or pelvic floor problem. All you need to do is complete the form on the right.

What will happen next?

A specialist physiotherapist will look at the information you have written on the form. We will then contact you and either offer you an appointment for an assessment or put you on our waiting list. The physiotherapy treatment you receive will be the same as if your GP had referred you.

How do I know whether I should see my GP?

If you have any concerns you can always make an appointment to see your GP in the usual way and ask about a physiotherapy referral.

FACT

1 in 3 of women suffer from leakage of urine at some time during life

You should always see your GP if:

- you think that you may have a urine infection i.e. you have a burning or stinging sensation when you pass urine and/or need to go to the toilet more often and more urgently than usual
- you notice any blood in your urine
- you have unexpected vaginal bleeding

What can I do to help myself in the meantime?

You could try to exercise your pelvic floor muscles but you need to make sure that you're doing this in the right way. Imagine that you're trying to stop yourself passing wind and at the same time trying to stop yourself from passing urine. It should feel like a 'squeeze and lift' inside. It's good to do a mixture of strong, long holds and short squeezes. Some women find this really difficult, so if you're not sure wait until you see the physiotherapist.

If you leak with exercise or when you cough or sneeze you can try to do a strong 'squeeze and lift' just before the activity which causes the problem. If possible you need to hold the 'squeeze and lift' until the activity is finished. For example, this may be before and whilst you lift a heavy object or cough or sneeze.

Try to drink about 1 ½ litres (3 pints) of fluid each day. If you need to rush to get to the toilet in time it may help to gradually reduce the amount of caffeine you drink. This includes tea, coffee and cola drinks, which could be replaced by water-based drinks.

Referring yourself to physiotherapy

Please complete this form and return it to your local women's health physiotherapist at the address on the back of this leaflet.

Name

Address

Date of birth | Todays date

e-mail

Your Phone numbers. Can we leave a message at these numbers?

Phone no. (home) ☐Yes ☐No

Phone no. (work) ☐Yes ☐No

Phone no. (mobile) ☐Yes ☐No

Your GP's name and surgery

Do you require an interpreter? ☐Yes ☐No

If yes, which language?

Please give a brief description of why you want a physiotherapy assessment:

CHARTERED SOCIETY OF PHYSIOTHERAPY

Appendix E: Data collection form (web-based)

Women's health data collection

Welcome to the data collection page for the Women's Health Physiotherapy self-referral pilot project.

Contact form

For the Women's Health self-referral project, a data form must be completed for ALL patients who are assessed via the primary care route.

This includes GP-referrals, patients referred by other primary healthcare professionals and those who self-refer or are prompted to refer themselves by another healthcare professional. It does not include secondary care (consultant) referrals.

NHS Trust: * Bradford Teaching Hospitals NHS Foundation Trust

Referral source: *
GP Referred
GP Suggested/prompted
Self-referral
Other healthcare professional - referred
Other healthcare professional - prompted

Waiting time

Date of referral to physiotherapy: * 1 Mar 2011

Date of receipt of referral: * 1 Mar 2011

Date of first physiotherapy appointment: * 20 Jan Year

Earlier appointment offered but declined?: * yes / no
This is to indicate if the patient was offered (but declined) an earlier appointment.

Total number of days from referral to appointment: *

CHARTERED SOCIETY OF PHYSIOTHERAPY

Patient

Age: * __ years

Ethnicity: - None -

Duration of symptoms:
< 2months / 2-6 months / 6-12 months / 1-5 years / > 5 years

Number of contacts: *

Condition category : *
Stress Urinary Incontinence
Urge urinary incontinence
Overactive bladder
Mixed urinary incontinence
Pelvic organ prolapse symptoms
Mixed urinary and prolapse symptoms
Pelvic floor muscle dysfunction without prolapse or urinary symptoms
Other

Health status at discharge: *
D/C without symptoms
D/C with manageable symptoms
D/C for further investigations/surgery
Failed to complete
DNA (never attended)

Outcomes - first assessment

If your patient attended for assessment you must complete the EQ-5D scores and EITHER the IIQ-7 OR the POP score measure, but not both.

EQ-5D - health status thermometer: *

If patient was a 'DNA' or 'failed to complete' submit as '0'.

EQ-5D - descriptor score: *

This must be a five figure score. If patient was a 'DNA' or 'failed to complete' submit as '00000'.

IIQ-7 score: 0

Select the appropriate score. If the patient was a DNA or failed to complete or presented with predominantly prolapse symptoms submit as '0'.

POP score: 0

Select the appropriate score. If the patient was a DNA or failed to complete or presented with predominantly urinary symptoms submit as '0'.

Outcomes - final assessment

If your patient attended for assessment you must complete the EQ-5D scores and EITHER the IIQ-7 OR the POP score measure, but not both.

EQ-5D - health status thermometer: *

If patient was a 'DNA' or 'failed to complete' submit as '0'.

EQ-5D - descriptor score: *

This must be a five figure score. If patient was a 'DNA' or 'failed to complete' submit as '00000'.

IIQ-7 score: 0

Select the appropriate score. If the patient was a DNA or failed to complete or presented with predominantly prolapse symptoms submit as '0'.

POP score: 0

Select the appropriate score. If the patient was a DNA or failed to complete or presented with predominantly urinary symptoms submit as '0'.

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