



Implementing patient direct access to musculoskeletal physiotherapy in primary care: views of patients, general practitioners, physiotherapists and clinical commissioners in England

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Abstract

Purpose Musculoskeletal problems are the leading cause of chronic disability. Most patients in the UK seek initial care from general practitioners (GPs), who are struggling to meet demand. Patient direct access to National Health Service physiotherapy is one possible solution. The purpose of this study was to understand the experiences of patients, GPs, physiotherapists and clinical commissioners on direct access in a region in England with it commissioned.

Methods The study was informed by Normalisation Process Theory (NTP). Data collection was via semi-structured individual face-to-face and telephone interviews with 22 patients and 20 health care professionals (HCPs). Data were analysed thematically using NTP.

Results Three themes emerged: understanding physiotherapy and the direct access pathway; negotiating the pathway; making the pathway viable. HCPs saw direct access as acceptable. Whilst patients found the concept of direct access, those with complex conditions continued to see their GP as first point of contact. Some GPs and patients reported a lack of clarity around the pathway, reflected in ambiguous paperwork and inconsistent promotion. Operational challenges emerged in cross-disciplinary communication and between HCPs and patients, and lack of adequate resources.

Conclusion Direct access to NHS musculoskeletal physiotherapy is acceptable to patients and HCPs. There is need to ensure: effective communication between HCPs and with patients, clarity on the scope of physiotherapy and the direct access pathway, and sufficient resources to meet demand. Patient direct access can free GPs to focus on those patients with more complex health conditions who are most in need of their care.

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Keywords: Physiotherapy; Patient direct access; Self-referral; Health services delivery; Primary care; Normalisation process theory

Introduction

Musculoskeletal conditions

Musculoskeletal conditions are common and are the leading cause of chronic disability worldwide with increasing

prevalence [1], resulting in 6.6 million lost working days in the United Kingdom (UK) in 2017/18 [2]. Prioritising primary care services will have greatest impact on improving functional ability into older age and containing health care expenditure [3]. However, UK primary care needs a significant shift towards “multi professional team-based general practice” if it is to meet patient demand [4].

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Patient direct access to NHS physiotherapy

The National Health Service (NHS) in the United Kingdom provides healthcare free at the point of delivery with General Practitioners (GPs) traditionally being the ‘gate-keeper’ from whom a referral is required to access specialist services. Slow to be adopted [5], particularly in England [6], patient direct access to NHS physiotherapy (i.e. self-referral) is widely used elsewhere [7]. The recent announcement of changes to GP contracts and setting up of Primary Care Networks promises more effective use of physiotherapy and the possibility of more wide-spread adoption [8,9], with support from both GPs and patients for physiotherapists being the first point of contact for those with musculoskeletal conditions [10]. However, previous studies suggest younger patients with higher education levels and those with previous experience of physiotherapy are more likely to use it than those who are older and with chronic health conditions [11–13]. Direct access sits within the context of NHS service commissioning. As part of a restructuring of the NHS in 2012 Clinical Commissioning Groups (CCGs) were created to commission healthcare, including elective hospital services, community care and physiotherapy services, taking into account the needs in local areas in England. Working closely with NHS England, Clinical Commissioners (CCs) consist of GPs, other clinicians including a nurse and a secondary care consultant, and lay members [14].

This study

Following a recent pilot cluster randomised controlled trial (RCT) with 4 general practices in England [blinded for review] [5], the 2 control practices introduced patient direct access to NHS physiotherapy, allowing a natural experiment across all 4 practices to further evaluate its feasibility. All 4 practices were in a region where direct access was funded through the NHS. The natural experiment had 3 aims: first, to identify changes in GP musculoskeletal-related workload over time; second, to identify cost effectiveness; and third to explore the experiences of patients, GPs, physiotherapists and clinical commissioners, particularly in terms of acceptability.

Findings thus far indicate that direct access appears to have no consistent impact on GP workload [15] and is potentially cost effective [16], supporting the need for a full RCT to test effectiveness. This paper reports the findings of the exploratory work into patient and clinician experiences in accordance with the Consolidated criteria for Reporting Qualitative research [17].

Normalisation process theory (NPT)

This exploratory study adopted the theoretical approach of NPT [18,19] to inform the study design. This included the development and focus of topic guides, data analysis, and interpretation of findings in relation to implications for service and practice development and implementation. NPT

Table 1
NPT constructs and definitions.

Constructs	Definition
Coherence	The sense-making people do individually or collectively when faced with operationalizing a set of practices
Cognitive participation	The relational work people do <i>to build</i> and <i>sustain</i> a community of practice around a new technology or complex intervention
Collective action	The operational work that people do to enact a set of practices (including professional interactions and resources)
Reflexive monitoring	The appraisal work that people do to assess and understand the ways that a new set of practices affects them and others around them

has been widely used in health research [20] to identify and explain key mechanisms that support or hinder the implementation, embedding and integration of new techniques and interventions [21]. It has four constructs (Table 1) [21].

Patient and public involvement

A patient and public involvement group informed the research design, interview guides, participant-facing documentation, the analysis and reporting. A group member was a co-applicant on the funding proposal and is an author on this paper (JM).

Methods

Qualitative individual semi-structured interviews with health care professionals and patients conducted face-to-face or by telephone according to participant preference.

Recruitment

Patients

Written invitations with a participant information leaflet sent to 150 patients registered at all 4 GP practices. Inclusion criteria were those aged ≥ 18 years who had accessed direct access within the past eighteen months. The patients were considered in two groups: those who were ‘True Self-Referrers (TSR)’ and had independently contacted a physiotherapist using the direct access model, without consulting their GP, and ‘Recommended Self-Referrers (RSR)’ who had visited the GP and received a recommendation to self-refer to a physiotherapist. A £15 token of appreciation was given to participants.

Health care professionals (HCPs)

A Clinical Research Network Facilitator contacted physiotherapists, GPs and CCs. If willing to be interviewed, a participant information leaflet was sent, and a time and place for interview arranged.

Table 2
Patient characteristics.

ID	Age	Gender F/M	Education ^b	Health literacy ^c	Limiting long-standing illness	Employed yes/no	Referral ^d TSF/RSR
P 14	73	F	1	Good	Yes	No	RSR
P 13	69	M	1	Good	No	No	RSR
P 24	70	F	1	Good	Yes	No	RSR
P 35	59	F	2	Good	Yes	Yes	RSR
P 52 ^a	66	F	3	Good	Yes	No	RSR
P 54	86	M	1	Poor	Yes	No	RSR
P 56	78	F	3	Good	Yes	No	RSR
P 60	54	M	1	Good	Yes	No	RSR
P 67	79	F	0	Good	No	No	RSR
P 79	82	F	4	Good	Yes	No	RSR
P 81	63	F	1	Good	Yes	No	RSR
P 87	57	F	1	Good	Yes	No	RSR
P 93	66	F	4	Good	No	No	RSR
P 97	56	M	4	Good	Yes	Yes	RSR
P 102	50	F	3	Good	No	Yes	TSR
P 108	55	F	3	Good	Yes	No	TSR
P 112	57	M	4	Good	Yes	No	TSR
P 113	36	F	2	Good	Yes	Yes	TSR
P 121	76	M	1	Poor	No	No	RSR
P 132	55	F	3	Good	No	Yes	TSR
P 136	42	F	3	Good	Yes	Yes	TSR
P 144	56	F	1	Good	No	No	RSR

^aIndian British: all others described themselves as White British.

^b Level 1: 1–4 GCSEs/equivalent; Level 2: 5 GCSEs/equivalent; Level 3: 2≥ A-levels/equivalent; Level 4≥: Bachelor's degree/equivalent/higher qualifications. 0: no formal education.

^c Single item health literacy question: How often do you need to have someone help you when you read instructions, pamphlets or other written material from your doctor or pharmacy? Response: rarely or never (good); often or always (poor).

^d True self-referral/recommended self-referral.

Data collection

Semi-structured topic guides ensured data collection was systematic whilst allowing unexpected issues to emerge. Although covering slightly different themes for each group, the guides shared an overall focus around personal, professional, organisational and commissioning challenges and facilitators to direct access, and its acceptability. In addition, patient socio-demographic information was collected, and the Health Literacy (HL) single item screening tool score [22]. HCPs were asked years of experience and qualifications; GPs were asked about specific training in musculoskeletal conditions. Interviews lasted between 40–90 minutes, were audio recorded with consent, transcribed verbatim and fully anonymised before analysis; all were conducted face-to-face except for 2 CCs and one GP who requested telephone interviews because of time pressures. All interviews were conducted by the same post doctoral research associate, who had a physiotherapy background (CNI-C). As the study progressed, a random selection of audio recordings were reg-

ularly audited by the study lead (BB, a social scientist, blinded for review) to ensure quality and adherence to protocol.

Data analysis

An inductive thematic analysis was applied to the data [23]. To ensure reliability, a process of inter-coder consensus was adopted [24], whereby a random sample of transcripts from both participant groups were independently coded by five of the authors with backgrounds in physiotherapy, social science and health services research, and included the lay member. The aim of analysis was to identify recurrent concepts and themes and develop a coding frame informed by NPT. Where discrepancies emerged these were discussed until consensus was reached within the group [24]. The coding frame was applied to the remainder of the data whilst allowing for the emergence of new insights. Connections between codes and themes, and across groups, including consistencies and variances, were explored to identify final themes. Data saturation was considered reached when no new

Table 3
HCP characteristics.

Study ID	M/F	Years in practice	Qualifications	MSK training
GP01	F	31	MBBS 1986; GP 1990	Yes
GP02	M	13	MBChB, FRCA, DRCAG, MRCP	Yes
GP03	F	27	MBBS; DROG	Yes
GP04	M	34	MBChB; MRCP/O&G	Yes
GP05	M	30	MBChB	No
GP09	F	23	MBChB; GP	Yes
PT01	F	3	BSc Physiotherapy, Diploma Sports massage	N/A
PT02	F	11	BSc Physiotherapy	N/A
PT03	M	4	BSc Physiotherapy	N/A
PT04	F	13	BSc Physiotherapy	N/A
PT05	F	2	BSc Physiotherapy	N/A
PT06	M	3	BSc Physiotherapy	N/A
PT07	M	12	BSc Physiotherapy; MSc Advanced Physiotherapy	N/A
PT08	F	5	BSc Physiotherapy	N/A
PT09	M	6	BSc Physiotherapy; BSc Exercise & Health Sciences	N/A
PT10	F	27	Graduate Diploma in Physiotherapy	N/A
CC1/GP	M	23	MBChB; JCTPGP(GP training); MRCP(Part 1)	Yes
CC2/PT	M	22	BSc (Hons) Physiotherapy	N/A
CC3/GP	M	20	MBChB; MRCP; GP	Yes
CC4/GP	M	22	MBChB; FRCP	Yes

themes emerged [blinded for review] [25]. To further ensure reliability, findings were presented to the patient and public involvement group for sense checking. In what follows we report key themes before discussing implications for direct access implementation.

Findings

Forty-two participants were interviewed (patients: $n = 22$; HCPs: $n = 20$). All patients but one were White British ($n = 21/22$); mean average age 63 (range 36–86); $n = 16/22$ women; $n = 20/22$ had good HL; 5 were in paid employment; $n = 15/22$ had a limiting long-standing illness (Table 2).

The 9 female and 11 male HCPs had 2–34 years clinical experience. Of the 4 CCs, 3 were GPs. Eight GPs had training in musculoskeletal conditions (Table 3).

Three key themes emerged: understanding physiotherapy and the direct access pathway (NTP: coherence); negotiating the pathway (NTP: cognitive participation); making the pathway feasible (NTP: collective action) (Table 4). The fourth construct of NPT, *reflexive monitoring*, is concerned with systemisation, appraisal and reconfiguration itself. Whilst elements of these are reflected in our data, this work constitutes part of the overall process of reflexive monitoring intended to feed into reconfiguring and strengthening the direct access pathway [21].

Reflecting the complex nature of introducing a patient direct access to NHS physiotherapy pathway as an intervention, although presented separately themes are inter-linked and inform each other. They are presented using illustrative quotations. Unique identifiers for patients include participant number, gender, age, education level (EL) and referral pathway (TSR/RSR); HCPs include professional group (PT/GP/CC), participant number and length in practice.

Understanding physiotherapy and the patient direct access pathway

Patients' understanding of physiotherapy and its scope of practice emerged as key:

“We quite often get patients saying, ‘the GP referred me but I don't know really know what physio is.’ (PT8/F/5)

“Unless you go to your doctor and the doctor suggested physio, you wouldn't know whether to go or not. . . How would they [physiotherapists] know? (P121/M/76/EL1/RSR) “. . .they [patients] think the diagnosis is only the GP's job” (PT1/F/3).

Ageing and co-morbidities also emerged as a factor:

“I'll go see my doctor, he'll tell me what to do. It's that reassurance. . . it's probably more comforting for an older person. . .” (P67/F/79/EL0/RSR).

Table 4

Summary of NPT constructs used and illustrative questions mapped against themes – adapted from Gillespie et al [19].

NTP Constructs	Questions	Themes
Coherence	1. How is physiotherapy understood by patients?	Understanding physiotherapy & the DA pathway
	2. How is DA understood?	<ul style="list-style-type: none"> • Patients' understanding of physiotherapy • Scope of physiotherapy practice • Understanding of DA • Acceptability of DA
	3. How do participants compare DA to usual practices?	
Cognitive Participation	4. How did participants come to use or not DA?	Negotiating the pathway
	5. What motivates them to participate?	<ul style="list-style-type: none"> • Awareness of DA • Accessibility • Participation
Collective Action	6. How is DA operationalised?	Making the pathway viable
	7. How are activities organised and structured?	<ul style="list-style-type: none"> • Cross-disciplinary communication • Patient/practitioner communication • Training and education

“Especially if they’ve got numerous co-morbidities as well... the older population tend to go to see their GP first.” (PT1/F/3).

The importance of patient education and HL also emerged:

“Education around what their problem is could be a factor as to whether they see physio as a benefit or not” (P8/F/5)

“Patients are not as well educated in this area. . .that’s a barrier to actually getting them to understand that they can self-refer and fill the forms in.” (PT4/F/13).

Linked to this, patients reported being more likely to use direct access if there was a pre-existing problem:

“I would go and see the GP first if it was anything new... If it was a pre-existing condition then I probably would go back to the physio. . .” (P144/F/56/EL1/RSR).

There appeared to be confusion about direct access in relation to other services:

“A little bit confusing in this area because we have Brief Intervention; we have the self-referral; we’ve ended up with what we call Physio First. . .the problem is that there are very loose definitions of what these services are. What’s the difference. . .?” (CC1/GP/23).

Secondary care practitioners could reinforce GP-referral:

“If you get seen by a specialist out of area, there’s a letter saying ‘please go and see your GP to refer to physio’. If I wrote to them about self-referral we’d be writing letters all day. . .I’m not doing that” (GP2/13).

Finally, some patients were confused as to whether direct access was the same as other NHS services no longer consistently free at the point of consultation:

“I still think people have a stigma [sic] that anything like physio is going to be money orientated, since the dental practices have all gone private.” (P87/F/57/EL1/RSR).

Negotiating the pathway

All HCPs saw timely access as reducing unnecessary referrals:

“Physios are more likely to understand what they can manage and not refer on, whereas GPs are less certain, and they refer to orthopaedics.” (CC1/GP/31)

Whilst patients found direct access acceptable, the majority were RSRs, either because they were unaware of the existence of or did not understand the pathway:

“That’s brilliant. I didn’t know that you could just go straight to a physio.” (P121/M/76/EL1/RSR).

Some patients found the self-referral form confusing, including those with a higher education level:

“Very confusing. First question was date of birth, ‘write in the patient’s date of birth’. The form was the GP’s referral form which I’d been told to fill in myself.” (P93/F/66/EL4/RSR).

The importance of including telephone self-referral for those with inadequate HL and older patients, and online self-referral emerged as important in improving engagement:

“. . .the feedback we often get from the patients is, ‘can’t I book an appointment online? So we are frustrating probably the 40s and under.’” (CC2/PT/22).

Motivation to self-refer and engagement with therapy appeared linked to physiotherapy as a first line treatment to be undertaken before other treatments could be accessed:

“[Physiotherapy] was more a hurdle to getting to somewhere else. . . because they wanted surgery or an orthopaedic review; not because they wanted physiotherapy.” (PT1/3).

Associated with this was the role of the GP in legitimating work absence:

“That [sick note] may force them [patients] to go to the GP. You’re never going to stop that ‘cause it’s big corporate companies.” (PT102/F/50/EL3/TSR).

Visibility of the service was an issue, both physically in practices and on-line:

“Those numbers [TSRs] are low because we did an initial marketing drive and as time passes, practice staff change, the poster falls off the wall, the message gets lost.” (CC2/PT/22).

There also appeared to be minimal training and involvement of reception staff:

“Our staff generally don’t do much signposting. . .” (GP5/30).

Making the pathway viable

As the issues of poor visibility and support highlighted, the initial drive to promote direct access appeared lost, with uncertainty as to why:

“Why isn’t it more successful? Is it the capacity issue? Is it the marketing?” (CC1/GP/23).

In terms of capacity, there was awareness of concerns over possible increased work-load:

“We were worried that opening up self-referral would increase the number of referrals coming in, but that didn’t actually happen.” (PT4/13).

Challenges emerged around data sharing between physiotherapists and GPs:

“So at first [GPs] weren’t happy with us having access to their medical information. . .all coming down to agreements on data sharing. We’re not quite there 100%” (PT2/11).

This was linked to difficulties posed by different electronic health record systems:

“[Physiotherapy records] are not on the EMIS system. . .we can’t see [them].” (GP2/13)

This impacted on patient care and time resources:

“I don’t know who’s on the waiting list for physio because there’s nothing reported back down the system. So it is ‘go and refer yourself for physio’ and that then becomes a black hole.” (GP2/13).

“Sometimes patients don’t complete [their medical history]. If we go and speak to the GPs. . . then we can get that. But it’s hard work at the moment.” (PT2/11).

“There didn’t seem to be any communication between the physio and the doctor. No record from the doctor’s point of view that I’d actually seen the physiotherapist.” (P132/55/F/EL3/TSR).

Some patients were dissatisfied with long waiting times after self-referral:

“Then you have to wait quite a long time, six weeks for the appointment to come, when they said I would be hearing in one to two weeks and then you don’t.” (P35/59/F/EL2/RSR).

The cause appeared to be the use of one central booking system with poor staffing levels:

“Everything goes to a central booking system. They have lost a couple of staff. They’re not just getting referrals from physio, they’re getting referrals for podiatry, for speech and language.” (PT4/13).

This could impact on patient outcomes, and GP time:

“If we can get it really slick through the booking service we actually see them in their acute stage. . . They won’t need as many follow ups or medications or further investigations which are sometimes done unnecessarily, and hopefully less days off work.” (PT4/F).

“They’ll come for two or three consultations, and they will have self-referred to physiotherapy and they will still be waiting to be seen.” (GP2/13).

Whilst direct access was seen to reduce onward referral, it was not necessarily seen to reduce costs:

“I spend the best part of £100,000 employing my two physiotherapists and I reduce [my] 10 hip replacements... the cost savings for the hospital of not doing 10 hip replacements are 10 times a bit of metal. . . that might only cost £1,000. You still need an operating theatre. . . you’re still doing 50. You still need a surgeon, an anaesthetist, the nurses, the ODA [operating department assistant]. None of your costs change. . .” (CC4/GP/22).

Funding models also presented challenges:

“We have always been on block contract. . . ‘this is your flat budget’. If the pressures go higher or lower you can’t really respond. For example, [CC G] has now doubled its allocation of physiotherapy. In theory, if that was tariff-based, we would now be asking for double the resource [but] it is just so unresponsive. . .so by the time you’ve needed what you’ve needed. . .it’s still not gone into finance. . .” (CC2/PT/M/22).

Physiotherapists in this study did not have advanced practice but there was support for it, particularly in direct access:

“. . .hopefully we’ll eventually have a bigger role in ordering x-rays, injections, non-medical prescribing, because that then cuts out our need to go to the GP as often...” (PT8/F/5).

Analysis and discussion

Findings indicate that patient direct access to NHS physiotherapy is acceptable to patients, GPs, physiotherapists and commissioners. However a range of issues were identified in relation to the three NTP constructs of coherence and sense-making, cognitive participation and collective action. We now explore in more detail the reasons behind these find-

ings, including the fact that the majority of patients in this study did not truly self-refer ($n=6/22$), before turning to the implications for practice and service provision.

Coherence and sense-making

Many patients did not understand physiotherapy, particularly the scope of practice. This meant they continued to see their GP as first point of contact, including those with previous experiences of physiotherapy, should a new condition or symptom develop. They also saw diagnosis as the domain of the doctor. The lack of coherence extended to poor understanding of direct access, with many of those advised to self-refer believing they were referred by their GP. This study took place in a low socio-economic area with less than half the patients educated to A-level, and all but two aged $50\geq$, yet they generally considered direct access acceptable compared to usual practice. At the same time, those who were older, with complex co-morbid conditions, were more reluctant to use direct access without the advice of their GP, reflecting existing research identifying it as acceptable particularly amongst those who are male, younger, higher educated, with conditions of shorter duration [11–13,26,27].

Cognitive participation

Reflecting this literature, 4/6 TSR patients were in employment, with education levels from 2 to 4, 4 with level 3; those who were RSRs had education levels from 0 to 4, with 9/16 having \leq level 1. However, of the remaining 8 RSRs, 3 patients were level $4\geq$, including one with a Master's degree, suggesting that education level alone does not explain participation in direct access but that the issue of age and co-morbid conditions are more likely to be the source of non-participation, as identified above.

Implementing and sustaining change in health care services is challenging [28,29]. In this study, it appears that the initial impetus to promote direct access was lost, with notices and information promoting the service often no longer visible. The pathway had to be explained to all RSRs patients during their interviews, as they were unaware and/or did not understand it. As in other work [6], the important role of reception staff in signposting emerged as key. Moreover, some GPs (including one CC) also expressed uncertainty about how direct access differed from the other referral pathways.

Some patients found the form confusing, and the importance of developing a range of access options emerged, including on-line and telephone. The latter was seen as particularly helpful for those who might need support, again highlighting the importance of training reception staff. Telephone support was available in the pilot RCT and may have contributed to the many more TSRs in that study (blinded for review) [10].

Collective action

Viability and practical challenges around implementing direct access were apparent. First amongst these were resource issues. Both physiotherapists and GPs had initial concerns about possible increases in service demand which, in keeping with existing evidence from elsewhere [11], and as in the pilot trial, did not prove to be the case. In this study, the processing system for direct access included processing referrals to a range of other services, and was under-staffed. It was this, rather than the lack of physiotherapists or increased demand for physiotherapy, that appears to have resulted in some patients reporting long-waiting times. However, it may be that if direct access were implemented successfully, demand would increase and investment in services will be necessary [Components 1 & 2 [15,16]].

In terms of service integration, our data identified effective and timely cross-disciplinary communication and data sharing as a major challenge. This had a direct impact on patient care, with GPs often unaware of who had taken the direct access route and/or what the outcome was, and physiotherapists struggling to ensure they were fully aware of the patient's medical history and any current treatments.

Whilst physiotherapists in this study did not have advanced practice there was support for this, not least as a way of making direct access more efficient and reducing GP appointments [30]. The lack of understanding of physiotherapy is further heightened when it comes to advanced practice, and physiotherapists need to proactively educate colleagues and patients to improve understanding of their roles [31].

In terms of costs, it appears that existing funding models are not sufficiently responsive to fluctuations in service demands, because funding is either fixed or not received in a timely way. This study contributes to the call for new funding models for health care delivery in primary care [32], and supports the findings from the linked component studies (blinded for review [15,16]).

Finally, our data highlight a reliance on traditional models of doctor-patient relationship and support the need for a new model of patient empowerment as a shared, iterative process creating a greater sense of health ownership in patients [33]. They also point to the need for patient education in terms of the GP as the first contact [6].

Strengths and limitations

So far as we are aware, this is the only study to include the views of patients on direct access using a theory-informed approach to analysis. In terms of limitations, the majority of patients were women and were retired. In addition, only one patient was not White British. Furthermore, given that the majority had low education levels ($n=12$), it is surprising that only two people self-reported low health literacy. It may well be that using the SIS health literacy tool failed to capture the multi dimensionality of what is a complex construct [34].

Conclusion

Direct access to physiotherapy in primary care is acceptable to patients and to health care professionals. A number of issues require consideration to ensure its effective and sustained implementation, not least increasing patient and public awareness around the scope of physiotherapy and the patient direct access pathway. Given the rising population of older people, careful thought should be given to the needs of those with co-morbidities, including mental health issues, and additional support to negotiate the direct access pathway developed. Linked to this, there is an urgent need for systems integration so that physiotherapists and GPs can access and input to the same patient medical records, improving cross-disciplinary and patient communication. Advanced practice physiotherapists could maximise the potential contribution of patient direct access in effective use of resources in primary care.

It is essential that the views of patients are taken into account in any service developments. Further qualitative research is needed to explore in more detail the views of men, those still in employment, older people with complex health needs, and those from diverse ethnic backgrounds. Such work also needs to take a more comprehensive approach to health literacy and identify patient-centred strategies that avoid a ‘one size fits all’ approach’ so as to ensure the full potential of patient direct access is implemented and sustained.

Finally, robust on-going process evaluation strategies are needed that take into account systematisation, communal and individual appraisal, detailed auditing and health economic assessment in order to identify emerging challenges and opportunities for new developments in what is the rapidly changing landscape of primary health care.

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