CHARTERED SOCIETY OF PHYSIOTHERAPY

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Information paper

Physiotherapy outpatient services survey 2012

reference PD103

issuing function Practice and Development

date of issue March 2013

CHARTERED SOCIETY OF PHYSIOTHERAPY

Physiotherapy outpatient services survey 2012

Contents

Table of Figures

Table of Tables

CHARTERED SOCIETY OF PHYSIOTHERAPY

Physiotherapy outpatient services survey 2012

Executive summary

The Chartered Society of Physiotherapy undertook a survey of every NHS organisation in the UK to gather information about physiotherapy outpatient services.

The survey was sent to the physiotherapy managers of 272 NHS organisations. The response rate was 54% (147 organisations).

Key findings

Waiting times

- 99% of organisations have average outpatient waiting times less than 14 weeks
- 100% of organisations have average outpatient waiting times less than 18 weeks
- 90% of organisations have longest outpatient waiting times less than 18 weeks

- 41% of organisations report an increase in their waiting times over the previous year
- 20% of organisations report a decrease in their waiting times over the previous year
- Longest waiting times have progressively increased from 18 weeks in 2010, to 40 weeks in 2011 and over 52 weeks in 2012

- 73% of organisations report an increase in demand affecting waiting times
- Approximately 50% of organisations report unfilled staff vacancies and vacancy control measures affecting waiting times
- 43% of organisations report reductions in permanent staff affecting waiting times

- Organisations with increasing waiting times most frequently report increase in demand, unfilled staff vacancies and vacancy control measures
- Organisations with decreasing waiting times most frequently report 'Did Not Attend' (DNA) management, increase in demand, increase in temporary staff, service re-design and changes in booking systems

- 83% of musculoskeletal services have shortest referral to treatment times (RTTs) less than one week
- 94% of musculoskeletal services have shortest RTTs less than two weeks
- 10% of musculoskeletal services have average RTTs less than two weeks
- Four% of musculoskeletal services have longest RTTs less than two weeks

- 64% of occupational health services have average RTTs less than two weeks
- Longest waiting times for occupational health services have progressively increased from 7 weeks in 2010, to 8 weeks in 2011 and 12 weeks in 2012

Self-referral

- 48% of organisations provide self-referral and 44% provide prompted referral to outpatient services
- Organisations who offer self-referral access to services have lower 'new to follow-up' ratios compared to organisations without self-referral access
- Less than 50% of organisations provide self-referral to occupational health services
- Almost one-third of organisations think it is unlikely that they can continue to offer self-referral access.

Of these,

- 100% reported that the service was not supported by commissioners or service planners

- Two-thirds indicated that self-referral was not within the Any Qualified Provider (AQP) specification

Recommendations

Health informatics

Robust systems need to be in place to capture information on physiotherapy services.

The profession should be represented on national health informatics strategic groups.

Specific data requirements are identified in relation to waiting times, new to follow-up ratios and the need for Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs).

Promotion of physiotherapy services, campaigning and influencing policy

The Chartered Society of Physiotherapy will utilise the findings of the survey to campaign for physiotherapy services and influence policy; in particular, in relation to the commissioning of services, self-referral and occupational health services for NHS staff.

The business case for physiotherapy services

Findings from the survey should be used by managers to make the business case for physiotherapy services.

Waiting times for physiotherapy services

Evidence based strategies to decrease waiting times should be implemented.

Acknowledgments

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The contributions of the following are gratefully acknowledged:
Natalie Beswetherick OBE MBA FCSP, CSP Director of Practice and Development
Jan Hague, CSP Marketing Insight Officer
Pat Olver, CSP Research Administrator
Ruth ten Hove MCSP, CSP Professional Adviser

Introduction

The Chartered Society of Physiotherapy (CSP) regularly monitors data about NHS physiotherapy outpatient services to inform influencing activity.

Three surveys had previously been commissioned by the CSP to collect data from physiotherapy managers, which were undertaken by JJ Consulting in 2009, 2010 and 2011. Questions about waiting times, patient self-referral and prompted referral to outpatient services were included in the surveys and reported on.[1-3]

Concerns were raised that continued structural reorganisation of NHS provider services and prolonged financial austerity would have a negative impact on waiting times and early access to outpatient physiotherapy services. The CSP therefore identified the need to ascertain whether waiting times and access to outpatient services had changed compared to previous years in which surveys were undertaken.

2012 survey

In 2012 the Chartered Society of Physiotherapy undertook a survey of physiotherapy managers working in NHS provider organisations across the UK. The survey repeated questions previously utilised in the surveys undertaken by JJ Consulting to enable comparison of data.

Methodology

A survey methodology was utilised to collect data from each NHS organisation in the four UK countries.

Participants

The participants were physiotherapy managers from the four UK countries. Utilising a database of NHS provider organisations and associated physiotherapy managers developed by the CSP, one physiotherapy manager from each NHS provider organisation was asked to complete the survey and to coordinate data collection from other managers within their organisation where appropriate.

Ethical approval was not required for the data collection methodology used in this study. Participants were informed that all data would be anonymised and reported in aggregate form.

Survey tool

The survey was adapted from the survey tool used in the 2010/11 survey.[3]

Based on feedback from 2011, the survey was reduced in length. To help ensure a good response rate throughout the whole survey, a response option of 'data not available' was provided for some questions.

The survey was divided into two main sections, one relating to physiotherapy outpatient services and the other on the impact of financial savings on all physiotherapy services.

This report provides the findings from the outpatient services section and includes:

- Demographic information
- Total number of patients seen
- New to follow up ratios
- Waiting times and factors affecting waiting times
- Access to services.

A copy of the survey text is in the Appendix.

Piloting the survey

The survey was sent for comment to the executive committee of the CSP Leaders and Managers of Physiotherapy Services (LaMPS) professional network.

As a result of feedback:

- Questions about seven-day and out of hours services were excluded from the survey, due to the wide variation in methods of service delivery reported by managers
- The wording of several questions was slightly edited for clarity
- Accurate timing was provided about how long it was likely to take to complete the survey.

Those piloting the survey were offered a choice of two formats:

- A SurveyMonkey web-based survey as used in previous years
- A PDF document format which could be downloaded and printed.

Based on feedback, the 'fillable' PDF form format was used for the main survey. Managers reported that they preferred the PDF form to the SurveyMonkey web-based survey as the former allowed for more than one person to complete different sections.

Procedure

The survey was emailed to all managers on 28 June 2012 in PDF format with the request to return the completed survey by email to the CSP Marketing Insight Officer by 31 July 2012.

If the manager was not the appropriate person to provide the information, they were requested to respond directly to the email with details of the correct person to contact. The contact details for 11 organisations were updated from responses received.

An email reminder was sent on 19 July 2012 and a further reminder on 2 August 2012 in which the deadline was extended to 24 August 2012.

On 17 August an email was sent to the CSP steward for each organisation asking them to encourage managers who had not already responded to complete the survey. As a result of this email, amended contact details for 14 organisations were received. The survey was sent to these 14 new managers with a completion deadline of 14 September 2012.

Timetable

28 June 2012	Survey sent to manager
19 July 2012	Email reminder
2 August 2012	Email extending deadline to 24 August
17 August 2012	Email to stewards, to encourage managers to complete survey
14 September 2012	Completion deadline

Data analysis

Descriptive statistics were used to summarise the data. Pearson's correlation coefficient was used to analyse the relationship between variables and one-way

analysis of variance to test for differences between groups. Statistical analysis was performed using IBM SPSS 19.0*

Results

Response rate

The survey was sent to the physiotherapy managers of 272 NHS organisations.

There were 147 responses representing an overall response rate of 54 per cent.

The response rate was 54 per cent for England, 60 per cent for Northern Ireland and Scotland, and 37.5 per cent for Wales.

Country	No. Responses	No. Sent	Response Rate (%)
England	132	244	54.1
Northern Ireland	3	5	60.0
Scotland	9	15	60.0
Wales	3	8	37.5
Total	**147**	**272**	**54.0**

Six non-responders emailed to explain that they were unable to respond due to recent organisational changes, time pressures, and/or being unable to identify the most suitable person to answer the different sections of the survey.

The response rate to individual questions varied, as some questions were not relevant to all organisations. There were 147 responses to the final question of the final section of the survey, suggesting that respondents completed the whole survey and answered all the questions relevant to their organisation.

* IBM SPSS Statistics for Windows, Version 19.0. Armonk, NY: IBM Corp

Population size covered by the organisation's physiotherapy service

The response rate to this question was 81 per cent (119 responses). 28 managers (24 per cent) did not respond.

Outliers were analysed and data from three organisations removed, as the data appeared to be inaccurate in relation to the size of the organisation and population sizes reported in annual reports for these organisations (population sizes 1,500, 5,000 and 2,000,000).

- There is large variation in population size covered by organisations; the smallest 20,000 and the largest 2,600,000
- The mean population size was 458,136 (standard deviation 363,000)
- From Figure 1 it can be seen that there are few organisations with population sizes over 1,000,000
- The organisation with a population size of 2,600,000 offers a regional tertiary service for heart and chest conditions

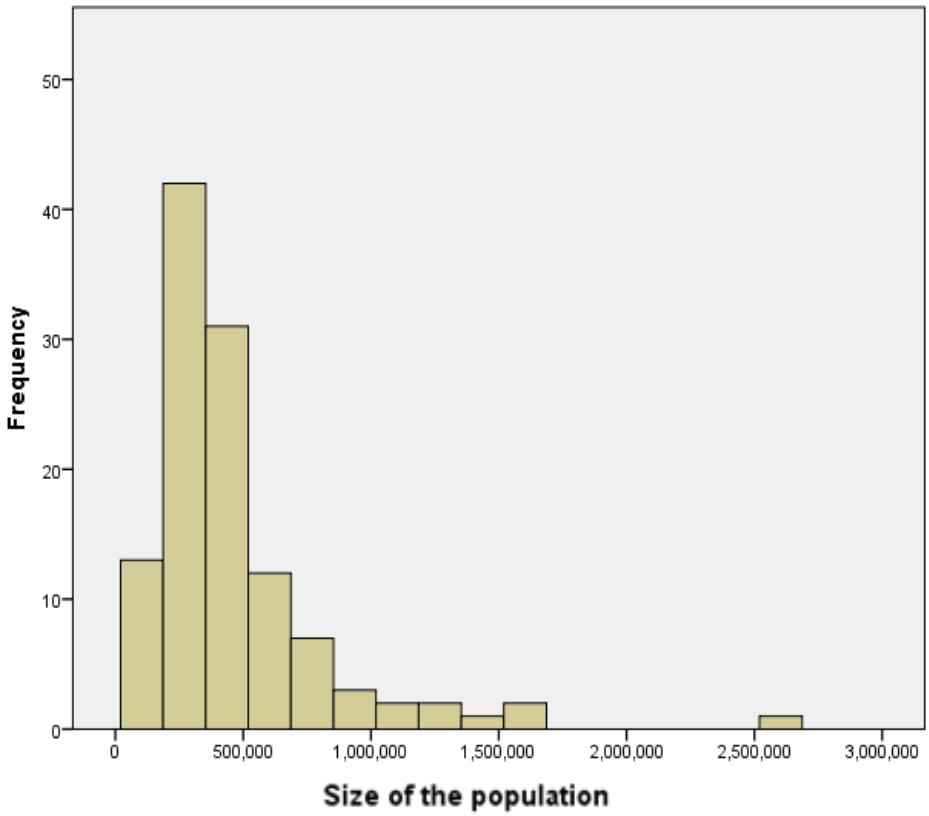

Figure 1: Variation in population size served

Organisations providing outpatient services

There was a 100 per cent response rate to this question.

120 (82 per cent) of the 147 responding organisations provided outpatient services.

Number of locations at which outpatient services were provided

The response rate to this question was 99 per cent (one non-responder).

- The number of locations reported per organisation ranges from one to 44 with an average of seven locations
- 21 per cent of organisations (25) reported providing services from 15 locations and 19 per cent (23) from a single location.

The survey design only gave the option to select up to 15 locations; therefore it is likely that some organisations who reported offering services from 15 locations in fact had a greater number of locations.
One respondent emailed to specifically report that their organisation had 44 outpatient locations.

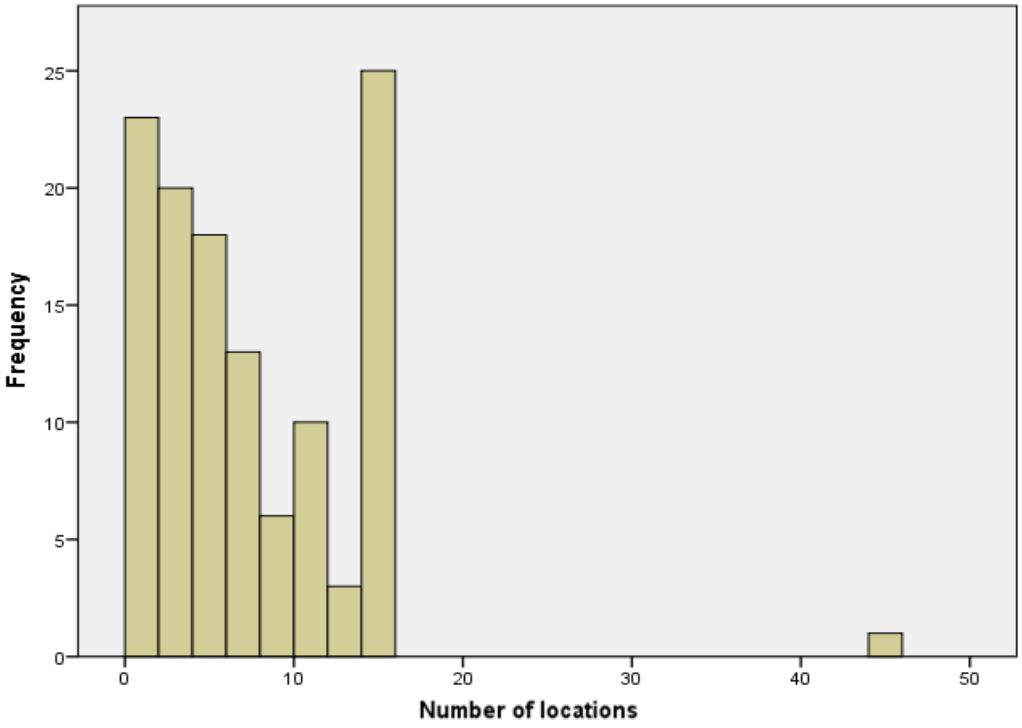

Figure 2: Number of locations per organisation where outpatient services are provided

Relationship between number of locations and population size

There is a significant relationship between number of locations and population size (Pearson's correlation coefficient r = 0.31, p < 0.002).

However, in Figure 3 it can be seen that there are a number of outliers where the correlation appears weak.

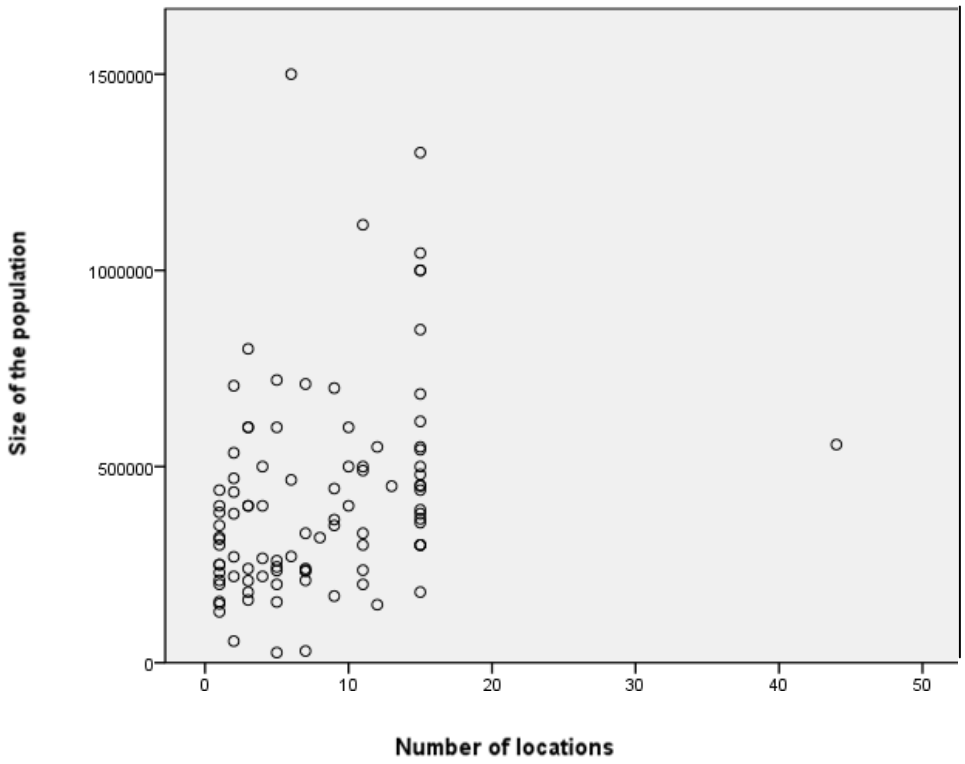

Figure 3: Relationship between number of locations and population size

Total number of new patients treated in all outpatients for financial year 2011/12

The response rate was 96 per cent (115).

Of those responding, 17 per cent (20) reported that data was not available.

- 95 respondents reported the total number of new patients treated in all outpatients for the financial year 2011/12
- The total number of new patients treated ranges between organisations from 353 to 81,422
- The mean number of new patients treated was 15,588

In Figure 4 it can be seen that only a small number of organisations (four) treated over 40,000 patients.

The total number of new patients treated by all the organisations who responded was 1,480,893.

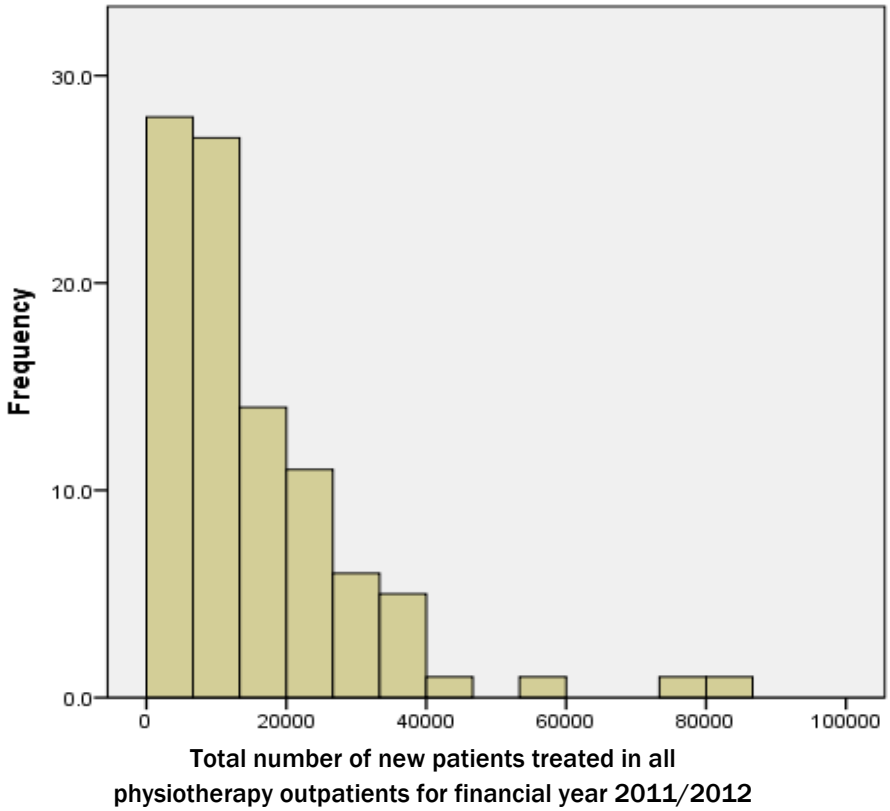

Figure 4: Total number of new patients treated 2011/12

Relationship between number of new patients treated and population size

There is a significant relationship between the number of new patients treated and population size (Pearson's correlation coefficient r = 0.41, p<0.001). The larger the population size covered by an organisation, the greater the number of new patients treated.

- The number of new patients seen per 10,000 population ranges from 17 to 4116
- The mean number of new patients seen per 10,000 population was 483

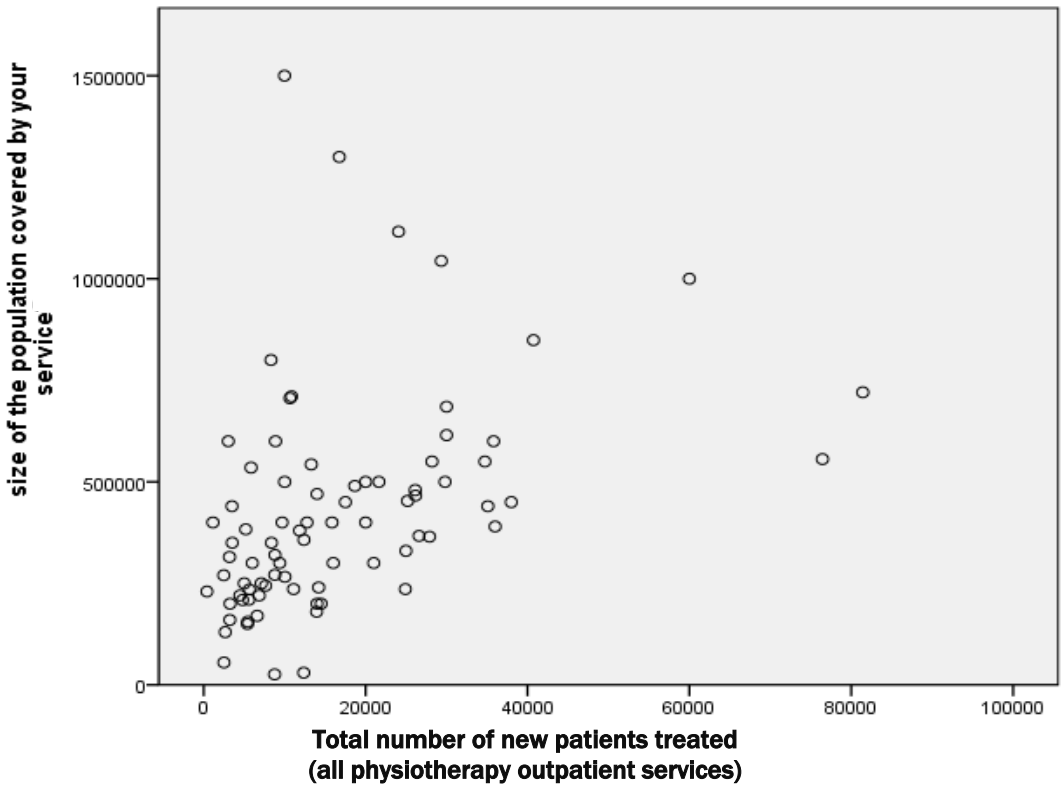

Figure 5: Relationship between number of new patients treated and population size

In Figure 6 it can be seen that only a few organisations saw more than 1,000 new patients per 10,000 population.

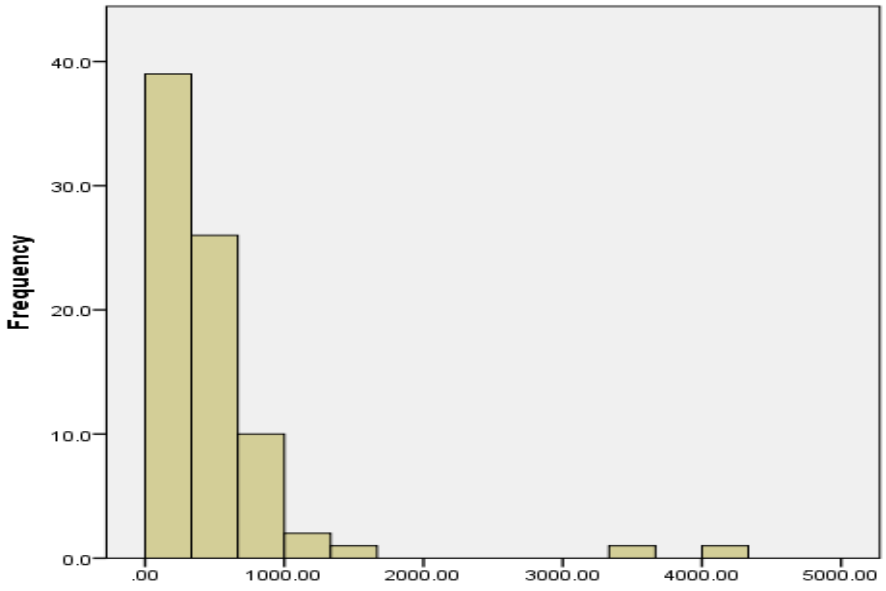

Figure 6: Number of new patients treated per 10,000 population

Analysing the outliers, the two organisations seeing over 3,000 new patients per 10,000 population have very small populations. Of the other outliers seeing more than 1,000 new patients per 100,000 population, two organisations have a very high referral rate in relation to an average population size, and one a greater than average referral rate in relation to a smaller than average population.

New to follow-up appointment ratio for financial year ending 31/3/12

The response rate was 96 per cent (115). Of those responding, six per cent (18) reported that data was not available.

97 respondents reported their new to follow-up ratio:

- The ratio ranges between organisations from 1:1.5 to 1:6
- The mean new to follow up ratio is 1:3.26 † (See Figure 7)

Organisations who offered self-referral and/or prompted referral had significantly lower ($p < 0.05$) new to follow-up ratios (mean ratio of 1:3.1) compared to those organisations who did not offer self- or prompted referral access (mean ratio of 1:3.5).

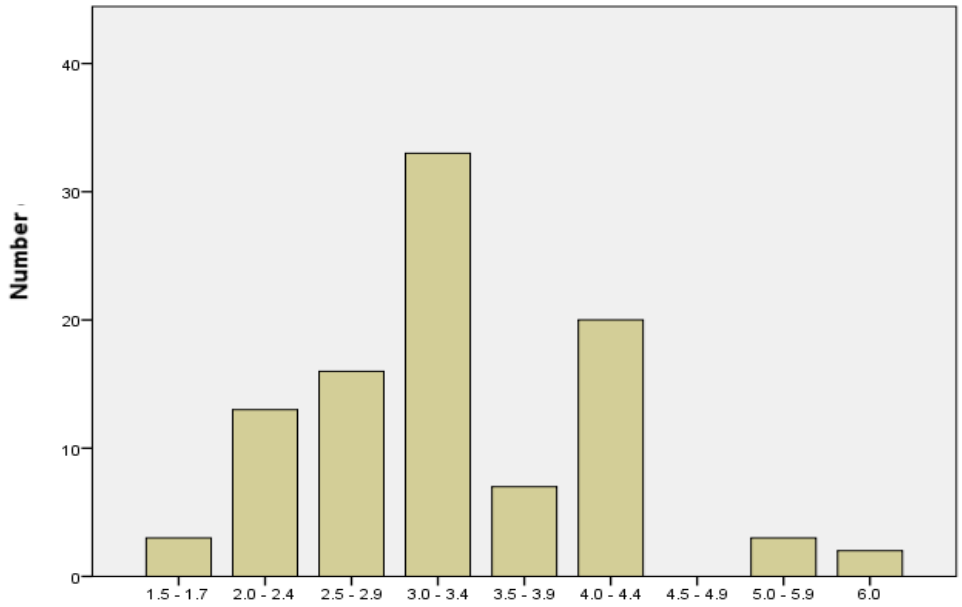

Figure 7: New to follow-up ratio

† This represents a mean ratio for a range of diverse outpatient services and should not be interpreted as the mean ratio for a specific type or specialty of outpatient service (see Discussion section)

Waiting times

Shortest, longest and average waiting times: all outpatient services

The response rate was 99 per cent (119 of 120 organisations).

Shortest waiting times ranged from less than one week up to 10 weeks, with 84 per cent of organisations having a shortest waiting time of less than one week and 94 per cent less than two weeks.

The responses for average and longest waiting times were almost identical. Data collected from different specialty outpatient services (see below) suggest that there is a difference between average and longest waiting times. Therefore, it is likely that this data for all outpatient services is inaccurate and should be interpreted with caution.

- Average and longest waiting times ranged from less than one week (seven per cent of organisations) to greater than 52 weeks (one organisation in England).
- 71 per cent of organisations had an average and longest waiting time of less than 14 weeks and 88 per cent less than 18 weeks.

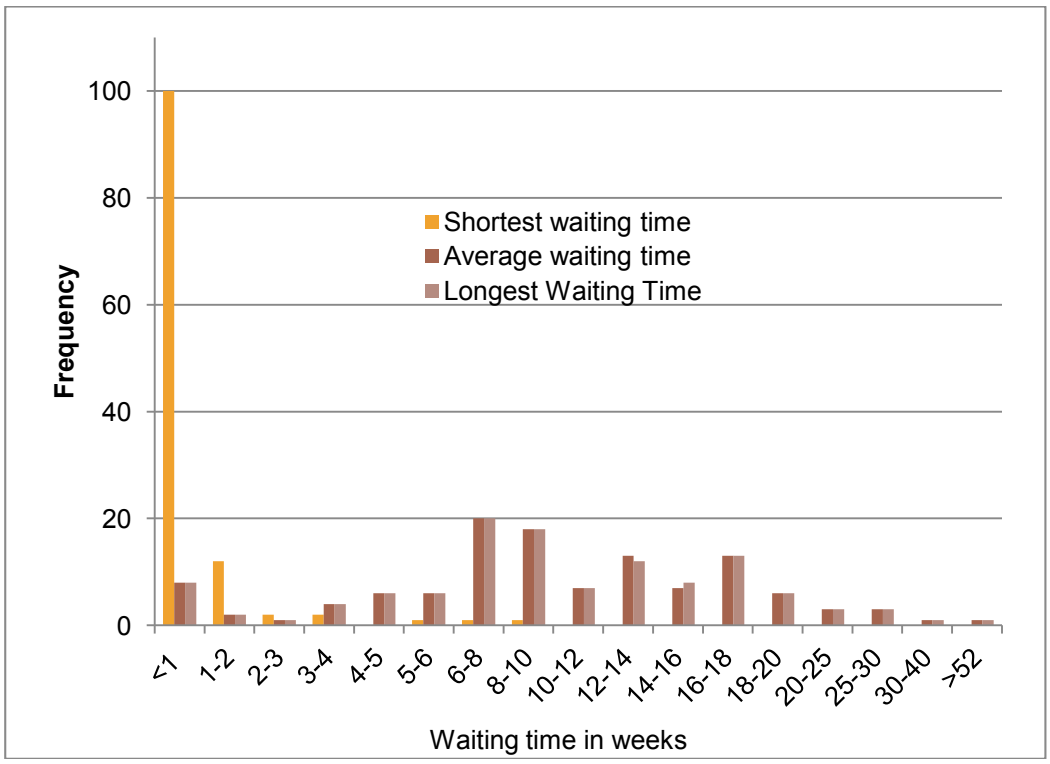

Figure 8: Shortest, average and longest waiting times – all outpatients

Waiting time (weeks)	*Shortest waiting time (number of organisations)*	*Average waiting time (number of organisations)*	*Longest waiting time (number of organisations)*
<1	100	8	8
1-2	12	2	2
2-3	2	1	1
3-4	2	4	4
4-5	0	6	6
5-6	1	6	6
6-8	1	20	20
8-10	1	18	18
10-12	0	7	7
12-14	0	13	12
14-16	0	7	8
16-18	0	13	13
18-20	0	6	6
20-25	0	3	3
25-30	0	3	3
30-40	0	1	1
>52	0	1	1

Table 1: Shortest, average and longest waiting times: all outpatients

Shortest, average and longest waiting times: musculoskeletal outpatient services

There were 102 responses to the shortest and longest waiting time sections of this question and 101 responses to the average waiting time section.

- Shortest waiting times range from less than one week (83 per cent of organisations) to between six and eight weeks (one organisation).
- 94 per cent of organisations have a shortest waiting time less than two weeks.
- Average waiting times range from less than one week to 16 weeks.

- Only 10 per cent of organisations have an average waiting time of less than two weeks, but 99 per cent have an average wait of less than 14 weeks and 100 per cent less than 18 weeks.

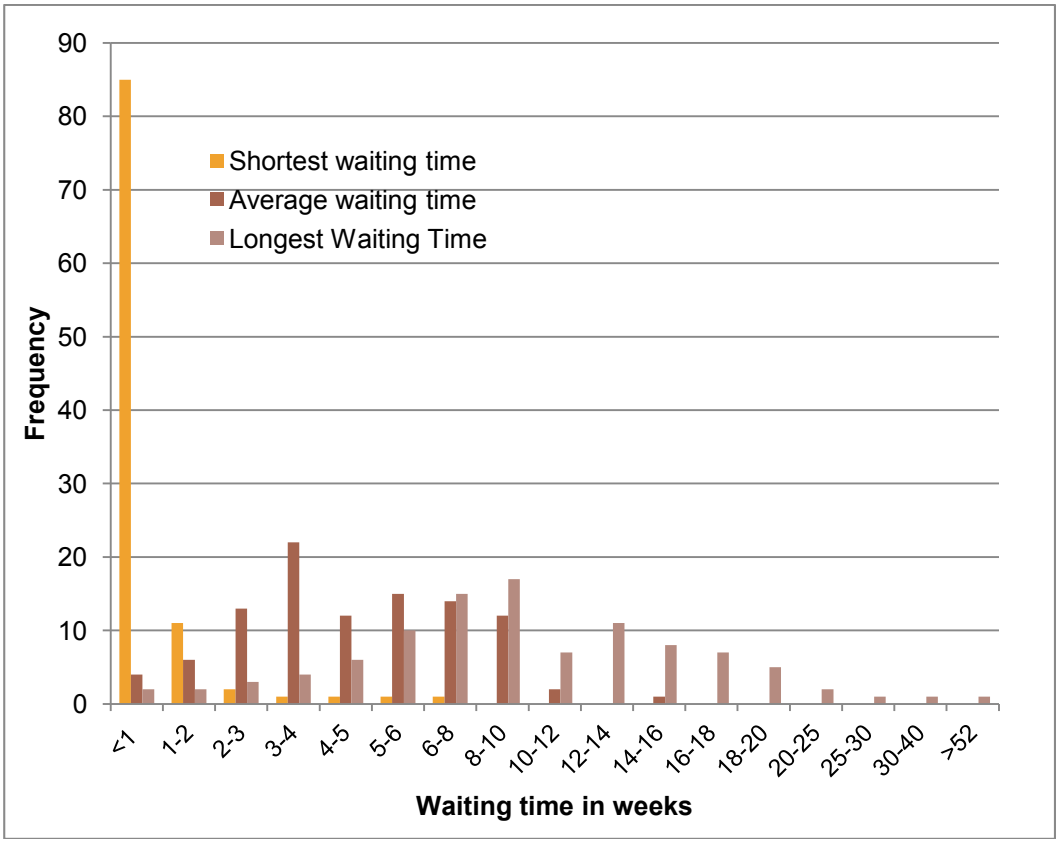

Figure 9: Shortest, average and longest waiting times: musculoskeletal services

- Longest waiting times range from less than one week to over 52 weeks.
- Eight per cent of organisations have a longest wait of less than two weeks, 75 per cent less than 14 weeks and 90 per cent less than 18 weeks.

Waiting time (weeks)	*Shortest wait (number of organisations)*	*Average wait (number of organisations)*	*Longest wait (number of organisations)*
<1	85	4	2
1-2	11	6	2
2-3	2	13	3
3-4	1	22	4
4-5	1	12	6
5-6	1	15	10

6-8	1	14	15
8-10	0	12	17
10-12	0	2	7
12-14	0	0	11
14-16	0	1	8
16-18	0	0	7
18-20	0	0	5
20-25	0	0	2
25-30	0	0	1
30-40	0	0	1
>52	0	0	1

Table 2: Shortest, average and longest waiting times: musculoskeletal outpatients

Shortest, average and longest waiting times: paediatric outpatient services

There were 40 responses to this question.

- 70 per cent of organisations had a shortest waiting time of less than one week, and one organisation up to six weeks

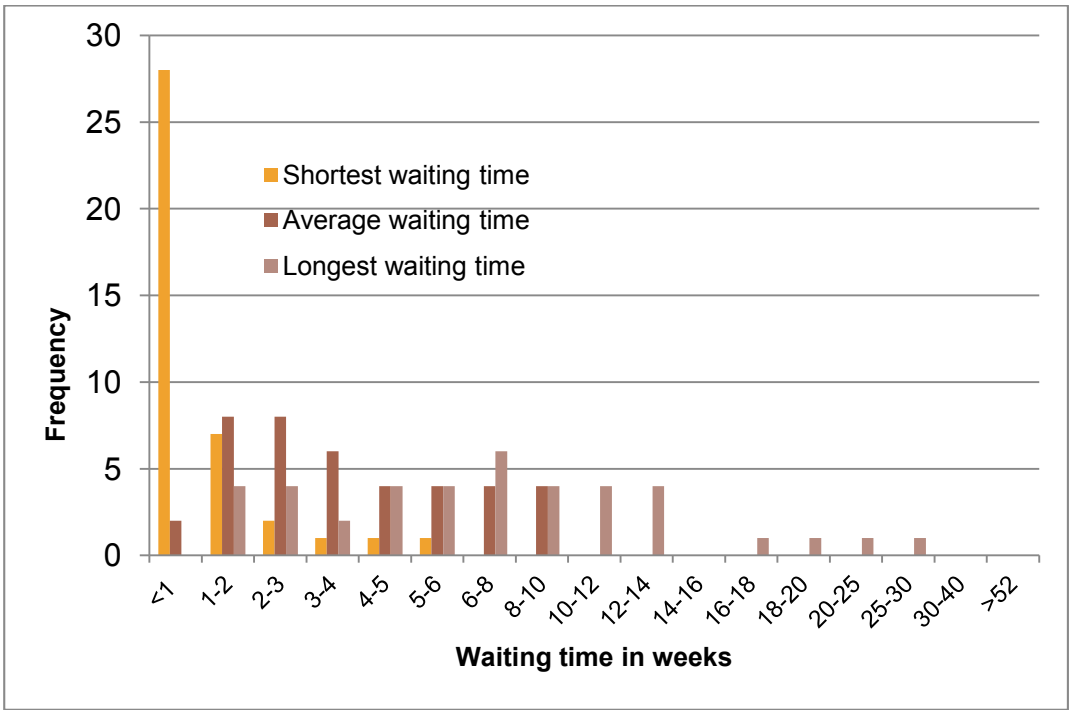

Figure 10: Shortest, average and longest waiting times: paediatric services

- Average waiting times range from less than one week to 8-10 weeks, 25 per cent of organisations having an average of less than two weeks and 100 per cent less than 10 weeks
- Longest waiting times ranged between one and 30 weeks
- 90 per cent of organisations had a longest waiting time of less than 14 weeks and 93 per cent less than 18 weeks.

Waiting time (weeks)	*Shortest wait (number of organisations)*	*Average wait (number of organisations)*	*Longest wait (number of organisations)*
<1	28	2	0
1-2	7	8	4
2-3	2	8	4
3-4	1	6	2
4-5	1	4	4
5-6	1	4	4
6-8	0	4	6
8-10	0	4	4
10-12	0	0	4
12-14	0	0	4
14-16	0	0	0
16-18	0	0	1
18-20	0	0	1
20-25	0	0	1
25-30	0	0	1
30-40	0	0	0
>52	0	0	0

Table 3: Shortest, average and longest waiting times: paediatric outpatients

Shortest, average and longest waiting times: occupational health outpatient services

There were 42 responses to the question on the shortest, 39 responses to the average and 41 responses to the longest waiting times.

- 90 per cent of organisations had a shortest waiting time of less than one week and one organisation up to four weeks
- Average waiting times range from less than one week to 6-8 weeks
- Only 18 per cent of organisations have an average wait of less than one week and 64 per cent less than two weeks
- 100 per cent of organisations had an average time less than 8 weeks.
- Longest waiting times ranged between one and 12 weeks
- Two per cent had a longest wait of less than one week and 37 per cent less than two weeks
- 100 per cent of organisations had a longest waiting time of less than 12 weeks.

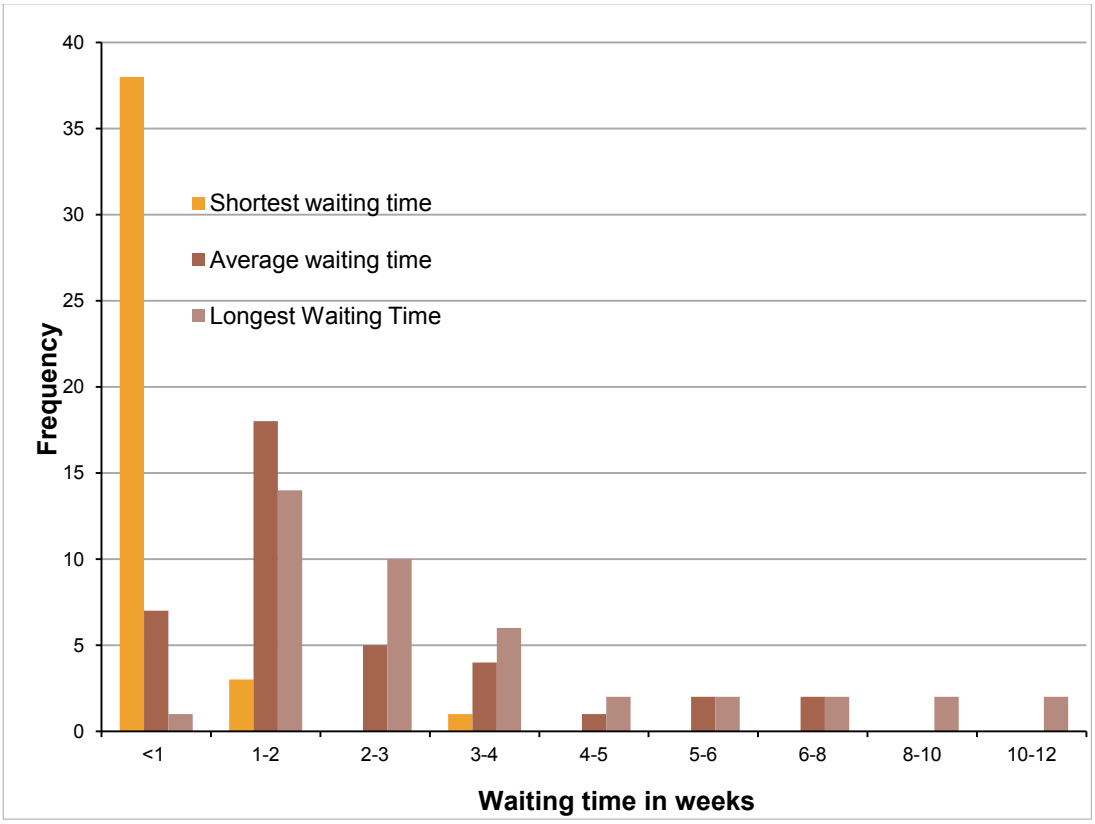

Figure 11: Shortest, average and longest waiting times: occupational health services

Waiting time (weeks)	*Shortest wait (number of organisations)*	*Average wait (number of organisations)*	*Longest wait (number of organisations)*
<1	38	7	1
1-2	3	18	14
2-3	0	5	10
3-4	1	4	6
4-5	0	1	2
5-6	0	2	2
6-8	0	2	2
8-10	0	0	2
10-12	0	0	2

Table 4: Shortest, average and longest waiting times: occupational health outpatients

Summary of outpatient waiting times

Table 5 on page 25 summarises the range of waiting of times for all outpatient services and individual services.

- 80-90 per cent of organisations had shortest waiting times less than one week and about 95 per cent less than two weeks
- The exception to this is paediatric services, where only 70 per cent of organisations had shortest waiting times less than one week and 88 per cent less than two weeks
- All organisations had average waiting times less than 14 weeks across all services, with the exception of one musculoskeletal service
- The data for average and longest waiting times for all outpatient services are almost identical, indicating inaccurate reporting of data, and should be interpreted with extreme caution
- Average waiting times indicate differences between specialties, with 64 per cent of occupational health services having average waits of less than two weeks, compared with 25 per cent of paediatric services and only 10 per cent of musculoskeletal services
- Approximately 90 per cent of all outpatient services had longest waiting times of less than 18 weeks
- Longest waiting times vary between specialties, with 100 per cent of occupational health services reporting waiting times less than 14 weeks

compared to 90 per cent of paediatric services and 75 per cent of musculoskeletal services

- For musculoskeletal services, four per cent of organisations had a longest waiting time of less than two weeks

		All outpatients (% of organisations)	*MSK (% of organisations)*	*Paediatrics (% of organisations)*	*Occ Health (% of organisations)*
Shortest waiting time	Range (weeks)	<1 - 10	<1 - 8	<1 - 6	<1 - 4
	% < 1 week	84	83	70	90
	%< 2 weeks	94	94	88	98
Average waiting time	Range (weeks)	<1 - >52	<1 - 16	<1 - 10	<1 - 8
	% < 1 week	7	4	5	18
	% < 2 weeks	8	10	25	64
	% < 14 weeks	71*	99	100	100
	% < 18 weeks	88*	100	100	100
Longest waiting time	Range (weeks)	<1 - >52	<1 - >52	1 - 30	<1 - 12
	% < 1 week	7	2	0	2
	% < 2 weeks	8	4	10	37
	% < 14 weeks	71*	75	90	100
	% < 18 weeks	88*	90	93	100

* inaccurate data

Table 5: Range of waiting of times for outpatient services: individual and total

Total number of patients currently waiting for outpatient services

The response rate was 97 per cent (116).

Of those responding, 33 per cent (38) reported that data was not available.

78 respondents reported their current number of patients waiting.

- The current number of patients waiting ranged between organisations from 0 to 5,907
- The mean number of people waiting was 946

From Figure 11 it can be seen that only a few organisations had more than 2,000 patients waiting.

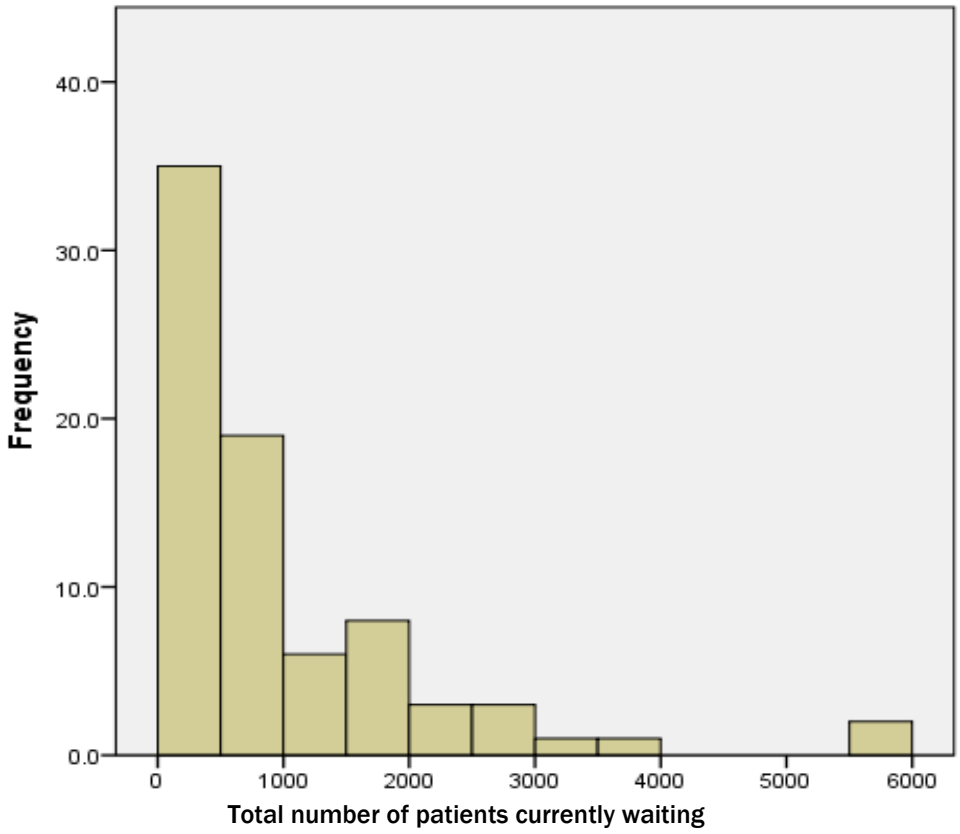

Figure 11: Total number of patients waiting for outpatient services

Number of patients waiting in different countries

- The mean number of people waiting in England was 684
- In Northern Ireland, Scotland and Wales means ranged between 2,274 and 3,859
- In some organisations in England and Scotland there were no people waiting for outpatient physiotherapy.

Relationship between number of patients waiting and population size

There is no significant relationship between number of patients waiting and population size (Pearson's Correlation Coefficient r = 0.13)

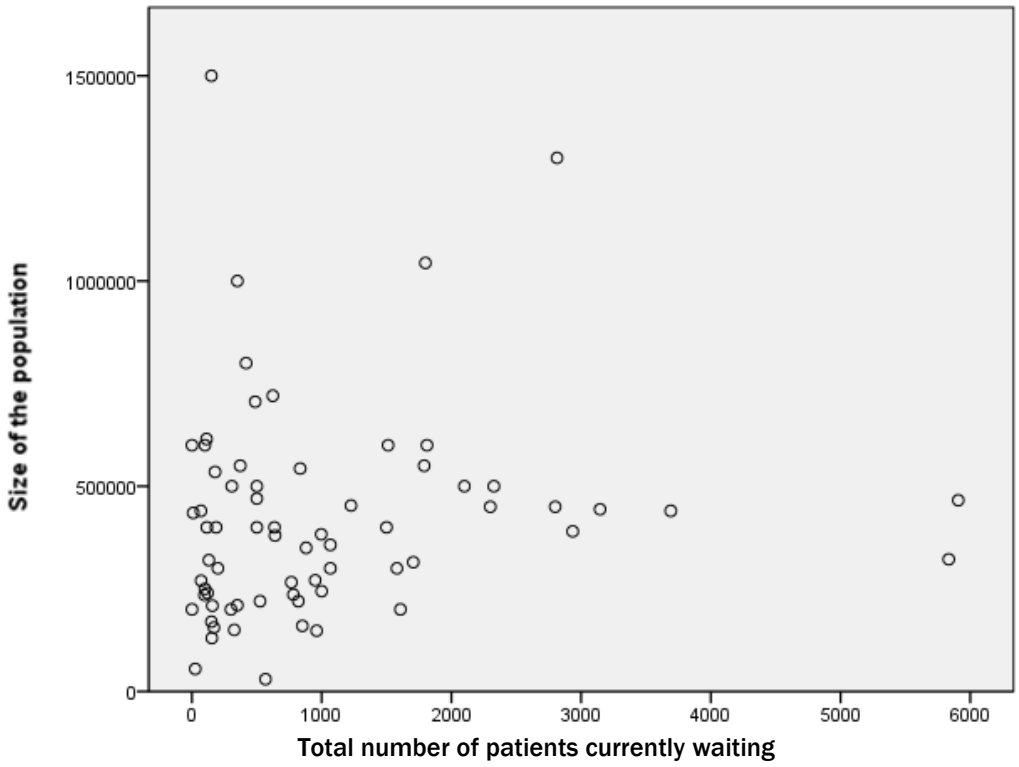

Figure 12: Relationship between number of patients waiting for treatment and population size

Trends in outpatient waiting times over the previous year

The response rate to this question was 98 per cent (118 responses).

- 41 per cent of organisations reported an increase in waiting times
- 23 per cent of organisations reported that the trend in waiting times varied across specialties
- 20 per cent of organisations reported a decrease in waiting times
- 16 per cent of organisations reported that their waiting lists had remained the same.

Factors affecting waiting times

Organisations were asked what factors had affected their outpatient waiting times.

Responses were categorised as staffing, skill mix, changes in referral pattern, or capacity and demand management factors.

Staffing factors

The most common staffing factors were unfilled staff vacancies (54 per cent of organisations), vacancy control measures (48 per cent) and reductions in permanent staff (43 per cent).

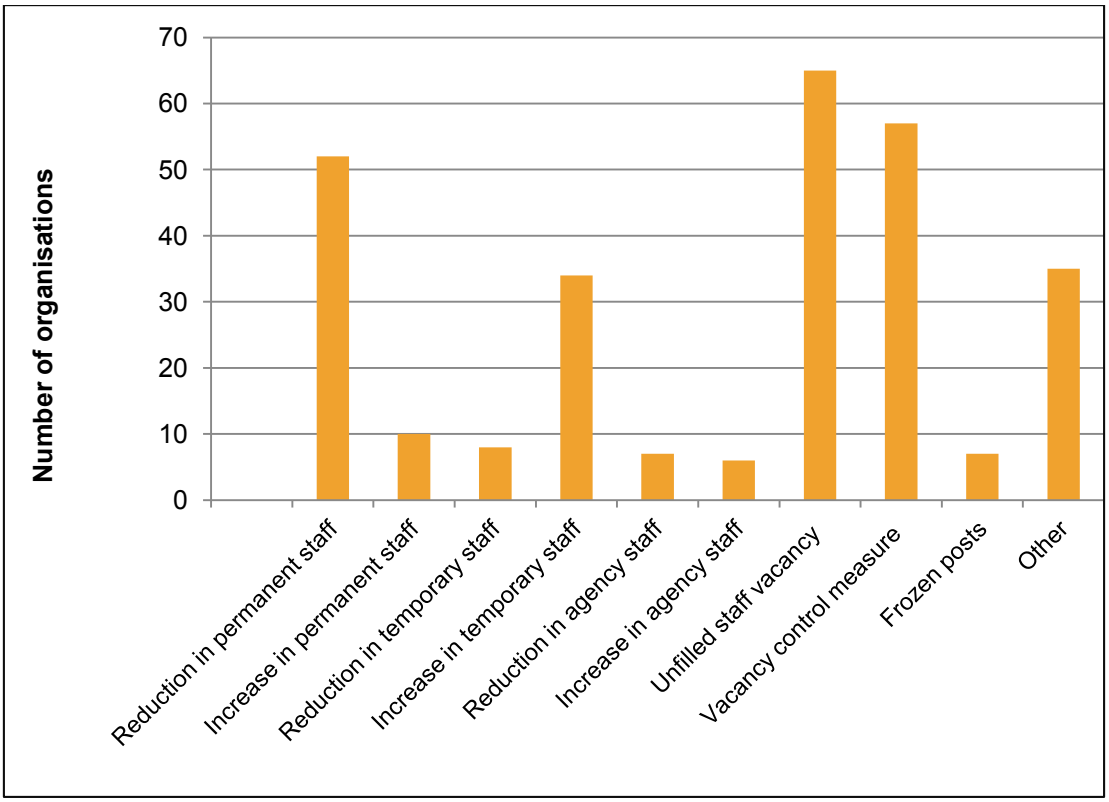

Figure 13: Staffing factors

Skill mix factors

The number of organisations reporting skill mix as a factor affecting waiting times is lower than for other factors.

The most commonly reported factor is skill mix to lower bands (35 per cent of organisations).

Nine organisations specified other skill factors which included: clinicians' time freed up with less administrative work; increase in lower bands due to change in orthopaedic case loads – more routine and less complex cases; maternity leave filled with lower band staff; and investment in outpatient staff to avoid breaching 18 week target.

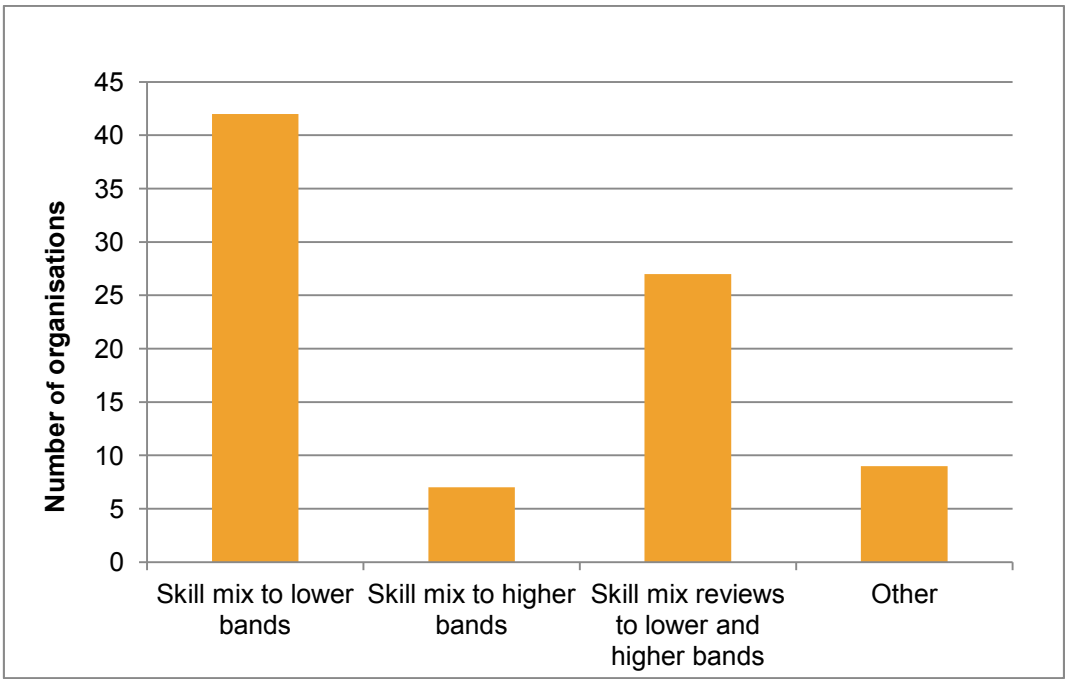

Figure 14: Skill mix factors

Change in referral pattern factors

73 per cent of organisations reported an increase in referrals - this was the most commonly reported of all factors.

Seven organisations specified other factors:

- Four of these related to specific reasons for increase in demand: increase in orthopaedic surgery; providing cover for inpatient areas; increased demand from MSK triage service; and an increase in the number of care pathways
- Two organisations mentioned cost implications, one specifying that additional services transferred to them were unfunded, and another that the number of referrals received exceeded the agreed activity levels
- One organisation mentioned an increase in awareness of the benefits of physiotherapy by referrers and the public

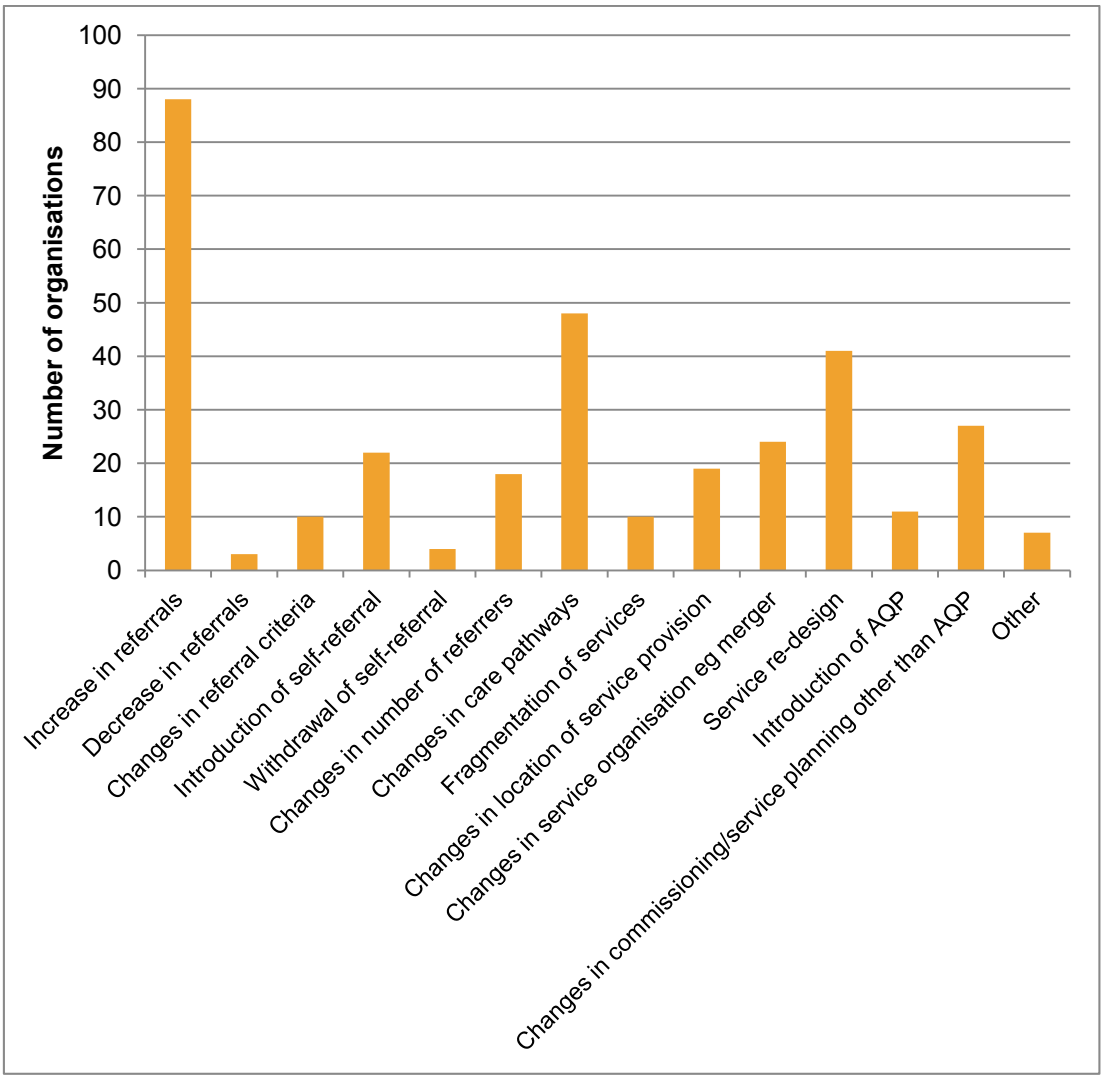

Figure 15: Change in referral pattern factors

Capacity and demand management factors

The most common factors were DNA management (63 per cent of organisations) and the use of groups/classes (58 per cent).

14 organisations specified other factors.

- Five of these related to new types of service, for example, triage and physiotherapy led clinics.
- Two organisations reported a change in assessment time, one a decrease and the other an increase.
- Two organisations mentioned new patient targets.

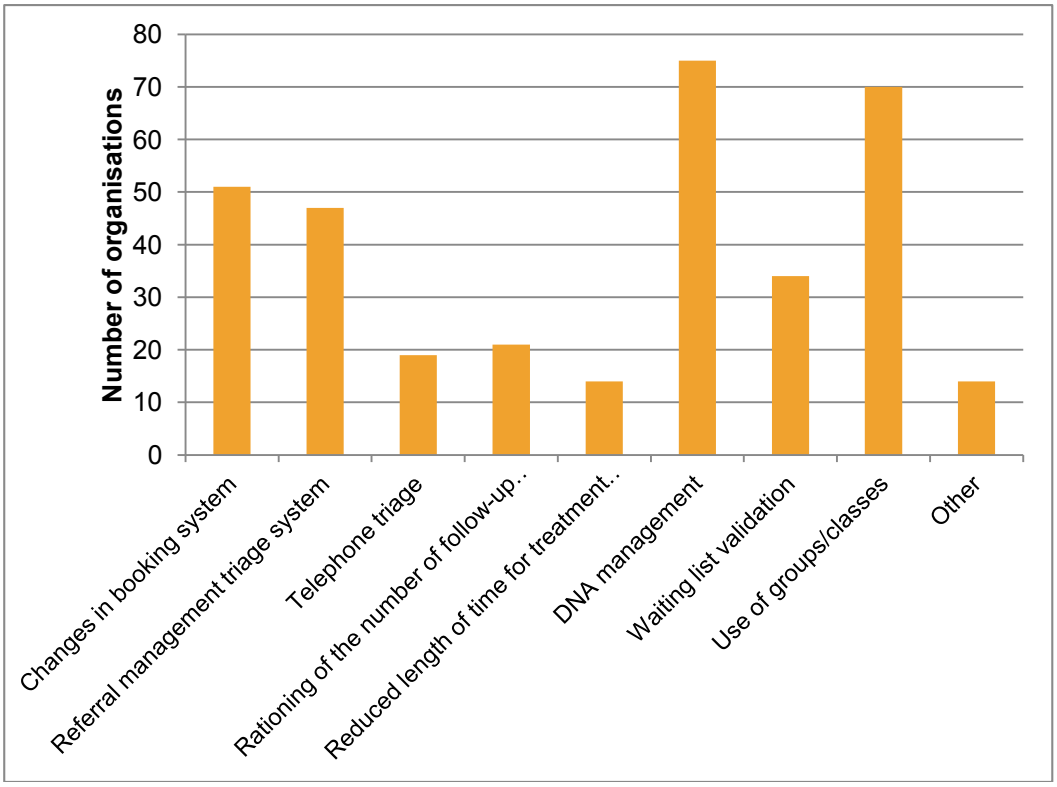

Figure 16: Capacity and demand management factors

- Other factors reported by individual organisations were: promotion of physiotherapy services to GPs; patients having to 'opt-in' to treatment by responding to an appointment invitation; and a poor computer system.

Table 6 summarises the percentage and number of organisations affected by each of the factors: staffing, skill mix, change in referral patterns, and capacity and demand management factors.

Factor	*Percentage (number) of organisations*
Staffing factors:	
Reduction in permanent staff	43% (52)
Increase in permanent staff	8% (10)
Reduction in temporary staff	7% (8)
Increase in temporary staff	28% (34)

Factor	*Percentage (number) of organisations*
Reduction in agency staff	6% (7)
Increase in agency staff	5% (6)
Unfilled staff vacancy due to maternity leave, sick leave etc	54% (65)
Vacancy control measure e.g. delay in recruitment	48% (57)
Frozen posts	6% (7)
Other	29% (35)
Skill mix:	
Skill mix to lower bands	35% (42)
Skill mix to higher bands	6% (7)
Skill mix reviews to lower and higher bands	23% (27)
Other	8% (9)
Changes in referral patterns:	
Increase in referrals	73% (88)
Decrease in referrals	3% (3)
Changes in referral criteria	8% (10)
Introduction of self-referral	18% (22)
Withdrawal of self-referral	3% (4)
Changes in number of referrers	15% (18)
Changes in care pathways	40% (48)
Fragmentation of services	8% (10)
Changes in location of service provision	16% (19)
Changes in service organisation eg merger	20% (24)
Service re-design	34% (41)
Introduction of AQP	9% (11)
Changes in commissioning/service planning other than AQP	23% (27)
Other	6% (7)

Factor	*Percentage (number) of organisations*
Capacity and demand management:	
Changes in booking system	43% (51)
Referral management triage system	40% (47)
Telephone triage	16% (19)
Rationing of the number of follow-up treatment sessions	18% (21)
Reduced length of time for treatment sessions	12% (14)
DNA management	63% (75)
Waiting list validation	28% (34)
Use of groups/classes	58% (70)
Other	12% (14)

Table 6: Factors affecting waiting times

Effects of different factors on waiting times

Staffing factors

For organisations whose waiting times had increased, the most frequently reported factors were unfilled staff vacancies (67 per cent), vacancy control measures (63 per cent), and reduction in permanent staff (60 per cent).

Unfilled staff vacancies, vacancy control measures and reduction in permanent staff were also the most frequently reported factors for those organisations whose waiting times varied across specialties.
These factors had also affected some, but a much smaller percentage of, organisations whose waiting times had increased or stayed the same.

The most frequently reported factor for organisations whose waiting times had decreased was an increase in temporary staff (50 per cent reported). This factor was also reported by 44 per cent of organisations whose waiting times varied.

29 per cent of organisations whose waiting times had decreased and 11 per cent whose waiting times varied reported an increase in permanent staff. This

factor was not reported by any organisation whose waiting times had increased or stayed the same.

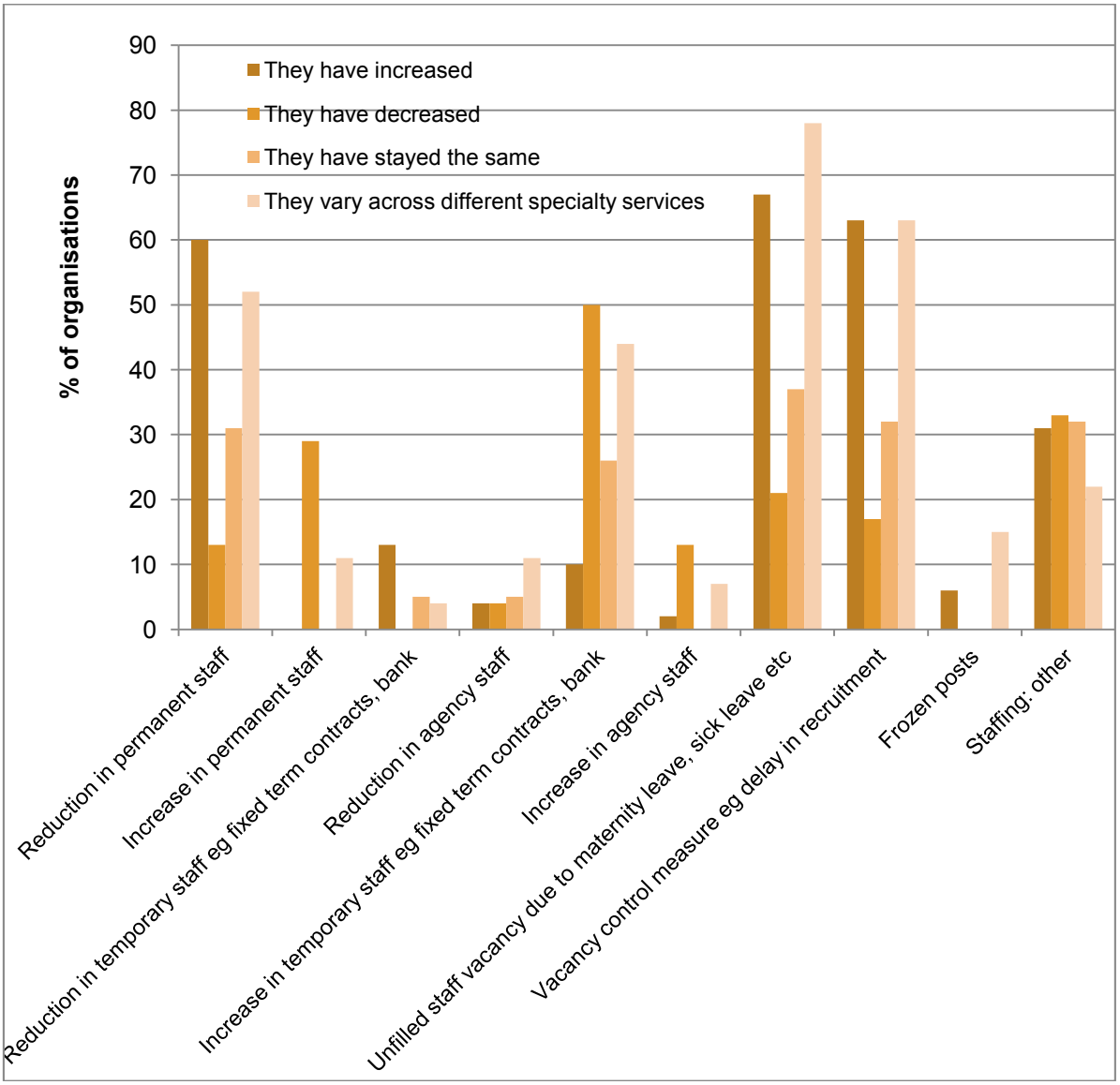

Figure 17: Effects of staffing factors on waiting times

Skill mix factors

Skill mix factors were not reported very frequently by organisations in comparison to other factors.

Skill mix to lower bands was the most reported, most frequently for those organisations whose waiting times varied (48 per cent of organisations) or whose waiting times had increased (38 per cent).

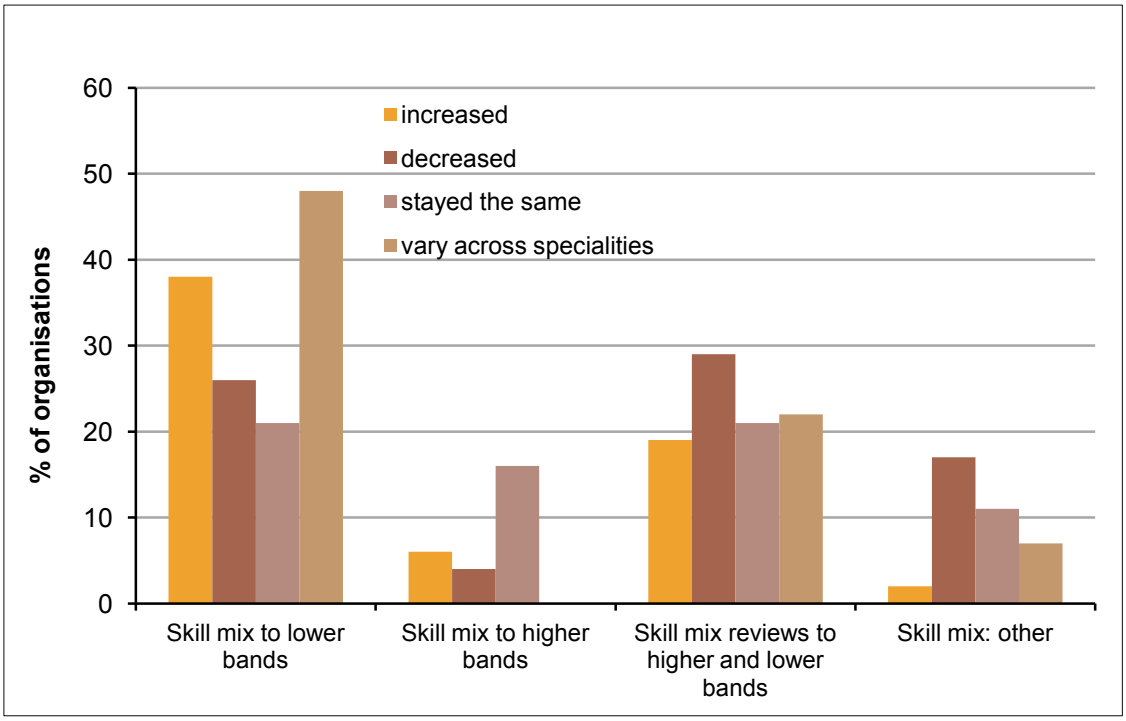

Figure 18: Effects of skill mix factors on waiting times

Changes in referral pattern factors

Increase in referrals was the most commonly reported factor for all organisations, but was reported by a greater percentage of organisations whose waiting times had increased (88 per cent of organisations) or varied (81 per cent) compared to those whose waiting times had stayed the same (58 per cent) or decreased (54 per cent).

For organisations whose waiting times had increased, changes in care pathways was a frequently reported factor (50 per cent of organisations).

50 per cent of organisations whose waiting times had decreased reported service redesign as a factor.

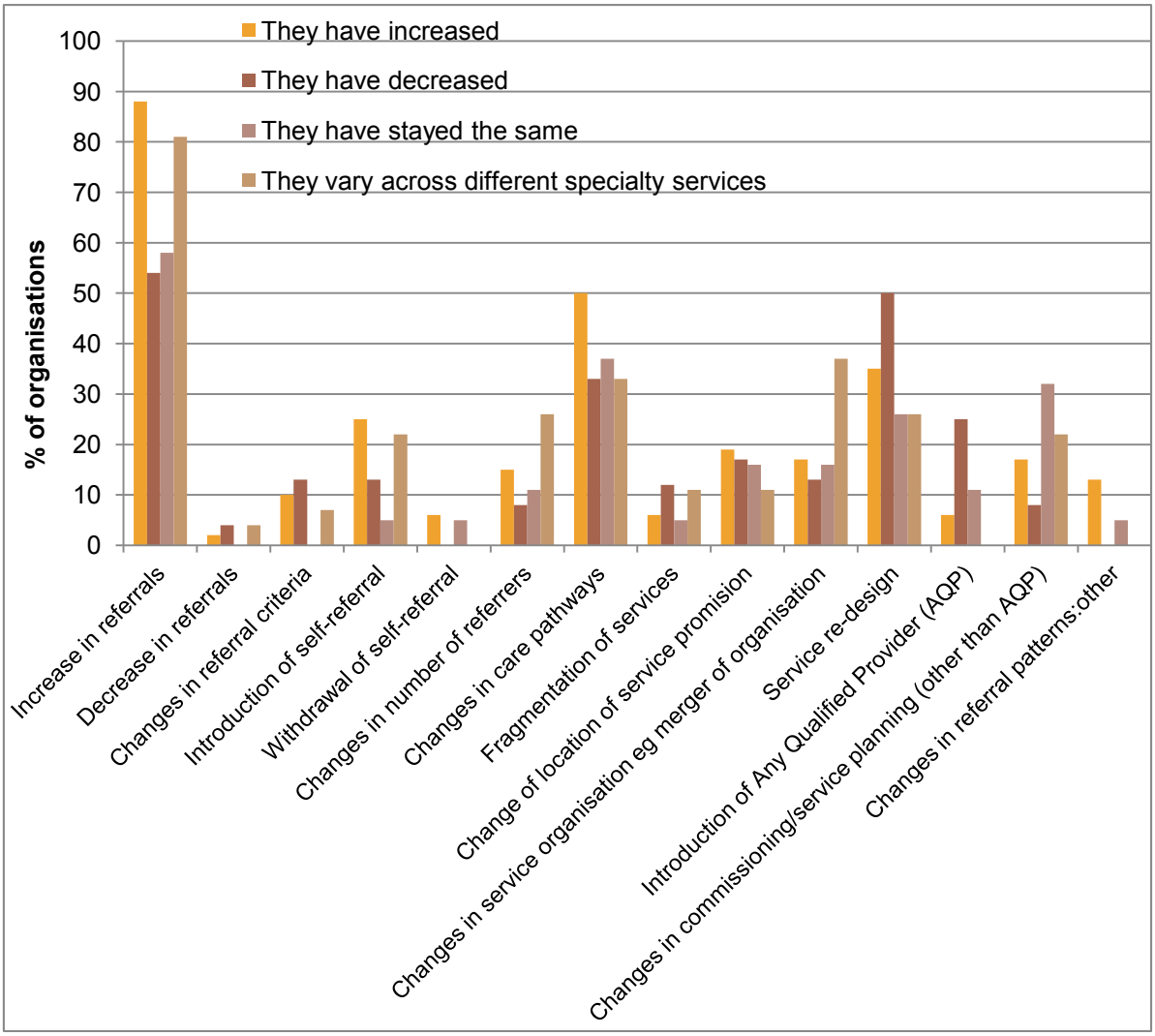

Figure 19: Effects of changes in referral pattern factors on waiting times

Capacity and demand management factors

Capacity and demand factors were reported less commonly by organisations whose waiting times had increased compared to those whose waiting times had decreased, stayed the same or varied.

The most reported factor was DNA management, most frequent for organisations whose waiting times have stayed the same.

The use of groups or classes was also commonly reported, especially in those whose waiting times had stayed the same or varied.

Three factors were reported more commonly in organisations whose waiting times had decreased: changes in booking system; reduced length of time for

treatment sessions; and rationing of the number of follow-up treatment sessions.

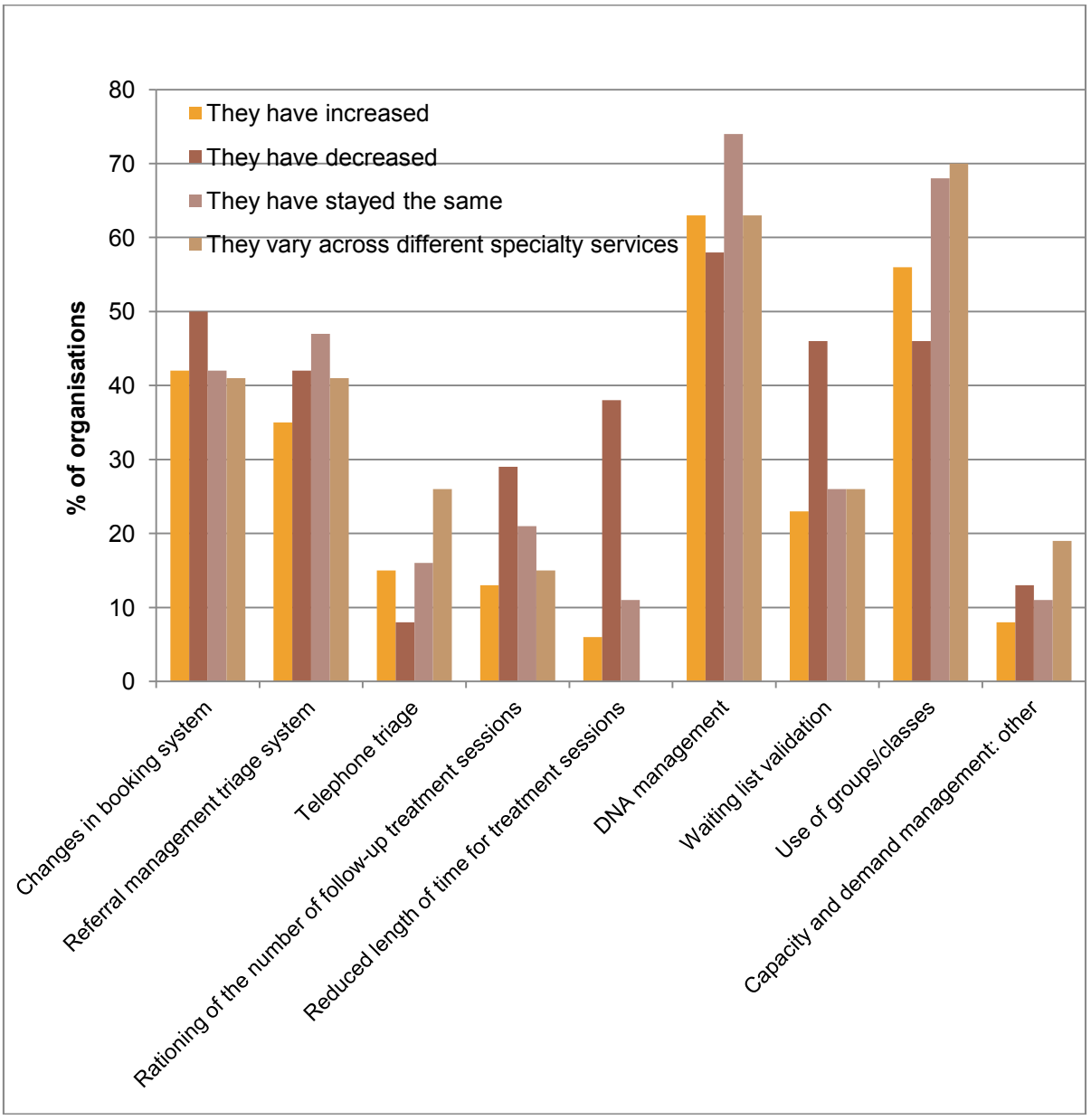

Figure 20: Effects of changes in capacity and demand management factors on waiting times

Table 7 shows the percentage of organisations reporting each factor affecting waiting times and how the waiting time was affected by that factor.

Factor	*Increase in waiting time*	*Decrease in waiting time*	*No change in waiting time*	*Vary across different specialty services*
Reduction in permanent staff	60	13	31	52
Increase in permanent staff	0	29	0	11
Reduction in temporary staff e.g. fixed term contracts, bank	13	0	5	4
Reduction in agency staff	4	4	5	11
Increase in temporary staff e.g. fixed term contracts, bank	10	50	26	44
Increase in agency staff	2	13	0	7
Unfilled staff vacancy due to maternity leave, sick leave etc	67	21	37	78
Vacancy control measure e.g. delay in recruitment	63	17	32	63
Frozen posts	6	0	0	15
Staffing: other	31	33	32	22
Skill mix to lower bands	38	26	21	48
Skill mix to higher bands	6	4	16	0
Skill mix reviews to lower and higher bands	19	29	21	22
Skill mix: other	2	17	11	7
Increase in referrals	88	54	58	81
Decrease in referrals	2	4	0	4
Changes in referral criteria	10	13	0	7
Introduction of self-referral	25	13	5	22
Withdrawal of self-referral	6	0	5	0
Changes in number of referrers	15	8	11	26

Factor	*Increase in waiting time*	*Decrease in waiting time*	*No change in waiting time*	*Vary across different specialty services*
Changes in care pathways	50	33	37	33
Fragmentation of services	6	12	5	11
Change of location of service provision	19	17	16	11
Changes in service organisation e.g. merger of organisation	17	13	16	37
Service re-design	35	50	26	26
Introduction of Any Qualified Provider (AQP)	6	25	11	0
Changes in commissioning/service planning (other than AQP)	17	8	32	22
Changes in referral patterns: other	13	0	5	0
Changes in booking system	42	50	42	41
Referral management triage system	35	42	47	41
Telephone triage	15	8	16	26
Rationing of the number of follow-up treatment sessions	13	29	21	15
Reduced length of time for treatment sessions	6	38	11	0
DNA management	63	58	74	63
Waiting list validation	23	46	26	26
Use of groups/classes	56	46	68	70

Table 7: Effects of various reported factors on waiting times

Organisations with an increase in waiting times

The most frequently reported factors (50 per cent or more of organisations) are:

- an increase in referrals (88 per cent)
- unfilled staff vacancies (67 per cent)

- vacancy control measures (63 per cent)
- DNA management (63 per cent)
- reduction in permanent staff (60 per cent)
- use of groups/classes (56 per cent)
- changes in care pathways (50 per cent).

Organisations with a decrease in waiting times

The most frequently reported factors are

- DNA management (58 per cent)
- increase in referrals (54 per cent)
- increase in temporary staff (50 per cent)
- service re-design (50 per cent)
- changes in booking system (50 per cent).

Organisations whose waiting times have stayed the same

The most frequently reported factors are use of groups/classes (68 per cent) and increase in referrals (58 per cent).

Organisations whose waiting times vary across specialties

The most frequently reported factors are

- increase in referrals (81 per cent)
- unfilled staff vacancies (78 per cent)
- use of groups/classes (70 per cent)
- vacancy control measures (63 per cent)
- DNA management (63 per cent)
- reduction in permanent staff (52 per cent).

Self-referral outpatient services

Self-referral is defined as “a system of access that allows patients to refer themselves directly to a physiotherapist without having to see or to be prompted by another healthcare professional. This can relate to telephone, IT or face-to-face services.”[4]

The response rate to this section was 99 per cent, representing 119 organisations.

48 per cent of organisations (57) stated that they offered self-referral outpatient services.

Proportion of patients who self refer

The response rate to this question was 63 per cent.
21 organisations (37 per cent) did not respond.

- For 53 per cent of organisations the proportion of patients who self-referred was less than 10 per cent
- For 22 per cent of organisations the proportion of patients who self-referred was between 10 and 20 per cent
- For 25 per cent of organisations the proportion of patients who self-referred was more than 20 per cent

Prompted referral outpatient services

Prompted referral is defined as occurring when a patient goes to see their GP, the GP suggests physiotherapy and prompts the patient to refer themselves.

The response rate to this question was 87 per cent representing 104 organisations.

44 per cent of organisations (46) accepted prompted referrals.

Proportion of prompted referral patients

The response rate to this question was 100 per cent.

- For 41 per cent of organisations the proportion of prompted referrals was less than 10 per cent
- For 20 per cent of organisations the proportion of promoted referrals was between 10-20 per cent
- For 39 per cent of organisations the proportion of prompted referrals was more than 20 per cent

Patient self-referral and prompted referral to different outpatient services

This question asked *those respondents who offered self-referral and/or prompted referral services* to indicate whether they offered self-referral only, prompted referral only, or both.
Respondents who *did not provide that specific outpatient service* were asked to indicate ‘not applicable’.

This question was misinterpreted by some respondents, who failed to respond. They were assumed not to offer self- or prompted referral services.

Patient self-referral and prompted referral to musculoskeletal outpatient services

There were 86 responses to this question, of which 37 were 'not applicable' responses.

For the purpose of analysis, it was assumed that 102 organisations offered musculoskeletal services (the number of responses to the musculoskeletal outpatient waiting time section).

- 49 organisations (approximately 48 per cent) offered self- and/or prompted referral services
- Of those offering these systems of access, 82 per cent offered both self- and prompted referral, 10 per cent offered self-referral only, and eight per cent offered prompted referral only

Patient self-referral and prompted referral to paediatric outpatient services

There were 84 responses to this question, of which 77 were 'not applicable' responses.

For the purpose of analysis, it was assumed that 40 organisations offered paediatric services (the number of responses to the paediatric outpatient waiting time section).

- Seven organisations (approximately 17.5 per cent) offered some form of self-referral service
- Of these, 28.5 per cent offered self-referral only, 28.5 per cent offered prompted referral only, and 43 per cent offered both self- and prompted referral

Patient self-referral and prompted referral to occupational health services

There were 85 responses to this question, of which 49 were 'not applicable' responses.

For the purpose of analysis, it is assumed that 77 organisations offered occupational health services, i.e. the number of respondents in the 'Saving requirements' section of the survey (see Appendix).

- 36 organisations (approximately 47 per cent) offered some form of self-referral service
- Of these, 25 per cent offered self-referral only, 11 per cent offered prompted referral only, and 64 per cent offered both self- and prompted referral

Patient self-referral and prompted referral to women's/men's health services

There were 81 responses, of which 61 were 'not applicable' responses.

Of the 20 organisations who responded that they offered some form of self-referral service:

- 13 offered both true and prompted self-referral
- five offered self-referral only
- two offered prompted referral only

Patient self-referral and prompted referral to pain management outpatient services

There were 83 responses, of which 78 were 'not applicable' responses.

Of the five organisations who responded that they offered some form of self-referral service, all offered both true and prompted self-referral.

Patient self-referral and prompted referral to neurology outpatient services

There were 81 responses, of which 71 were 'not applicable' responses.

Of the 10 organisations providing some form of self-referral service, nine offered both self- and prompted referrals, and one offered prompted referral only.

Patient self-referral and prompted referral to long term conditions outpatient services

There were 81 responses, of which 59 were 'not applicable' responses.

Of the 22 organisations offering some form of self-referral service:

- 17 offered both self- and prompted referrals
- Three offered self-referral only

- Two offered prompted referral only.

Continuation of self-referral access

Of the 63 organisations offering some form of self-referral service:

- 71 per cent (45 organisations) thought it was likely that they could continue to offer self-referral access
- 29 per cent (18 organisations) thought it unlikely that they could continue to offer self-referral access.

Organisations who thought they were not likely to be able to continue to offer self-referral access were asked what factors affected their ability to offer self-referral.

- 100 per cent of respondents reported that the service was not supported by commissioners or service planners
- 67 per cent of respondents indicated that self-referral was not within the AQP specification (England only)
- 57 per cent of respondents reported that self-referral was not supported by GPs
- 24 per cent of respondents indicated that self-referral was not supported strategically within the organisation and that there was difficulty with funding streams.

Other factors specified by individual organisations

Eight organisations reported that they had very limited self-referral access. Of these, three specified that it was restricted to occupational health only; two that it was limited to a small number of practices; and two that it was limited to certain conditions or specialties (back and neck only, not paediatrics).

Two organisations specified that they no longer offered true self-referral as they had to obtain GP approval for patients who self-referred.

One organisation reported that their successful self-referral service had been decommissioned by new commissioners.

CHARTERED SOCIETY OF PHYSIOTHERAPY

Discussion

Response rate

The 54 per cent response rate was higher than the 50 per cent response rate in the 2011 survey [3]
This is a good response rate for an email survey.[5]

It is important to note that in the 2012 survey the response rate was consistently 54 per cent throughout, compared to the previous year where the response rate fell significantly for many sections of the survey.

Acceptable response rates are dependent on how representative the sample is of the population of interest.
The response rate in the 2012 survey is likely to be representative of NHS organisations in England, Northern Ireland and Scotland, but findings may be less valid for Wales.

A significant factor affecting response rates in the context of this survey is the ongoing changes occurring in NHS organisations.
The impact of this is to lower response rates due to difficulties obtaining current contact details for the managers of some organisations, and some managers feeling unable to provide data for organisations which had recently changed.

Although there was a good response rate throughout the survey, the number of organisations responding that data was not available is of concern.
Robust data is essential in making the business case for physiotherapy services.
In addition, mandatory data reporting requirements are likely to increase in the near future.[6]

Population sizes

There is huge variation between organisations in the size of populations covered by physiotherapy services.

As organisations merge, population sizes will tend to increase. However, interpretation of population size is complex and will be influenced by the size, nature and range of physiotherapy services offered.

For example, the organisation with the largest population of over 2.5 million provides a regional tertiary service for heart and chest conditions.

Theoretically, a more valid population size could be estimated if prevalence figures for those conditions are taken into account.

Population size can be difficult to estimate if services accept referrals from outside their catchment area; for example, referrals for patients working but not living in the catchment area.

It is essential that managers understand the size and nature of the population that their services cover.
It is of concern that in the 2012 survey, approximately one quarter of respondents were unable to report their population size.
In England, population sizes and local health profiles are accessible from the Network of Public Health Observatories.[7]

Number of locations at which outpatient services are provided

There is wide variation in the number of locations that services are provided from, with 20 per cent of organisations reporting one location and a similar percentage 15 or more locations.
Servicing a high number of locations can potentially decrease both productivity and the opportunity to use the most efficient skill mix.

A benchmarking report of musculoskeletal therapies by the North West Alliance of Chief Operating Officers showed that over half of the community musculoskeletal services operated from more than 10 locations and one provider operated from 30 locations.[8]

The number of locations will be influenced by a number of factors, and the results of the current survey show that population size is one significant factor.

It is likely that geographical location, nature of the population and types of services also influence the number of locations.

In determining the number of locations, managers may need to compromise between providing care as close to the patient as possible and the efficient use of resources.

Total number of new patients treated in all outpatients for financial year 2011/12

The total number of new patients treated in the 2011/12 financial year by the 95 organisations who provided data was 1,480,893.

In 2009/10 in England, physiotherapy outpatients services managed 1.9 million adults with a first appointment and 4.8 million follow-up attendances.[9]

Seventeen per cent of managers were unable to report the number of new patients seen by their physiotherapy services.

There is wide variation across organisations in the number of new patients seen. This to a large extent reflects variations in population size. The results of the 2012 survey demonstrate a significant relationship between the number of new patients and population size. However, there are some notable outliers to this relationship and there is also wide variation in the number of new patients seen per 10,000 population.

In the North West Alliance benchmarking musculoskeletal therapies report[8], the average number of referrals per 100,000 population for 2010/11 was 3,383 for community services and 2,328 for interface services.
These figures are lower than the average of 4,830 in the current survey, but considerable variation occurs across all outpatient services.
The findings from the North West Alliance report also demonstrate that within musculoskeletal services there is a notable difference between community and interface services.

New to follow-up ratio

The new to follow-up ratio is a useful measure of activity, but it is important that it is interpreted correctly, and a number of potential limitations recognised.

The new to follow-up ratio is observational data, measuring how many sessions a patient has received. In isolation, it provides no indication of the quality or outcome of treatment. Evidence including outcome data should be used to evaluate the optimum number of treatment sessions.

In this survey the range of ratios and the mean are reported:

- The mean ratio reflects the average number of follow-up sessions each new patient receives
- The range demonstrates the extent to which this varies

The highest ratio in the range, rather than the average, should be used to inform the maximum number of sessions some patients will receive.

The ratios reported in the current survey represent averages across a wide range of different outpatient specialties and types of service.
This illustrates the overall picture for physiotherapy services but has very limited application.
New to follow-up ratios will vary widely according to the nature of the service and also the type and complexity of conditions seen.

With regard to the nature of a service, an interface/triage service is likely to have low new to follow-up ratios. This was demonstrated in the North West Alliance benchmarking report[8] where the ratio for interface services was 1:1. These services do not necessarily represent the end of the pathway; patients may go on to orthopaedics, physiotherapy or self management.

Interpretation of new to follow-up ratios over successive years is complex, and a decrease in ratios is likely to reflect the rationing measures being introduced in service specifications.[10]

Factors affecting new to follow-up ratios

Patient self-referral

The results from the current study demonstrate significantly lower new to follow-up ratios in organisations offering some form of self-referral. This finding is in agreement with those from national studies.[4, 11]

Telephone services

A recent randomised controlled trial of PhysioDirect services (where patients receive initial assessment and advice by telephone followed by face-to-face treatment if necessary) demonstrated that patients required fewer face-to-face appointments and fewer physiotherapy consultations of any type compared to patients receiving usual face-to-face physiotherapy services.[12]

Stratification of low back pain in primary care

The stratified management approach uses prognostic (low, medium or high risk) screening combined with matched treatment pathway targeting, and has been shown to result in significant health benefits and cost savings compared to non-stratified care.

Patients in the low risk group receive one physiotherapy session in addition to initial assessment, those in the medium risk group up to six treatment

sessions, and those in the high risk group the option of more than six sessions where appropriate.[13]

A recent study has demonstrated that stratified management of low back pain is more clinically and cost effective in comparison to current best practice.[14] The new to follow-up ratios in both the stratified and current best practice groups were similar, but ratios within the stratified groups, although not reported, would clearly vary.

The new to follow-up ratios reported in previous surveys should be interpreted with extreme caution as the data used (average number of contacts) cannot provide a valid calculation of new to follow-up ratio.[2, 3]

Waiting time data

A number of different measures of waiting time were used in the survey; the shortest, average and longest waiting times for all outpatient services and for musculoskeletal, paediatric and occupational health services individually, and also the number of patients waiting for all outpatient services at a specific time point.

In previous surveys only the longest waiting times have been reported, which represents a negative interpretation of overall waiting times.

Policy and standards in relation to waiting time vary between countries and specialties.

General waiting time targets for the four UK countries

In England and Scotland there is a general waiting times standard of 18 weeks from Referral to Treatment (RTT), although this is not specific to physiotherapy.[15, 16]

The operational standard for access to therapy services in Wales is 14 weeks. The main target around time to treatment for the NHS in Wales is that 95 per cent of patients will have a RTT which is less than 26 weeks.[17]

In Northern Ireland waiting time targets for all outpatient services are specified in the Commissioning Plan for the Health and Social Care Board and Public Health Agency.
This states that from April 2012, at least 50 per cent of patients should wait no longer than nine weeks for their first outpatient appointment, with no-one waiting longer than 21 weeks.

By March 2013, 60 per cent should wait no longer than nine weeks, and no-one longer than 18 weeks.[18]

The data from the current survey was analysed in the context of current policy around 14 and 18 weeks.
All musculoskeletal, paediatric and occupational health outpatient services reported average RTTs less than 18 weeks, and also less than 14 weeks with the exception of one musculoskeletal service.
Ninety per cent of all services reported longest RTTs of less than 18 weeks.

There is currently little published data to compare these findings with.

In Scotland a one week census was undertaken in February 2012 which included RTTs for all physiotherapy services in Scotland.
For adult physiotherapy services waiting times ranged from 0 to 81 weeks, with a median waiting time of three weeks and 95 per cent of patients being seen within 16 weeks.[19]

There was insufficient data from some countries in the 2012 CSP survey to allow comparison of RTTs between countries.

Targets for different outpatient specialties

The results of the survey show variation between outpatient specialties and this is reflected in emerging policy and standards for different services, in particular musculoskeletal services.

In England, proposed service standards to support commissioners to deliver Any Qualified Provider (AQP) in musculoskeletal services suggest short referral response times which also differentiate between 'urgent' and 'non-urgent' referrals; for example, for back and neck pain services, a referral to initial assessment time within 72 hours for urgent, and within 10 working days for non-urgent referrals (subject to patient choice).[10]

During 2013/14 the Scottish Government will work with the NHS Boards on a developmental Health Improvement, Efficiency, Access to Services and Treatment (HEAT) target to decrease musculoskeletal AHP waiting times.[20]

The results for musculoskeletal services in the current survey do not differentiate waiting times according to urgency of referral, but to some extent that will be reflected by comparing shortest waiting times to average and longest times. Shortest waiting times compare reasonably well with proposed

AQP standards, with 83 per cent of organisations having RTTs of less than one week and 94 per cent less than two weeks.

Average and longest waiting times compare less favourably, with only 10 per cent of organisations having an average RTT of less than two weeks, and only four per cent a longest RTT of less than 2 weeks.

The NHS Health and Well-being review recommends early access for NHS staff to interventions for musculoskeletal disorders; and, in addition, that there should be nationally agreed service standards for early intervention.[21]

The importance of rapid access to treatment and rehabilitation for NHS staff has been emphasised in the NHS Health and Well-being framework and in the NHS Employers guidance for Trust Boards.[22, 23]

The benefits are not just for the individual: rapid access has been demonstrated to result in substantial cost savings and improved patient care.[21, 23]

Although the results of the current survey indicate shorter waiting times for occupational health services compared to musculoskeletal services, the average and longest waiting times are of concern, with only 64 per cent of organisations having average waiting times less than two weeks.

Comparison of shortest, average and longest waiting times suggests differences between specialties.
For example, shortest waiting times for paediatric services are higher than for musculoskeletal and occupational health services, but longest waiting times are less than for musculoskeletal services.
The Scotland 2012 census report showed that the median waiting time for adult and child physiotherapy services was the same (three weeks) but the maximum waiting time for child services was 32 weeks compared to 81 weeks for adult services.[20]

In the *Survey of NHS physiotherapy waiting times and musculoskeletal workload and caseload in the UK 2010-2011*, longest waiting times were reported for different outpatient specialties.[3]
For musculoskeletal outpatient services the range of longest waiting times was from less than one week up to 40 weeks.
This range has increased in 2012, with the longest wait being over 52 weeks.
The range of longest waiting times for paediatric services in 2011 was from

less than one week up to 25 weeks.
The range in the current survey was less than two weeks up to 30 weeks.

In relation to occupational health services, the longest maximum wait has progressively increased from less than seven weeks in 2010, to less than eight weeks in 2011 and less than 12 weeks in 2012.

Total number of patients currently waiting for outpatient services

There was wide variation in the number of patients waiting for physiotherapy in 2012, with some organisations in England and Scotland having no patients waiting, whilst in one organisation there were 5,907 people waiting.
On average, there were fewer people waiting in England than in the other three UK countries.

The total number of people waiting cannot be directly interpreted in relation to waiting time; however, it is an indicator of waiting time performance and is a useful metric if repeated regularly.
For example, in Wales, the total number of people waiting for physiotherapy is reported monthly.
At the end of November 2012 the total number of patients in Wales waiting for physiotherapy was 24,344. This is further broken down into the number waiting up to eight weeks (18,024, or 74 per cent), over eight weeks and up to 14 weeks (4,272, or 18 per cent) and over 14 weeks (2,048, eight per cent).[24]

It is important to note that some organisations have no waiting list, and it would be useful to investigate what demand management factors or processes contribute to this.

It is of concern that a third of organisations were unable to report the number of patients waiting. It is likely that provision of this data will be mandatory in all countries in the near future.

Comparison of outpatient waiting times (all services) with previous years

In relation to trends in outpatient waiting times, the greatest percentage of organisations (41 per cent) reported an increase in their waiting times over the previous year. However, 20 per cent reported that their waiting times had decreased.

Compared to the 2011 report, the number of organisations reporting an increase in waiting times has risen by eight per cent and the number reporting a decrease has fallen by 18 per cent.(3)
In response to the 2012 survey, almost a quarter of organisations reported that the trend in their waiting times varied between specialties, which indicates that the waiting times for individual specialties may be affected by different factors.
Organisations were not given this response option in the 2011 survey.

In the 2011 survey, only longest waiting times were reported.
The range of longest waiting times was from less than one week up to 40 weeks.
The results from the 2012 survey show that the upper end of the range has increased to over 52 weeks.
In 2010, the longest wait was notably less at 18 weeks.

Factors affecting waiting times

There is a wide range of factors which can influence waiting times and there appear to be complex interactions between these factors.
An increase in demand, DNA management, use of groups and classes, unfilled staff vacancies, vacancy control measures and reductions in permanent staff are all important factors influencing waiting times.

It would seem logical for increases in demand and decreases in staffing to increase waiting times, and for efficient capacity and demand management factors to decrease waiting times.
However, the results suggest that one factor in isolation will not predict the overall trend in waiting time

Demand

The most commonly reported factor is an increase in demand, with almost three quarters of organisations reporting an increase in referrals.
Interestingly, both increases and decreases in waiting time are reported by those organisations with increasing demand.

This demonstrates that an increase in demand does not necessarily result in longer waiting times and suggests that different factors may interact to affect overall waiting times.

For example, an increase in demand may be counterbalanced by an increase in staff resources or more efficient referral management systems.

However, the percentage of organisations reporting an increase in demand is higher in those with increasing waiting times (88 per cent) than in those with decreasing waiting times (54 per cent).

The next most common factors affecting waiting times are capacity and demand factors, with 63 per cent of organisations reporting DNA management and 58 per cent the use of groups or classes as factors.

Again, these factors vary in how they influence waiting times:

- The number of organisations reporting DNA management and increasing waiting times is fairly similar to the number with decreasing waiting times
- The percentage of organisations reporting the use of groups or classes was 10 per cent higher in those with decreasing waiting times compared to those with increasing waiting times

Staff

Staffing factors are commonly reported, with approximately half of all organisations reporting unfilled staff vacancies and vacancy control measures, and 43 per cent reporting reductions in permanent staff.
These factors are most commonly reported in organisations whose waiting lists have increased (60 – 67 per cent of organisations) but a small number of organisations whose waiting list has decreased also report these factors (13 – 21 per cent).

Skill mix factors are less commonly reported, with 35 per cent of organisations indicating skill mix to lower bands as a factor.
This factor is 12 per cent higher in organisations whose waiting times have increased (38 per cent of organisations) compared to those whose waiting times have decreased (26 per cent).

The interaction between different factors can be also be analysed by studying the combination of factors which most frequently affect those organisations with increases and those with decreases in waiting times.

Organisations with increasing waiting times

The most frequently reported factors are

- increase in referrals
- unfilled staff vacancies
- vacancy control measures
- DNA management
- reduction in permanent staff
- use of groups or classes
- changes in care pathways

It is clear how increase in demand and decrease in staff resources could adversely affect waiting times. It is less obvious how DNA management, use of groups or classes and changes in care pathways influence waiting time and this requires further investigation.

Organisations with decreasing waiting times

Despite an increase in demand reported by over half of organisations with a decrease in waiting times, this appears to be compensated for by DNA management, increase in temporary staff, service re-design and changes in booking system.
This suggests that changing capacity and demand management processes can have a significant effect on waiting times and merits further investigation.

It is important to note that lowering waiting time does not guarantee better outcomes from physiotherapy intervention.
Some of the factors contributing to decreasing waiting times, such as reduced length of treatment sessions or rationing of follow-up sessions (38 per cent and 29 per cent respectively of organisations with decreasing waiting times), may result in poorer outcomes.

In the 2011 report, the most frequently reported factors for organisations with an increase in waiting times were: increase in referrals (78 per cent of organisations); vacancy control measures (60 per cent); and unfilled staff vacancies (56 per cent).

For organisations with decreasing waiting times, changes in the booking system (64 per cent) and DNA management (57 per cent) were the most commonly reported factors.[3]

However, this finding should be interpreted with extreme caution, as the design of the 2011 survey assumed that specific factors can only affect waiting times in one direction; for example, a decrease in permanent staff is associated with an increase in waiting times, and vice versa.

The results of the current survey demonstrate that this assumption is seriously flawed.

Self and prompted referral to outpatient services

48 per cent of organisations reported providing self-referral outpatient services and this same percentage was reported in 2011.[3]

The proportion of patients who self-refer is lower than expected. When a self-referral service is properly advertised and marketed, the rate of true self-referral is between 20 – 30 per cent.[4, 11]
This lower rate may be because the self-referral route of access is not actively promoted and marketed to patients.

Patient self-referral gives a 'kite mark' to the physiotherapy service.
This method of access has been through a robust and unbiased 'Quality Assurance' process as part of the NHS Evidence QIPP Collection.
It provides a high quality element of the service and it should always be part of the way that patients can access physiotherapy services.[25]

It is surprising that the percentage of organisations accepting prompted referrals (44 per cent) is less than those offering self-referral.
Prompted referral has been shown to save GPs time as there is no need for a second GP appointment, no administration costs, and it also promotes patient responsibility and autonomy.
A similar percentage of organisations (46 per cent) accepted prompted referrals in 2011.[3]

37 per cent of organisations do not have data on what proportion of their patients self-refer. For the purposes of costing services and evaluating cost effectiveness, it is important that this data is collected separately. The cost of true self-referral is less than for prompted referral.

Systems of access for different outpatient specialties

Approximately 48 per cent of musculoskeletal services offer self- or prompted referral, and it is encouraging to see that most of these offer both types of access.

The finding that less than 50 per cent of organisations offer self-referral to occupational health services is of great concern.
A recommendation of the Boorman report is that all NHS services should have self-referral access as well as access through management referral.[21]

It is not possible to estimate the percentage of organisations offering self-referral to women's/men's health, paediatric, neurology or long term conditions services from data collected in the 2012 survey.
It is likely that some organisations who offer these services did not respond to this question if they did not provide self-referral to these services.

Future work will evaluate self-referral to women's/men's health services.
The proportion of patients who self-refer to these services is lower than to MSK physiotherapy.
National opinion polling suggests that this could be because members of the public are not confident in their knowledge of how physiotherapy/exercise can help incontinence, bladder and bowel problems.[26]

Paediatric, pain management, neurology and long term conditions services tend not to offer self-referral, but a system of 'open access' is important in terms of patient choice and autonomy. This kind of open access should be a focus of future surveys.

Continuation of self-referral services

Almost one-third of organisations thought that it was unlikely that they would continue to offer self-referral access.
It is of great concern that 100 per cent of these organisations reported that the service was not supported by commissioners or service planners.

Two-thirds of these organisations indicated that self-referral was not within the AQP specification.

However, there have been two positive developments in relation to self-referral since managers completed the survey:

- Firstly, patient self-referral has been recognised in the NHS Evidence QIPP Collection[25]
- Secondly, NHS Supply2Health has updated the section on patient self-referral in its back and neck service standards to support commissioners to deliver AQP
  This now specifies that a patient can initiate a referral via an agreed 'prompted' route, and reports and references the NHS Evidence QIPP pages on self-referral.[10]

Recommendations

Health informatics

Managers need to ensure that their organisation has robust systems in place to capture information on physiotherapy services. The CSP will continue to represent the profession on national Health Informatics strategic groups and communicate developments to members.

Data collected by physiotherapy services should include:

- Referral numbers
- Waiting times, allowing for analysis of shortest, average and longest times and the proportion of patients seen within a specific length of time
- New to follow-up ratios, allowing for analysis by specialty and, where appropriate, sub-classifications, and type of service
- Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)

Making the business case for physiotherapy services

Managers need to:

- understand the size and nature of the population covered by their services
- evaluate the effectiveness of the number of locations they provide, in terms of both provision of services as close to the patient as possible and efficient use of resources
- develop or update the business case for self- and prompted referral services
- develop or update a business case for staff occupational health services, including the option of self-referral access

Promotion of physiotherapy services, campaigning and influencing policy

The CSP will utilise the findings of this survey to campaign for physiotherapy services and to influence policy, particularly in relation to the commissioning of services, self-referral, and occupational health services for NHS staff.

The CSP will continue to utilise and evaluate published health informatics reports/data available through the Freedom of Information Act.

The need for further surveys or other methods to collect information directly from members will be regularly assessed.

Waiting times for physiotherapy services

In order to be in a position to provide competitive services, managers need to consider introducing strategies to reduce waiting times.

These should be based on evidenced approaches that also demonstrate increased quality of services.

Use of the new to follow-up ratio

- New to follow-up ratios should be interpreted, applied and cited with respect to the specific type and nature of service they represent
- Average new to follow-up ratios should not be utilised to set limits on the maximum number of treatment sessions
- The optimum number of treatment sessions for a specific service should be determined from evidence which includes the evaluation of outcome.

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Recommended resources

Making the business case for physiotherapy services

The Chartered Society of Physiotherapy. Your business - information on marketing and promoting physiotherapy services.
http://www.csp.org.uk/professional-union/practice/your-business

The Chartered Society of Physiotherapy. Information on understanding and navigating the new NHS. London: The Chartered Society of Physiotherapy; 2012.
http://www.csp.org.uk/publications/understanding-navigating-new-nhs

The Network of Public Health Observatories. Health profiles. The Network of Public Health Observatories
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Keele University. STarT Back Screening Tool Website http://www.keele.ac.uk/sbst/

Occupational health services for NHS staff

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Appendix: The 2012 survey