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# Information paper

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## **A survey of NHS Physiotherapy waiting times, workforce and caseloads in the UK 2010-2011**

Report by JJ Consulting

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# A survey of NHS Physiotherapy waiting times, workforce and caseloads in the UK 2010-2011

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# A survey of NHS Physiotherapy waiting times, workforce and caseloads in the UK 2010-2011

## Executive summary

JJ Consulting were commissioned by the Chartered Society of Physiotherapy (CSP) to undertake a survey of physiotherapy outpatient waiting times and workforce and caseload levels in the United Kingdom. The intention was to provide the Society with a report setting out a comprehensive picture of these issues within UK physiotherapy services.

Quantitative and qualitative data was collected on waiting times, waiting time trends, possible reasons for increase and decrease in waits, the volume and impact of Did Not Attend (DNAs), and levels of implementation of self referral. Where possible, comparison was made with the results of the surveys carried out in 2009-2010 and 2008-2009.

The report contains a section on physiotherapy activity, caseloads and workforce in musculoskeletal outpatients, inpatient trauma and orthopaedics, accident and emergency and stroke services.

For the survey to be successful it was essential that the most senior physiotherapy manager or physiotherapy lead in each NHS provider organisation across the UK was contacted. However, this proved to be extremely challenging in the context of NHS reorganisation, upheaval and reconfiguration on an unprecedented scale. Most English organisations were being reconfigured, with many physiotherapy managers changing jobs, roles and organisations, as well as posts being disestablished and downgraded. It was therefore unsurprising that the response rate was reduced compared to previous surveys.

Data was received from 109 respondents working for 141 NHS organisations, providing services to 401 physiotherapy outpatient departments. The individual physiotherapy manager response rate was 50 per cent, and the provider organisation response rate was 64 per cent.

This level of response is generally regarded as good in the context of national questionnaire surveys, further strengthened by the nature of a homogenous group of physiotherapy managers and leaders working in the NHS. This is confirmed by several authorities.

The organisational response rate was lower than in the surveys of 2009-2010 (86 per cent) and 2008-2009 (70 per cent).

A comparison of responses for the three years surveyed showed that respondents provided services to 401 outpatient departments in 2010-2011, compared with 569 in 2009-2010 and 204 for the financial year 2008-2009.

The survey took place during the summer of 2011 and data collection was completed at the end of August. Data collected was for the financial year 2010-2011.

Analysis of the data has been set in the context of the number of respondents to each question. Not all respondents answered every question; therefore caution should be used where respondent numbers are low.

In 2011 the longest wait reported by the majority of organisations was six to eight weeks, broadly similar to seven weeks in 2010: while the shortest maximum wait reported in 2011 was less than one week, compared to two weeks in 2009-2010.

In 2011 the longest wait was 30-40 weeks, compared with 18 weeks in the previous year.

The report includes a wide range of information relating to waiting times, for example on the number of managers who have systems capable of subdividing waiting times into weekly categories: only 50 per cent of respondents to this question were able to do this, which suggests that this will be a significant problem for those in England who will be required to report on Referral To Treatment (RTT) data.

The report sets out comparative data on waiting time trends, possible reasons for changes in waiting times, and the use of demand and capacity management techniques.

DNA figures for 2010-2011 were comparable with those for the previous year, 9.45 per cent as against 9.58 per cent.

54 per cent of services responding provided some form of self referral compared with 41 per cent in 2009-2010, though the response rate was smaller than in that year.

In 2009-2010 first to follow-up ratios were 1 to 3.41, but 1 to 2.31 in 2010-2011, indicating a significant decrease.

As in 2009-2010, participants were asked to divide their waiting time reports into six major categories: musculoskeletal, neurology (including stroke), paediatrics, pain management, women's and men's health, and occupational health.

The report contains data on non-Health Professions Council (HPC)-registered assistants/ support workers, and administrative and clerical staff support. The information in this section is wide-ranging, including: numbers of referrals, average face-to-face contacts, DNA rates, first to follow-up ratios, and caseloads by bands for HPC and non-HPC registered staff.



The report concludes with a set of recommendations which the authors were invited to make for the CSP to consider.

### **Acknowledgements**

We would like to thank Phil Gray, Chief Executive Officer (CEO) of the Chartered Society of Physiotherapy (CSP), and Natalie Beswetherick, Director of Practice and Development (DPD), for commissioning JJ Consulting to undertake this survey.

Thanks to Jan Hague, Marketing Insight Officer, CSP for her support and expertise in data management and statistical analysis.

Many thanks to the 109 physiotherapy managers and leads who kindly participated in the survey, without whose support and contributions the survey would not have been possible.

Dr Robert Jones and Fiona Jenkins  
JJ Consulting

## Section One: About the survey

### 1.1 Background

This survey of physiotherapy outpatient waiting times, workforce and caseloads in England, Northern Ireland, Scotland and Wales was commissioned by the CSP following surveys previously undertaken in England only (2008-2009 and 2009-2010)<sup>(1,2)</sup>.

In addition to this report, a secondary product was formed during the course of the project: a database of senior managers across the UK.

The main objectives of this survey were to:

- provide information about outpatient waiting times, workforce and caseloads of physiotherapy services within NHS provider organisations across the UK (as far as was practicable given the disruption caused by the NHS reforms);
- ensure that the CSP had reliable and up-to-date data on current key performance indicators and workforce issues, which would be used to inform discussions at national and local levels, to form an evidence base for the profession, and to support physiotherapy managers and leaders.

Physiotherapy waiting time data reporting is a mandatory requirement in Wales, with a maximum wait set at 14 weeks.

Currently in England there is voluntary reporting of outpatient waiting times and a national pilot of the data collection process, with mandatory reporting from 2013.

Northern Ireland had mandatory reporting in place until 31 March 2011 with an outpatient waiting time target of 9 weeks.

There is currently no mandatory requirement for reporting of waiting times in Scotland.

The literature search included in the two previous surveys<sup>(1,2)</sup> laid out the evidence base supporting the need to minimise physiotherapy waiting times to improve recovery and maximise independence.

A further literature search was undertaken to draw out more recent supportive evidence. AMED, CINAHL, MEDLINE and EMBASE databases were used to review evidence from 2010 and 2011.

Keywords and search terms used to locate references were: physiotherapy, physical therapy, physical therapy modalities, chest physiotherapy, respiratory care, respiratory tract diseases, emergency care, musculoskeletal disease, stroke, mobilization, early ambulation.

There were 27 new references commending early access to physiotherapy.<sup>(3-28)</sup>

The previous two surveys undertaken by JJ Consulting were focused largely on outpatient waiting times and self referral. However, the 2009-2010 survey also included musculoskeletal outpatient workforce and caseload data.

Physiotherapy managers have increasingly requested the CSP to provide benchmark data and guidance on staffing levels and caseloads to support a range of areas such as business planning, capacity and demand management, and service re-design. This survey was therefore broadened to include data capture for caseloads and workforce in inpatient Trauma & Orthopaedics (T&O), Stroke, and Accident & Emergency services.

The findings of this report build on the evidence base developed in the two previous surveys, providing a contemporary analysis on the basis of which the CSP will be able to advise and support physiotherapy managers and leaders.

## 1.2 Project plan

The project plan timescale agreed for this work is shown below.

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Preparatory work and commissioning	■	■	■												
Questionnaire design			■	■	■	■	■								
Piloting questionnaire and revision							■								
Questionnaire 1 <sup>st</sup> mailing								■							
Questionnaire survey data collection								■	■	■					
Analysis and collation of findings											■	■	■		
Preparation of draft report, discussion with CEO, DPD											■	■	■		
Final report													■	■	
Communication and publicity															■

Project plan timeline: Nov 2010 – Jan 2012

### **1.3. Contact database**

The CSP NHS managers' database for England, which had been revised in the previous year by the authors, was further developed and extended to include all organisational changes as far as was possible. Given the upheaval in organisational configuration taking place, this was an extremely difficult and time-consuming task. Not only did organisations change names and configurations, but physiotherapy managers were also significantly re-organised during this period.

### **1.4. Survey method**

The questionnaire was designed to be completed by the most senior physiotherapy manager or lead in all NHS provider organisations. The survey reporting ensured that none of the respondents or their employers would be individually identifiable.

#### **1.4.1 Survey tool**

SurveyMonkey web-based software was used for the online survey, administered under the CSP licence by Jan Hague (Marketing Insight Officer, CSP).

#### **1.4.2 Questionnaire**

This was developed using the template of the previous two years, as requested in the commission, and was forwarded to the DPD for comment and approval.

The survey was in two parts: the JJ Consulting questionnaire, and a further section asking questions to gather information for the CSP Employment Relations and Union Services (ERUS) department and DPD (Appendix 1).

#### **1.4.3 Senior managers' email database**

ERUS created a list of senior physiotherapist managers based on the list previously compiled during 2009-2010.

The updated list was checked by the authors and the Marketing Insight Officer to validate it as far as possible and resolve gaps in its completeness where they existed.

However, it was not possible to get a full list of organisations or managers and leaders of physiotherapy services because of the radical organisational change process and the changing or disestablishment of manager posts taking place during 2010-2011.

#### **1.4.4 Participants**

The invitation to participate in the survey was sent to 257 senior physiotherapy managers.

#### **1.4.5 Survey pilot**

JJ Consulting drafted the questionnaire based on the previous questionnaires of 2008-2009 and 2009-2010. The draft was sent for comment to the CEO and DPD, as well as to six physiotherapy managers (members of the CSP professional network Leaders and Managers of Physiotherapy Services [LaMPS]), to pilot it and provide comments and suggestions.

The link to the questionnaire was distributed on June 1 2011.

It was agreed to send three reminders over the allocated response period due to the NHS reconfigurations taking place.

Full year data was requested for the year 2010-2011.

#### **1.4.6 Collation and analysis**

This took place from September to November 2011. Survey results were collated and analysed. IBM SPSS Statistics 19 software was used for statistical analysis and presentation of results. Detailed discussions took place between the authors and the Marketing Insight Officer throughout this process.

#### **1.4.7 Reporting**

A draft report was reviewed with the CEO and DPD in November 2011. Subsequently the final report was submitted in December 2011.

#### **1.4.8 Communication strategy**

The final report has been made available in electronic (PDF) format.



## Section Two: Survey responses

The survey was sent to the 257 provider organisations employing physiotherapists in the UK which were included in the CSP managers' email database at that time. However, it transpired that the CSP database was inaccurate.

40 of the initial 257 emails “bounced back” (either due to incorrect email address, no longer in post, or no longer a provider organisation) and were therefore undelivered.

All “bounce-backs” were followed up and these organisations invited to provide contact details for their physiotherapy manager or physiotherapy lead.

The final total of questionnaires successfully sent to managers and leads was 220.

### 2.1 Analysis of respondents

#### 2.1.1 Response rate

Of the 220 invitations, 109 physiotherapy managers responded (a 50 per cent response rate). The respondents worked for 141 NHS organisations, providing services to 401 physiotherapy outpatient departments.

A 50 per cent response rate is considered to be an acceptable response rate in line with advice sought from four university departments and two national survey organisations (Mori, Gallup, University of Brighton, University of Plymouth, University of Kent and Cardiff University).

#### 2.1.2 Response by country

Country	Invitations sent	Responses received from individual managers	per cent response by individual managers	Responses received from provider organisations	per cent response from provider organisations
England	192	93	48	125	65
Northern Ireland	5	3	60	3	60
Scotland	15	8	53	8	53
Wales	8	5	63	5	63
<b>Total</b>	<b>220</b>	<b>109</b>		<b>141</b>	
<b>Average</b>			<b>50</b>		<b>64</b>

*Table 1. Survey response by country*

- Wales had the highest individual manager response rate per country (63 per cent) and England the lowest (48 per cent).

- England had the highest response from organisations (65 per cent) as several respondents provide services for more than one organisation. Scotland had the lowest (53 per cent).

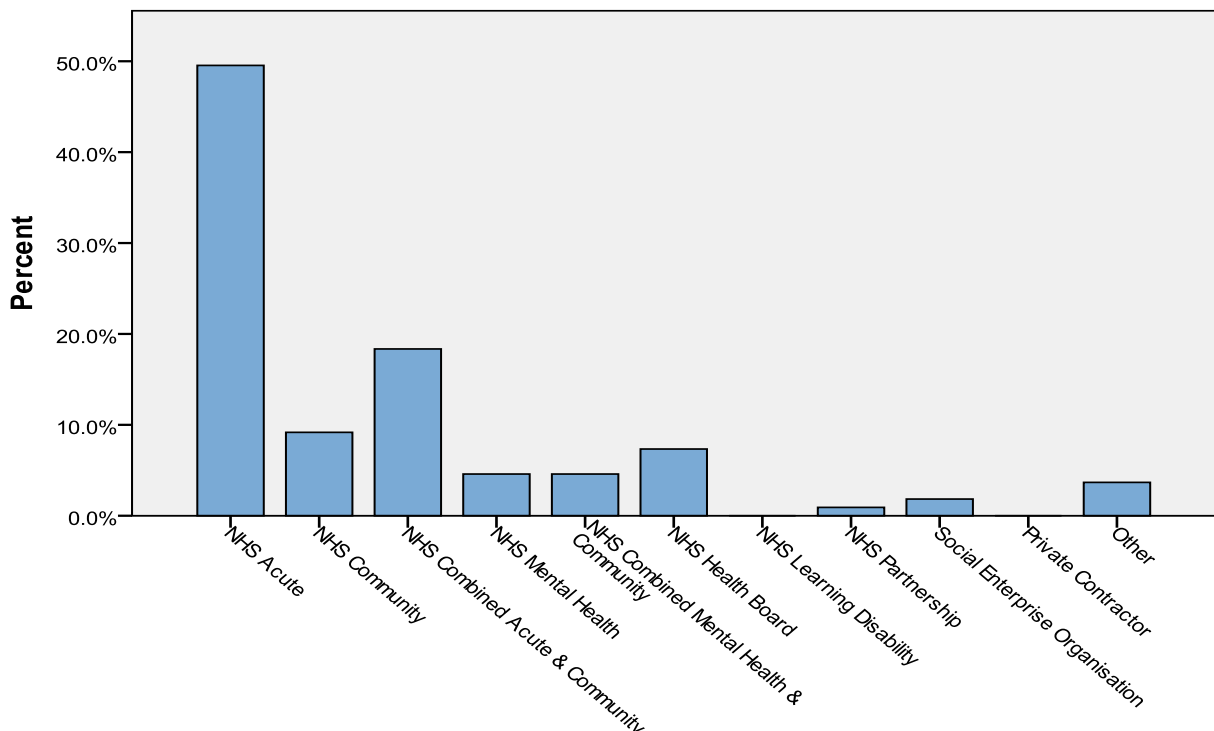
### 2.1.3 Size of population covered by physiotherapy service

	N	Minimum	Maximum	Total UK	Mean	Std Deviation
What is the size of the population covered by your service(s)?	77	1000	800,000	26,963,021	350,169	187491.4

**Table 2. Physiotherapy service population catchment**

- The smallest provider service reported in the UK covered a population of 1000, the largest 800,000. The mean population size was 350,169.

### 2.1.4 Response by employer type



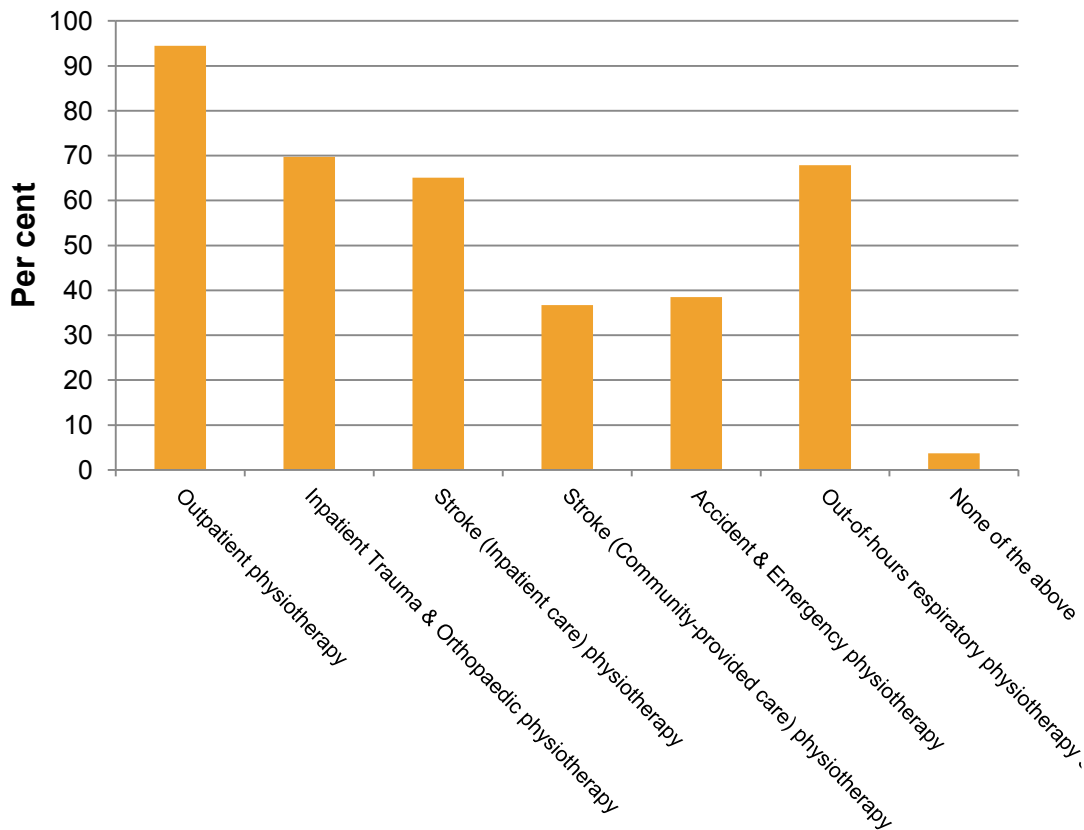
**Figure 1. Response by employer type**

This figure indicates information about patterns of service provision and employment.

- Half the respondents were employed by an acute hospital provider service;
- 30 per cent were employed by combined providers of either acute and community or acute, community and mental health or integrated Health Boards;

- 9 per cent were employed by a community organisation;
- 2 per cent were employed by social enterprises.

### 2.1.5 Type of physiotherapy services provided



**Figure 2. Type of physiotherapy services provided**

Physiotherapy managers were asked to detail the services they provided.

- 95 per cent (103) provided outpatient physiotherapy services;
- 70 per cent (76) provided inpatient trauma and orthopaedic services;
- 65 per cent (71) provided a stroke inpatient service;
- 68 per cent (74) provided an out-of-hours respiratory service;
- 39 per cent (42) provided an A&E service;
- 37 per cent (40) provided a community stroke service;
- 4 per cent (4) did not provide any of the listed services.

### 2.1.6 Number of organisations for which physiotherapy services were managed per manager

In answer to the question: “Are you responsible for providing physiotherapy services for more than one NHS provider organisation?” there were 109 responses.

Number of organisations provided for	Respondents
1 Organisation	86
2 Organisations	14
3 Organisations	9

**Table 3. Number of organisations’ physiotherapy services managed per manager**

23 respondents provided physiotherapy services for more than one organisation; all of these were in England.

The majority of respondents (86) provided services for one organisation only.

### **2.1.7 Number of physiotherapy departments**

The questionnaire enabled each manager to respond for up to 15 departments within their areas of responsibility.

Responses ranged from one to 15 departments.

401 departments in total were included in the responses.

The number of physiotherapy departments covered in this survey is less than the previous year (569 in 2009-2010), but almost double the number of departments covered in the first year of the survey (204 in 2008-2009).

## **2.2 Response comparison with 2008-2009 and 2009-2010 surveys**

The 2011 survey was extended to include all NHS providers in the UK.

220 surveys were sent to valid email addresses of physiotherapy managers, compared with 260 in 2009-2010, and 255 in 2008-2009.

	2008-2009	2009-2010	2010-2011
<b>Surveys sent</b>	255	260	220
<b>Valid responses from managers</b>	180	224	109
<b>Physiotherapy outpatient departments providing services</b>	204	569	401
<b>Organisations providing outpatient physiotherapy</b>	154	201	141

**Table 4. Response comparison between 2008-09, 2009-10, 2010-11**

Scotland, Northern Ireland and Wales do not have large numbers of organisations. England has reduced the number of provider organisations following reconfiguration



during 2011.

Therefore, although the number of managers contacted was less in 2011, the geographical spread was significantly larger.

The responses for 2010-2011 covered 401 physiotherapy outpatient departments.

## **Section Three: Waiting times**

The 2008-2009 survey<sup>(1)</sup> indicated that there were six main categories of outpatients, though there were 17 specialties widely reported and 42 different sub-specialty waiting lists.

The 2009-2010 and 2010-2011 surveys asked about total numbers of patients waiting for all categories of outpatient physiotherapy, then focused on the six main specialties for further detail of waiting times, workforce and service provision.

### **3.1 Definition of a waiting time**

To ensure respondents were reporting consistently, a waiting time definition was given:

“The time between the date that a referral is received, and the date the patient attends for treatment.”

This is consistent with the Department of Health (DH) definition of Clock Start for Allied Health Professional Referral to Treatment Time (RTT).

### **3.2 Analysis of waiting time data**

#### ***3.2.1 Total number of patients waiting for all types of outpatient physiotherapy***

Of the 109 respondents who provided information, only 72 provided data regarding the numbers of patients waiting for treatment at the time of the survey.

- 72 physiotherapy managers reported a total of 39,788 patients waiting for outpatient physiotherapy on 31st March 2011 in the UK (average 523 per department).
- This compared to 142 respondents reporting 115,510 patients waiting in England alone on 31st March 2010 (average 813 per department).

Caution must be exercised in interpreting this data, as only 72 of the 109 respondents provided data.

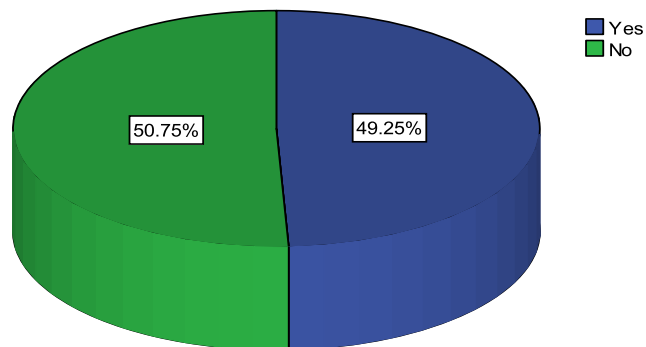
Although comparison with data from 2009-2010 has been made for illustrative purposes, caution again should be exercised.

However, it does indicate that 72 managers were well informed about the number of patients on their waiting lists.

### **3.2.2 Systems to enable waiting times to be subdivided into weekly categories - DH methodology**

*“The way in which your information is currently held, is it possible to subdivide the waiting list into the time periods identified in the survey?”*

There were 67 respondents to this question.



**Figure 3. Systems to enable waiting times to be subdivided into weekly categories**

This question was significant as it was based on the methodology used by the DH for RTT reporting, indicating the level of readiness or systems ability to collect and report data.

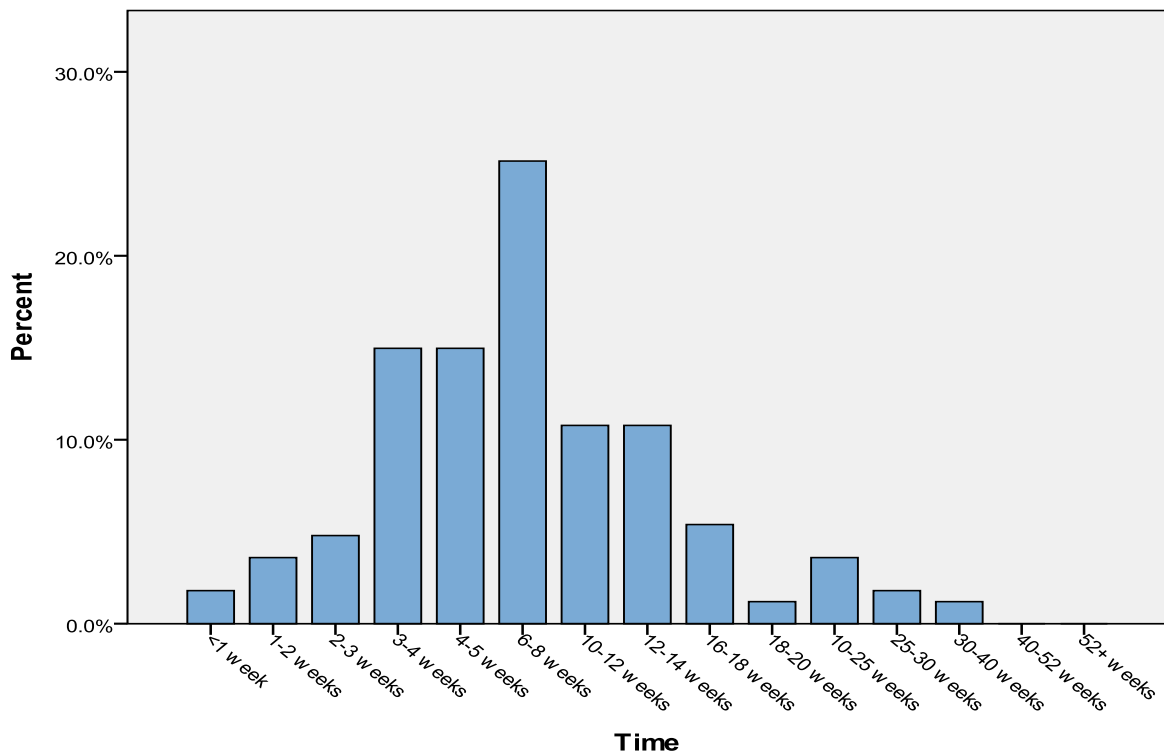
- 33 respondents (49 per cent) identified that they could subdivide waiting lists into time period categories as required by the DH
- 34 respondents (51 per cent) reported that they could not subdivide waiting lists into time period categories.

In 2010, 71 respondents identified that they could subdivide waiting lists into time period categories. The number of managers able to access data in this format has more than halved.

### 3.2.3 Longest waiting time for referral to treatment as at 31/03/2011

#### 3.2.3.1 All outpatient services

This data was provided by the 69 organisations and 167 departments who gave their longest waiting time in weeks.



**Figure 4. Longest wait for referral to treatment as at 31/3/11: all outpatient services**

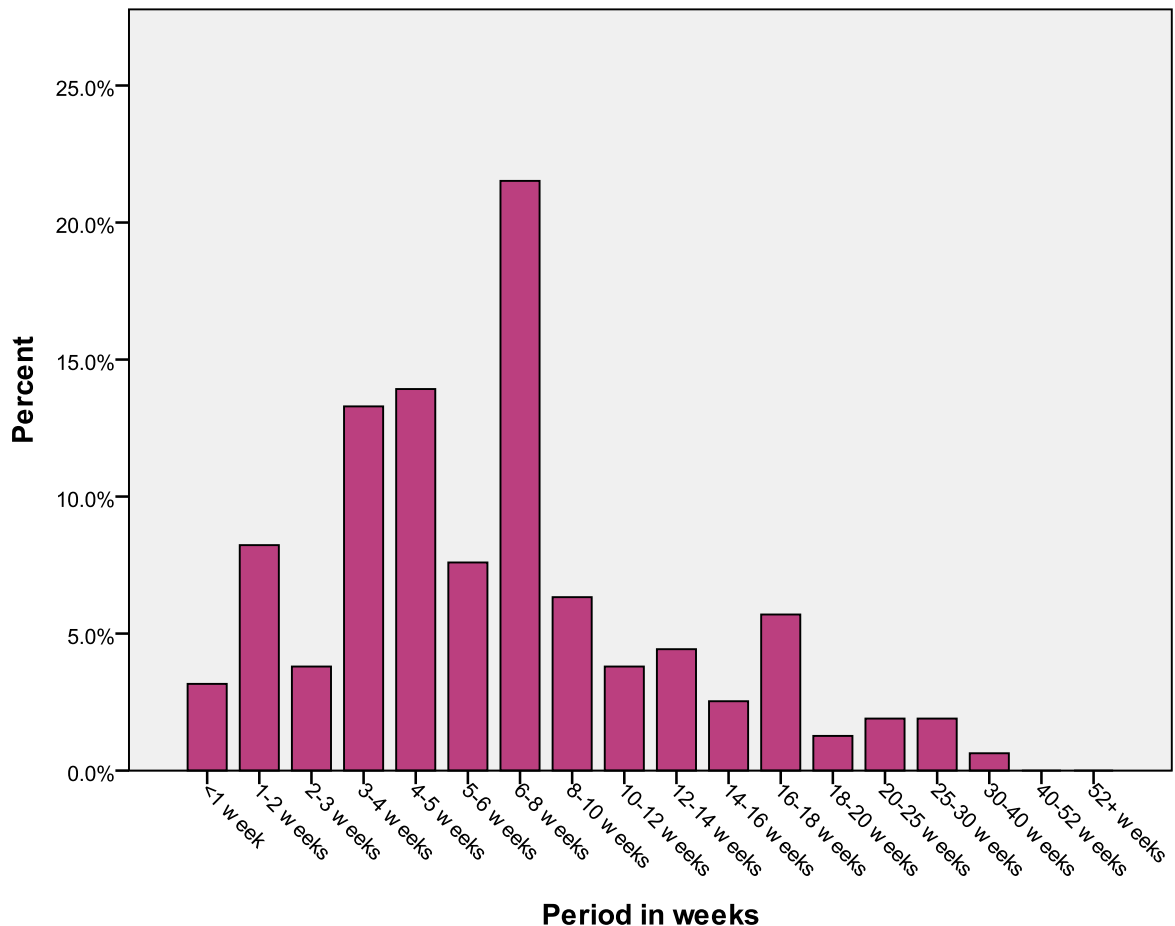
- The longest wait reported by the majority of respondents was 6-8 weeks, compared with the 7 weeks reported in 2010
- The shortest maximum waiting time reported in 2011 was less than one week, compared to 2 weeks in 2010
- The longest wait was 30-40 weeks in 2011, compared to 18 weeks in 2010.

The longest waiting time appears to have substantially increased.



### 3.2.3.2 Musculoskeletal

There were responses from 158 departments.

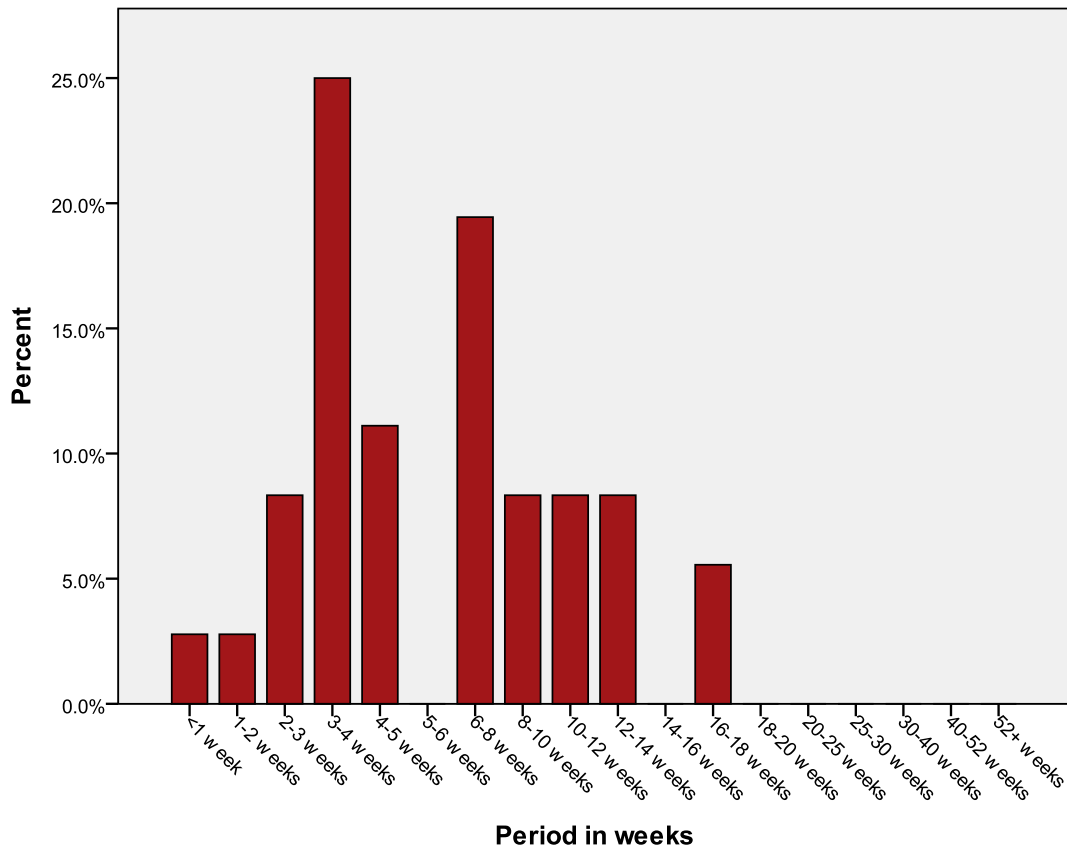


**Figure 5. Longest wait from referral to treatment – musculoskeletal**

- For musculoskeletal services the longest wait reported by the majority of respondents was 6-8 weeks (compared to 7 weeks in 2010)
- 71 per cent of patients were seen in 8 weeks or less ( compared to 68 per cent in 2010)
- The shortest maximum waiting time was less than 1 week, and the longest maximum waiting time 30-40 weeks.

### 3.2.3.3 Pain management

There were responses from 36 departments.

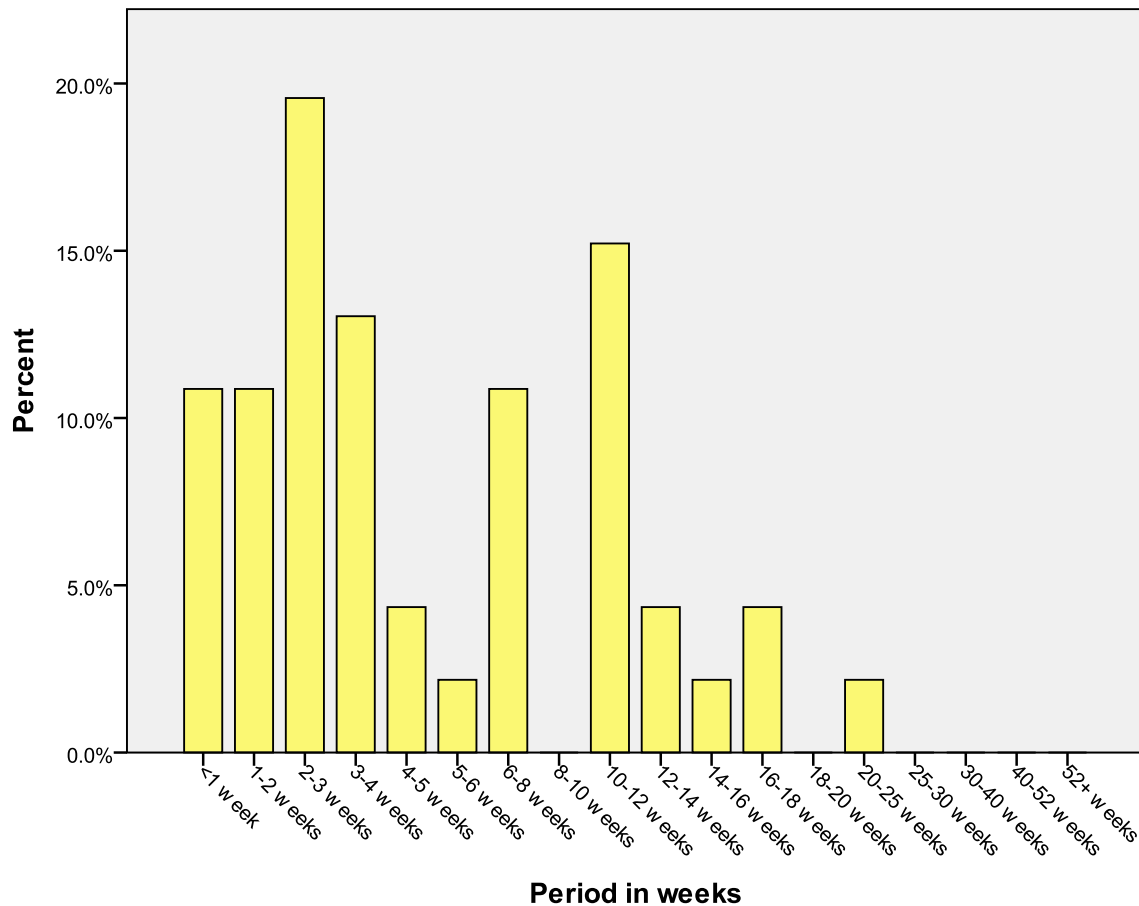


**Figure 6. Longest wait from referral to treatment - pain management**

- For pain management services the longest wait reported by the majority of respondents was 3-4 weeks (compared to 7 weeks in 2010)
- 69 per cent were seen in 8 weeks or less (compared to 80 per cent in 2010)
- The shortest maximum waiting time was less than 1 week, and the longest maximum waiting time 16-18 weeks.

### 3.2.3.4 Paediatrics

There were responses from 46 departments.

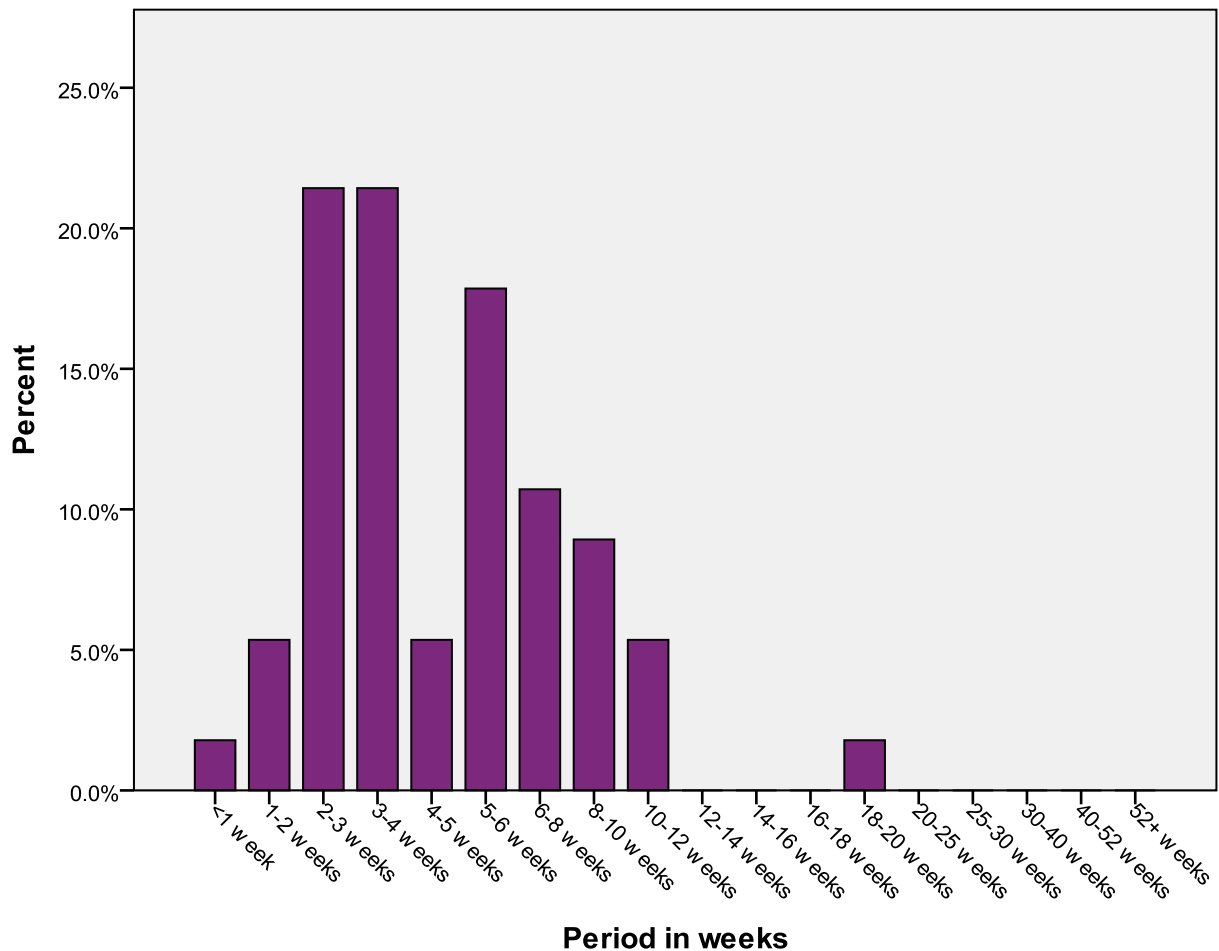


**Figure 7. Longest wait from referral to treatment – paediatrics**

- For paediatric services the longest wait reported by the majority of respondents was 2-3 weeks (compared to 6 weeks in 2010)
- 72 per cent were seen in 8 weeks or less (compared to 76 per cent in 2010)
- The shortest maximum waiting time was less than 1 week, and the longest maximum waiting time 20-25 weeks.

### 3.2.3.5 Neurology (including stroke)

There were responses from 56 departments.

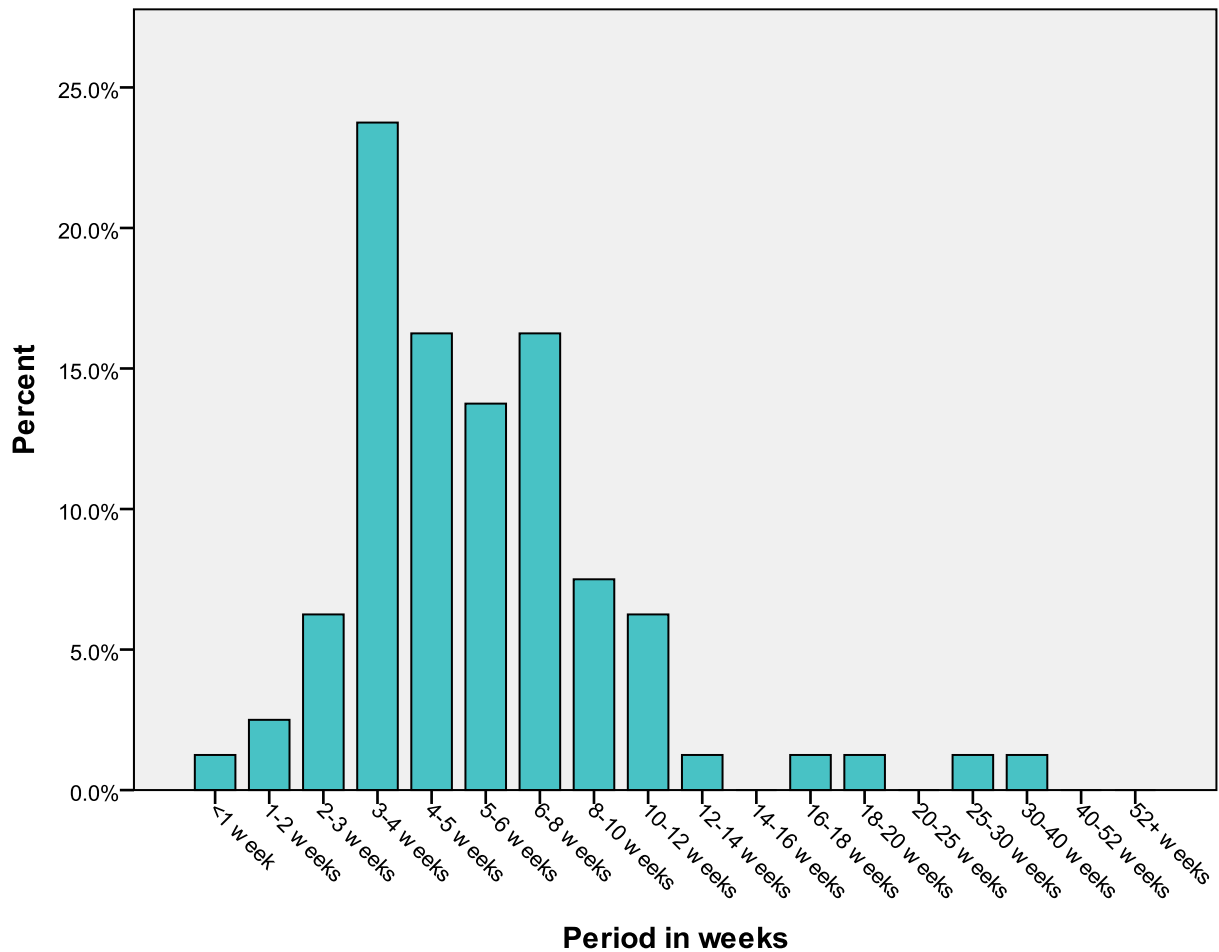


**Figure 8. Longest wait from referral to treatment – neurology (including stroke)**

- For neurological services the longest wait reported by the majority of respondents was 2-4 weeks (compared to 4 weeks in 2010)
- 83 per cent were seen in 8 weeks or less (compared to 68 per cent in 2010)
- The shortest maximum wait was less than 1 week, and the longest maximum wait 18-20 weeks.

### 3.2.3.6 Women's/men's health

There were responses from 80 departments.

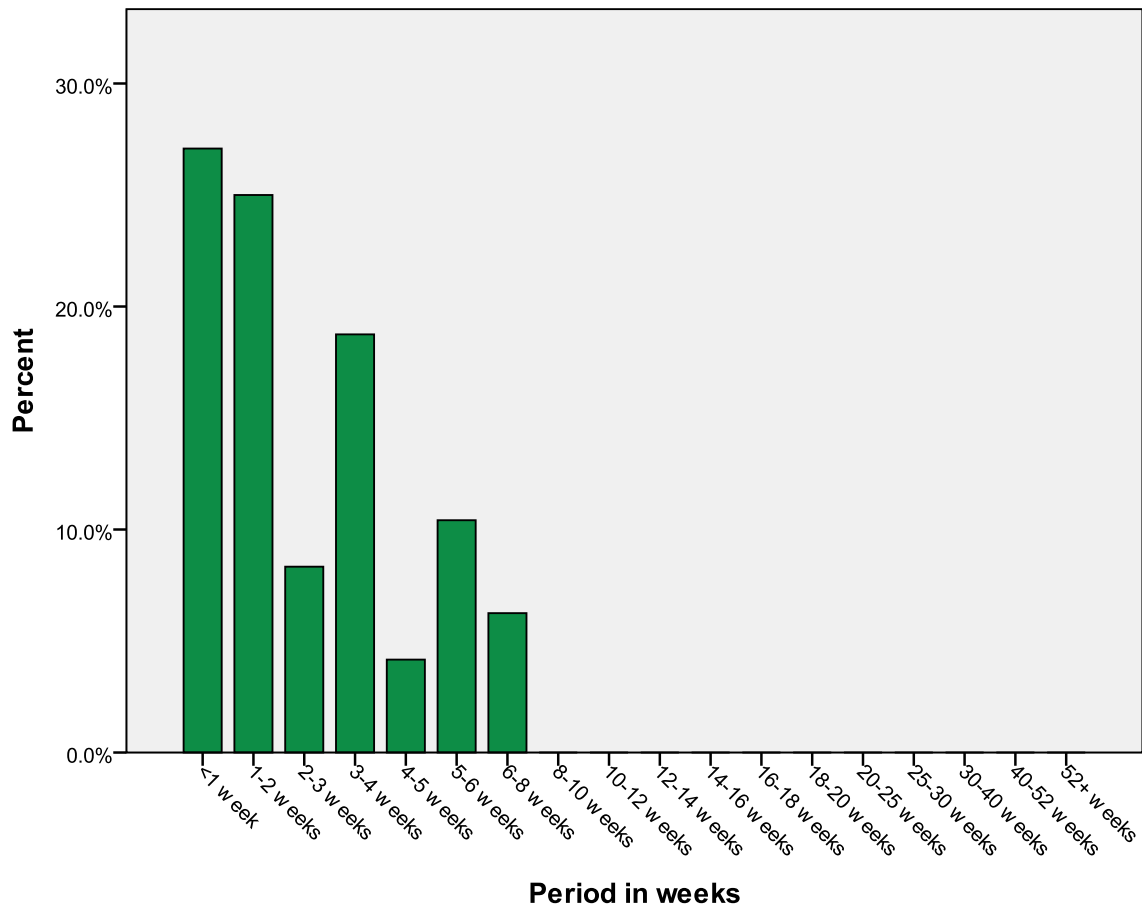


**Figure 9. Longest wait from referral to treatment – women's/men's health**

- For women's/men's health services the longest wait reported by the majority of respondents was 3-4 weeks (compared to 3 weeks in 2010)
- 80 per cent were seen in 8 weeks or less (compared to 80 per cent in 2010)
- The shortest maximum waiting time was less than 1 week and the longest maximum wait 30-40 weeks ( up from 15 weeks in 2010)

### 3.2.3.7 Occupational health

There were responses from 48 departments.



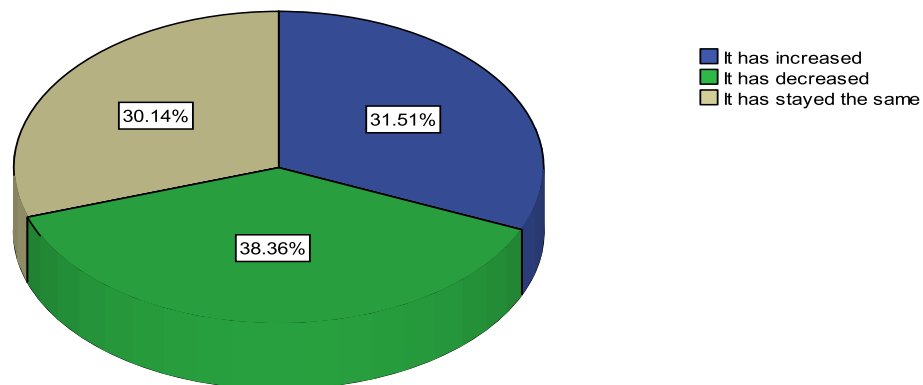
**Figure 10. Longest wait from referral to treatment – occupational health**

- For occupational health services the longest wait reported by the majority of respondents was less than 1 week (compared to 3 weeks in 2010)
- 100 per cent were seen in 8 weeks or less (compared to 7 weeks in 2010)
- The shortest maximum waiting time was less than 1 week, and the longest maximum wait 6-8 weeks.

### 3.3. Waiting time trends

There were 73 individual respondents to the question:

*“For all the outpatient physiotherapy services that you provide, what has been the trend in waiting times within your service over the last year?”*



**Figure 11. Trends in waiting times comparing 2009-2010 to 2010-2011**

Physiotherapy managers were asked to compare the trends in waiting times for outpatient physiotherapy, comparing the year ending March 2011 with the year ending March 2010.

- 32 per cent (23) reported that waiting times had increased
- 38 per cent (28) reported that waiting times had decreased
- 30 per cent (22) reported no change in the length of waiting time.

### 3.4 Possible reasons for increased waiting times

#### 3.4.1 Staffing changes

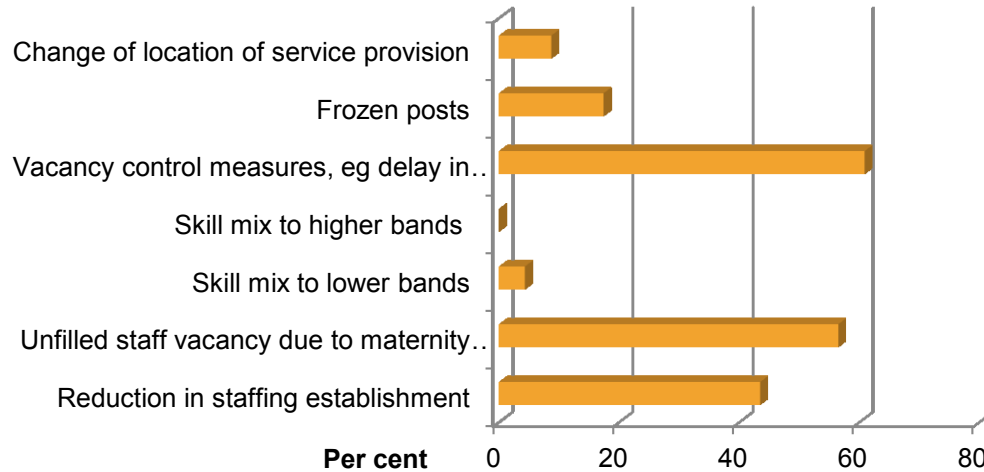
There were 23 respondents to the question:

*“If the trend in waiting times has increased over the last year, what is/are the cause(s)?”*

The staffing related issues that managers identified as relevant to increased waiting times were:

- Vacancy control measures
- Unfilled staff vacancies
- Reduction in staffing establishment
- Frozen posts
- Skills mix to lower bands

- Change of location of service provision.



**Figure 12. Staffing changes possibly contributing to increased waiting times**

### 3.4.1.1 Disestablished outpatient physiotherapy posts during 2010-2011

“If you have lost posts in your outpatient services during 2010/11, how many (WTE) posts have you lost per band?”

	N	Minimum	Maximum	Sum
<b>Band 3</b>	0			
<b>Band 4</b>	2	1.0	1.0	2.0
<b>Band 5</b>	5	1.0	4.0	12.0
<b>Band 6</b>	6	1.0	3.0	12.2
<b>Band 7</b>	7	0.2	6.0	10.7
<b>Band 8a</b>	2	0.5	0.5	1.0
<b>Band 8b</b>	1	1.0	1.0	1.0
<b>Band 8c</b>	0			
<b>Band 8d</b>	0			
<b>Band 9</b>	0			

**Table 5. Loss of outpatient physiotherapy posts during 2010-2011**



23 respondents reported loss of outpatient posts from band 4 to band 8b.

- The highest number of posts lost was six band 7 posts disestablished, reported by one respondent
- 38.8 WTE posts in total were lost.

### 3.4.1.2 Frozen outpatient physiotherapy posts during 2010-2011

*“If you have had posts frozen in your outpatient services during 2010/11, how many (WTE) posts have you had frozen per band?”*

	N	Minimum	Maximum	Sum
<b>Band 3</b>	0			
<b>Band 4</b>	0			
<b>Band 5</b>	3	1.0	2.0	4.0
<b>Band 6</b>	2	0.5	2.0	2.5
<b>Band 7</b>	0			
<b>Band 8a</b>	0			
<b>Band 8b</b>	1	0.5	0.5	0.5
<b>Band 8c</b>	0			
<b>Band 8d</b>	0			
<b>Band 9</b>	0			

**Table 6. Frozen outpatient physiotherapy posts during 2010-2011**

6 respondents reported frozen outpatient posts.

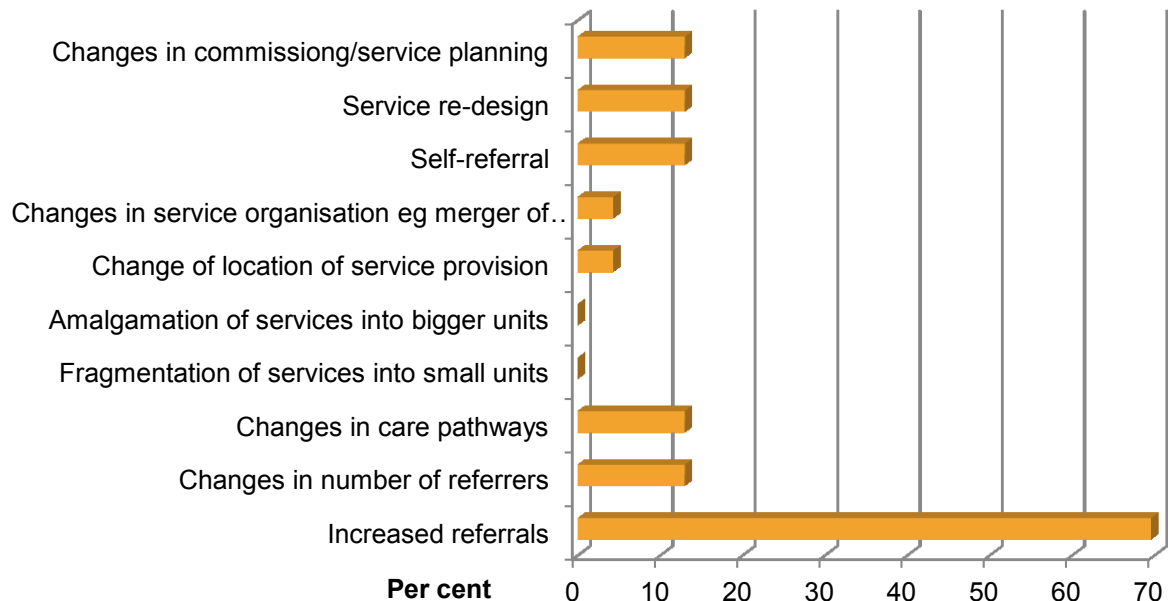
- 7 WTE posts were reported as frozen during 2010-2011
- As at 31/03/11 there were four WTE band 5 posts frozen, 2.5 WTE band 6 posts frozen, and 0.5 WTE of a band 7 post frozen.

As the number of respondents to this question is very small, the data must be treated with caution.

If the lost posts and frozen posts were added together, the figure might be more significant.

### 3.4.2 Changes in referral patterns

33 respondents reported change in referral patterns leading to increased waiting times.



**Figure 13. Referral pattern changes possibly leading to increased waiting times**

The reasons cited in this category were:

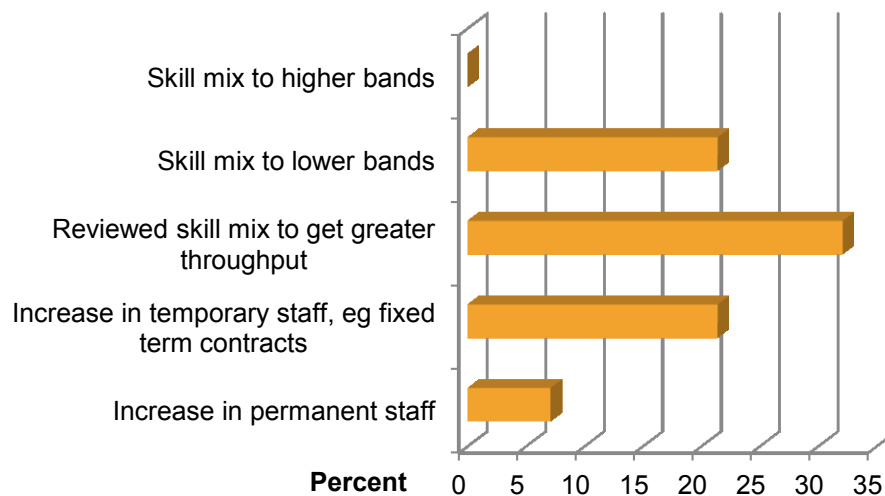
- Increased referrals
- Changes in the number of referrers
- Changes in care pathways
- Self-referral
- Service re-design
- Changes in commissioning/planning
- Changes in service organisation ( eg. merger)
- Change in location of service.

There were other reasons given, but it was not possible to attribute these to one cause.

### 3.5 Possible reasons for decreased waiting times

#### 3.5.1 Staffing changes

28 respondents reported decreased waiting times, 23 citing staffing changes as a cause.



**Figure 14. Staffing changes possibly leading to decreased waiting times**

The reasons cited were:

- 32 per cent (9), Review of skill mix to get greater throughput
- 21 per cent (6), Increase in temporary staffing
- 21 per cent (6), Skill mix to lower bands
- 7 per cent (2), Increase in permanent staff.

There were other reasons given, though these were individual responses and not possible to group, due to very limited information or comment given.

They included:

- Patient productivity targets set/ monitored
- Improved waiting time management processes (capacity and demand)
- Closer attention to MSK pathways
- Self referral is more frequent
- Changes in way of working.

### 3.5.1.1 Increased staffing

*“If you gained posts in your outpatient services in 2010/11, how many?”*

17 respondents reported an increase in staffing establishment for outpatient services.

	N	Minimum	Maximum	Sum
<b>Band 3</b>	3	1	2	4
<b>Band 4</b>	0			
<b>Band 5</b>	3	0	2	4
<b>Band 6</b>	7	1	3	10
<b>Band 7</b>	2	0	1	1
<b>Band 8a</b>	1	1	1	1
<b>Band 8b</b>	0			
<b>Band 8c</b>	1	1	1	1
<b>Band 8d</b>	0			
<b>Band 9</b>	0			

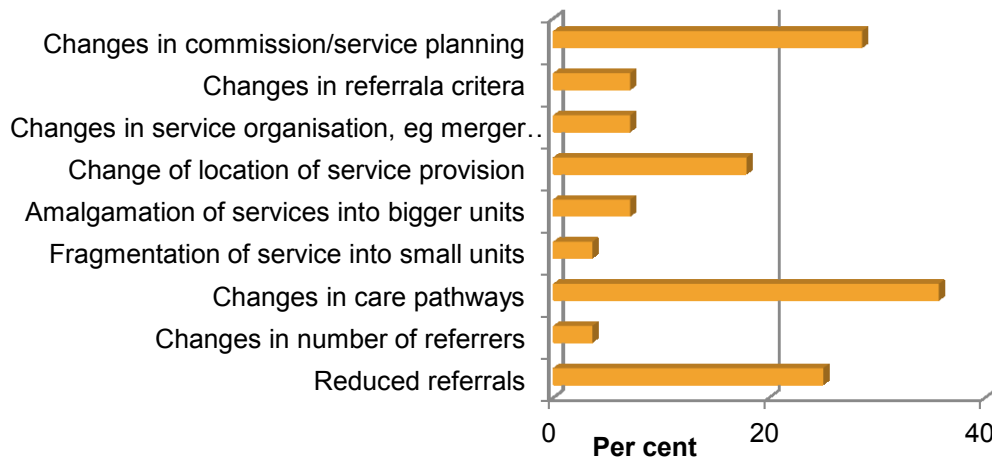
**Table 7. Increase in establishment of outpatient physiotherapy posts during 2010-2011**

- 21 new outpatient physiotherapy posts were established.

This compares with the 38.8 WTE posts that were disestablished, and the 7 WTE posts that were frozen, giving a net reduction of 24.8 WTE posts.

### 3.5.2 Changes in referral patterns

28 respondents reported decreased waiting times. There were nine main reasons for reduced waiting times relating to referral pattern changes.



**Figure 15. Referral pattern changes possibly leading to decreased waiting times**

The reasons cited were:

- 36 per cent (10) Changes in care pathways
- 29 per cent (8) Changes in commissioning/service planning
- 25 per cent (7) Reduced referrals
- 18 per cent (5) Change of location of service provision
- 7 per cent (2) Changes in service organisation, eg merger of organisation
- 7 per cent (2) Changes in referral criteria
- 4 per cent (1) Fragmentation of service into small units
- 4 per cent (1) Changes in number of referrers.

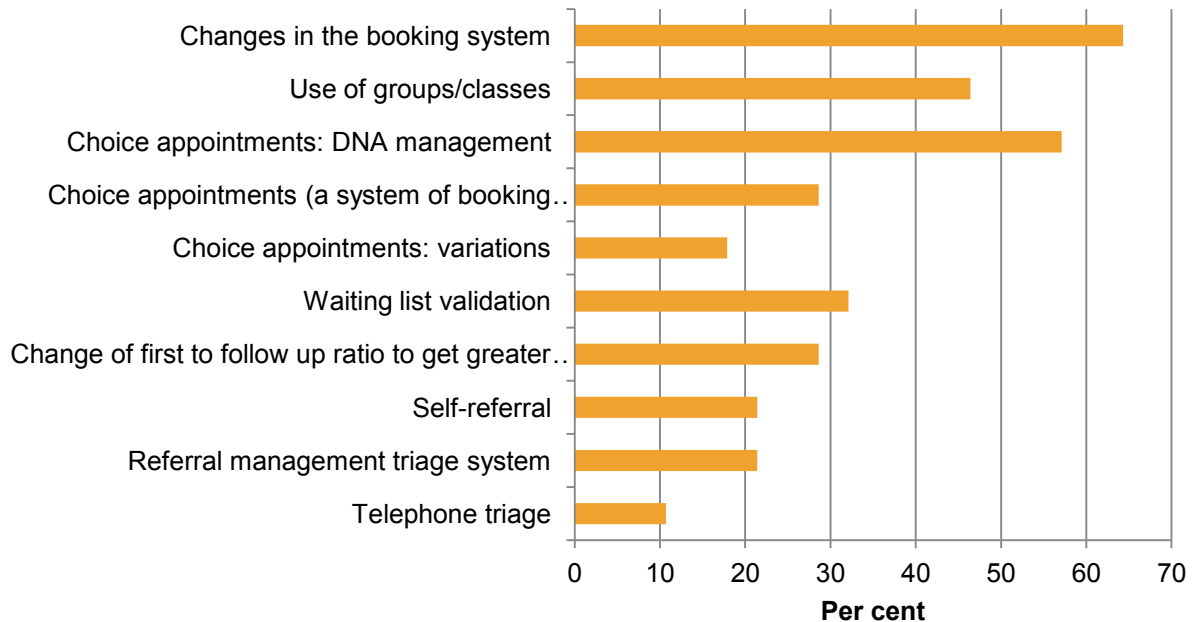
There were other reasons given, though these were individual responses and not possible to group due to lack of information given. They included:

- Introduced opt in booking system
- Occupational Health self referral introduced
- Have a limited self referral component and GP directed referral in existence
- Extended opening hours
- Introduction of education DVD
- Started centralised booking through call centre
- Advice was sent out to patients on receipt of referrals.

### 3.5.3 Capacity and demand management

There were 10 main reasons for reduced waiting times relating to capacity and demand management. These were:

1. 64 per cent (18) Choice Appointments (a system of booking first and following appointments by telephone): Changes in the booking system
2. 57 per cent (16) Choice appointments :DNA management
3. 46 per cent (13) Use of groups/classes
4. 32 per cent (9) Choice appointments: Waiting list validation
5. 29 per cent (8) Choice appointments
6. 29 per cent (8) Choice appointments : Change of first-to-follow-up ratio to get greater throughput
7. 21 per cent (6) Referral management triage system
8. 21 per cent (6) Self-referral
9. 18 per cent (5) Choice appointments: variations
10. 11 per cent (3) Telephone triage



**Figure 16. Possible reasons for decreased waiting times - capacity and demand management**

This demonstrates that the respondents were using multiple methods to support capacity and demand management.

### 3.5.3.1 “Choice Appointments” and variations

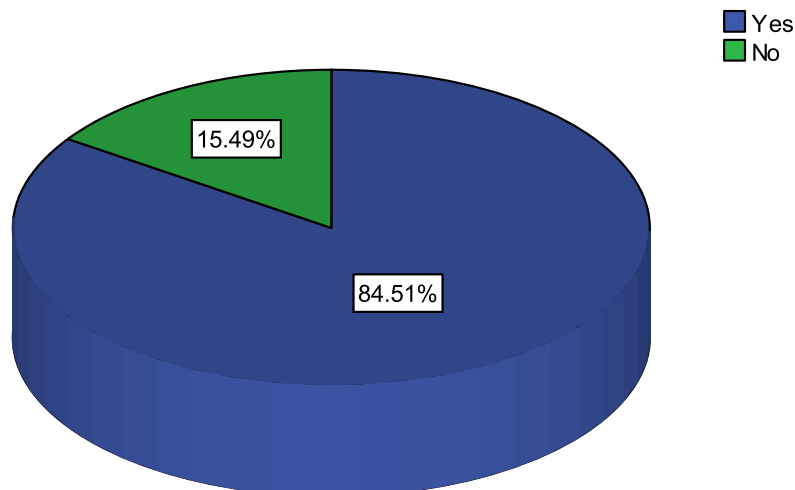
“Choice Appointments” is a system of booking first and follow-up appointments by telephone, with the aim of reducing DNA rates and thereby impacting favourably on waiting times. “Choice Appointments” and elements of its methodology featured highly in the methods cited to support capacity and demand management.

64 responses cited different aspects of “Choice Appointments” that contributed to reduced waiting times for outpatient physiotherapy.

### 3.6 Referral to treatment (RTT) targets

71 respondents answered the question:

*“Have you been set a target for referral to treatment by your commissioners?”*



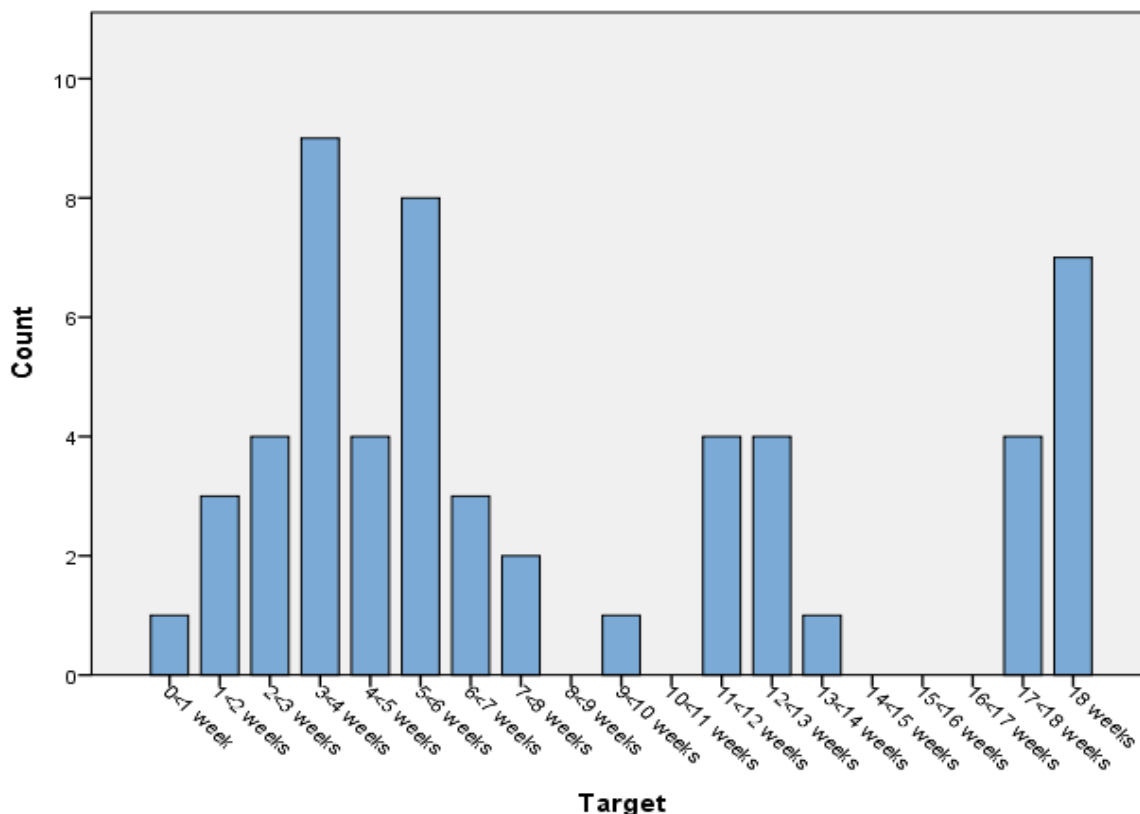
**Figure 17. Referral to treatment targets**

- 85 per cent of respondents (60) reported that their service had a target for RTT for outpatient physiotherapy
- 15 per cent (11) reported that their service did not have an RTT target for outpatient physiotherapy.

### 3.6.1 Length of RTT target

Of the 60 respondents who reported that they had a RTT target:

- The range of RTT set was between 0-1 weeks and 18 weeks
- The most frequent RTT set was 3-4 weeks (reported by 9 respondents)



**Figure 18. RTT in weeks**

- 8 respondents had their RTT set by national government, though not all Welsh and Northern Irish respondents reported that there was a national target, and 5 English respondents reported that there was a national physiotherapy target when there was not
- 24 respondents had the RTT set by a commissioner and/or service planner
- 15 respondents had the RTT set by themselves
- 10 respondents had the RTT set by their organisation.



### 3.6.2 RTT for year ending March 2011

	Frequency	Per cent
<b>Reported</b>		
The same as the year ending 31/03/2010	39	65.0
Longer than the year ending 31/03/2010	2	3.3
Shorter than the year ending 31/03/2010	15	25.0
<b>Total reported</b>	<b>56</b>	<b>93.3</b>
<b>Not reported</b>	<b>4</b>	
<b>Total respondents</b>	<b>60</b>	

*Table 8. RTT for year ending 31st March 2011*

- 65 per cent of the 60 respondents (39) reported the RTT on 31/03/2011 being the same as the previous year
- 3 per cent (2) reported the RTT on 31/03/2011 being longer than the previous year
- 25 per cent (15) reported the RTT on 31/03/2011 being shorter than the previous year.

## Section Four: Self referral

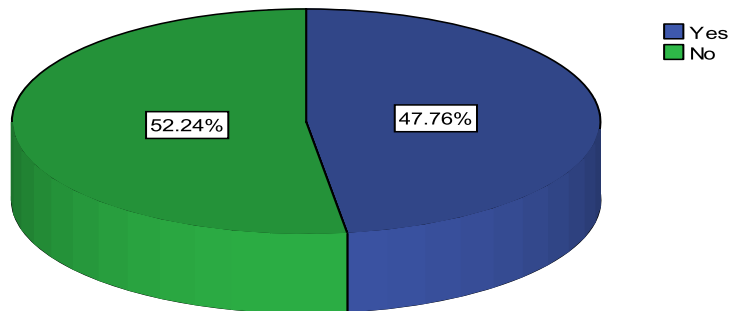
Self-referral is defined by the DH as:

*“Patients are able to refer themselves to an allied health professional without having to see anyone else first, or without being told to refer themselves by another health professional. This can relate to telephone, IT or face-to-face services”<sup>4</sup>*

### 4.1 Self referral data analysis

#### 4.1.1 Percentage of patients self-referring adhering fully to the DH definition

There were 67 respondents to this question.

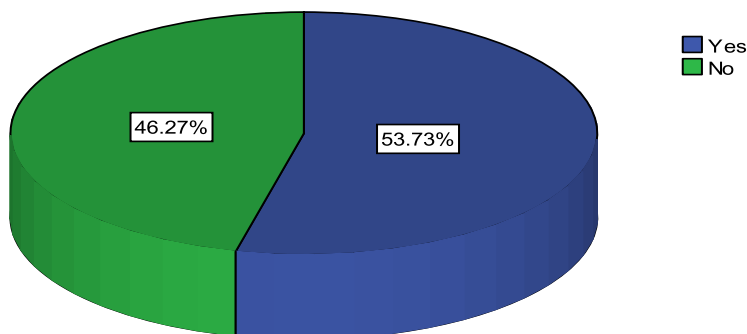


**Figure 19. Percentage of patients self-referring adhering fully to the DH definition**

- 48 per cent (32) provide self referral strictly following the DH definition
- 52 per cent (35) do not provide self referral using the DH definition.

#### 4.1.2 Physiotherapy outpatient self-referral directed by another health practitioner

There were 67 respondents to this question.

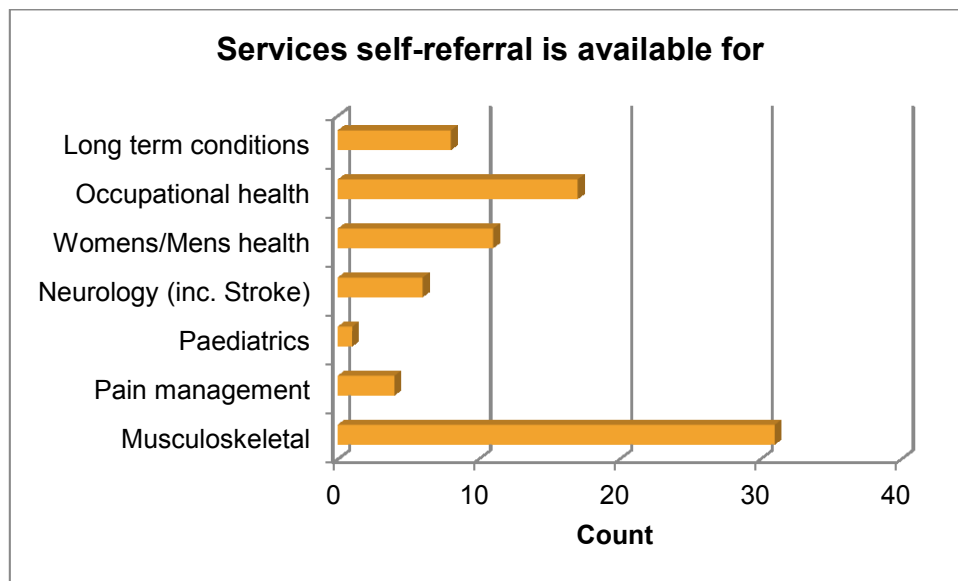


**Figure 20. Percentage of patients self-referring as directed by another healthcare practitioner**

- 54 per cent (36) provide self referral using the broader definition
- 46 per cent (31) did not provide self referral using the broader definition.

#### **4.1.3 Physiotherapy services available for self-referral**

There were 67 respondents to this question.



**Figure 21. Physiotherapy services available for self-referral**

- Musculoskeletal services have the greatest access to self-referral : 46 per cent (31) respondents
- 25 per cent (17) have self-referral for occupational health physiotherapy
- 16 per cent (11) have self-referral for women's/men's health
- 12 per cent (8) have self-referral for long term conditions
- 9 per cent (6) have self-referral for neurology (including stroke)
- 6 per cent (4) have self-referral for pain management
- 1.5 per cent (1) have self-referral for paediatrics.

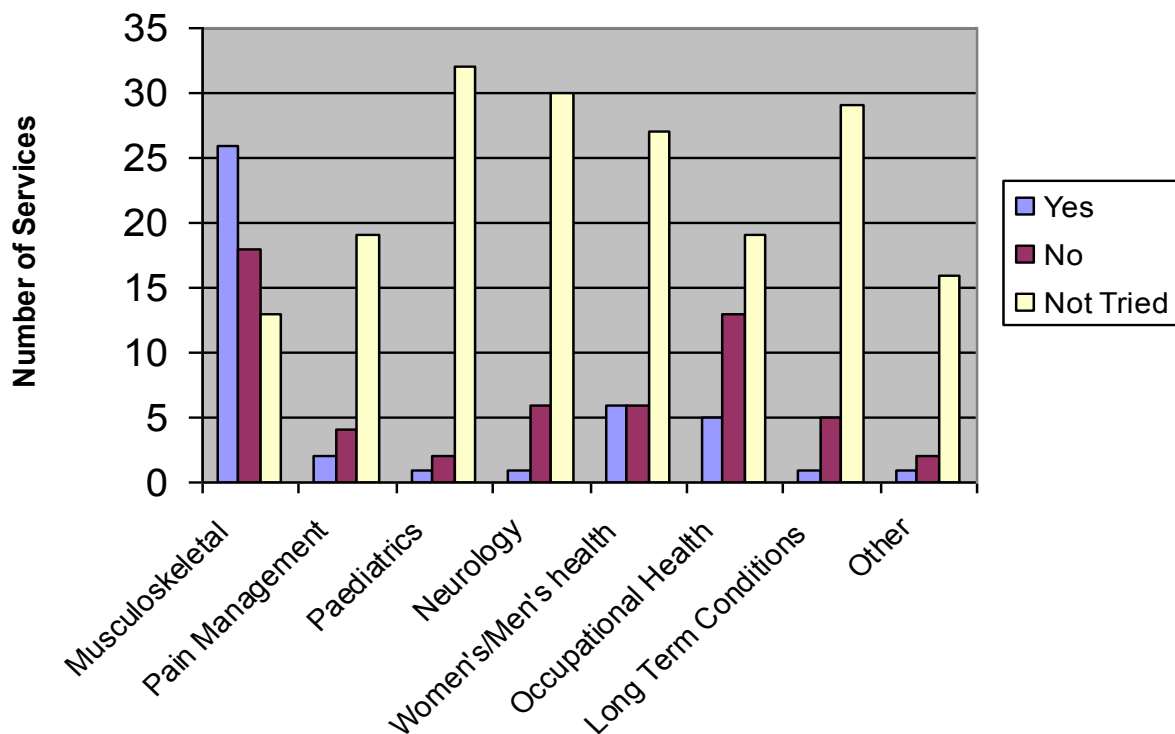
There were several other services for which self-referral was open. These included single sites mentioning that they were looking to pilot in the 2010/2011 financial year:

- Obstetrics and Gynaecology
- Respiratory out-patients
- Rheumatology
- Spinal cord Injury
- Prosthetics

- Urgent care centre
- Staff ( not via occupational health)

#### 4.1.4 Obstacles to introducing self referral

There were 67 respondents to this question.

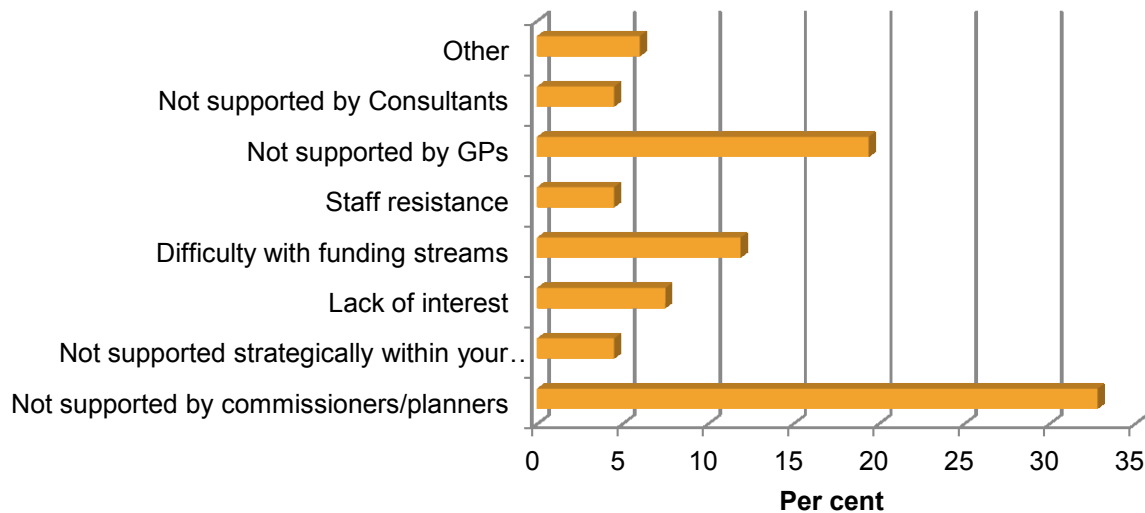


**Figure 22. Obstacles to introducing self referral**

- Musculoskeletal services had received the most resistance to establishing self-referral (26 services), though also the greatest success in implementing it (18 services). 13 services had not tried to introduce self referral.
- There was less success in initiating self-referral for other services, and also less resistance to its implementation.
- The non-musculoskeletal services had fewer attempts to introduce self-referral.

#### 4.1.5 Reasons for not offering self-referral

There were 67 respondents to this question.



**Figure 23. Reasons for not offering self-referral**

- 33 per cent (22) were not supported by commissioners/planners
- 19 per cent (13) were not supported by GPs
- 12 per cent (8) had difficulty with funding streams
- 7.5 per cent (5) reported lack of interest
- 4.5 per cent (3) were not supported by consultants
- 4.5 per cent (3) reported staff resistance
- 4.5 per cent (3) reported not being supported strategically within their organisation
- 6 per cent (4) reported other reasons including: finding a venue, other physiotherapy departments in the area, poor communication, and misunderstanding by GPs.

#### 4.2 Services providing self-referral: Comparison between 2008-2009, 2009-2010 and 2010-2011 surveys

	2008-2009	2009-2010	2010-2011
<b>Yes</b>	58 (45 per cent)	72 (41 per cent)	36 (54 per cent)
<b>Total respondents</b>	129	172	67

*Table 9. Self-referral: comparison between 2008-09, 2009-10 and 2010-11 surveys*

There were fewer respondents this year offering self-referral although, as a percentage of total respondents, this year was the highest percentage (54 per cent) offering self-referral.

However, the figures must be treated with caution due to the low response rate.

## Section Five: Physiotherapy activity and workforce

### 5.1. Musculoskeletal outpatients

There were 69 respondents to this question.

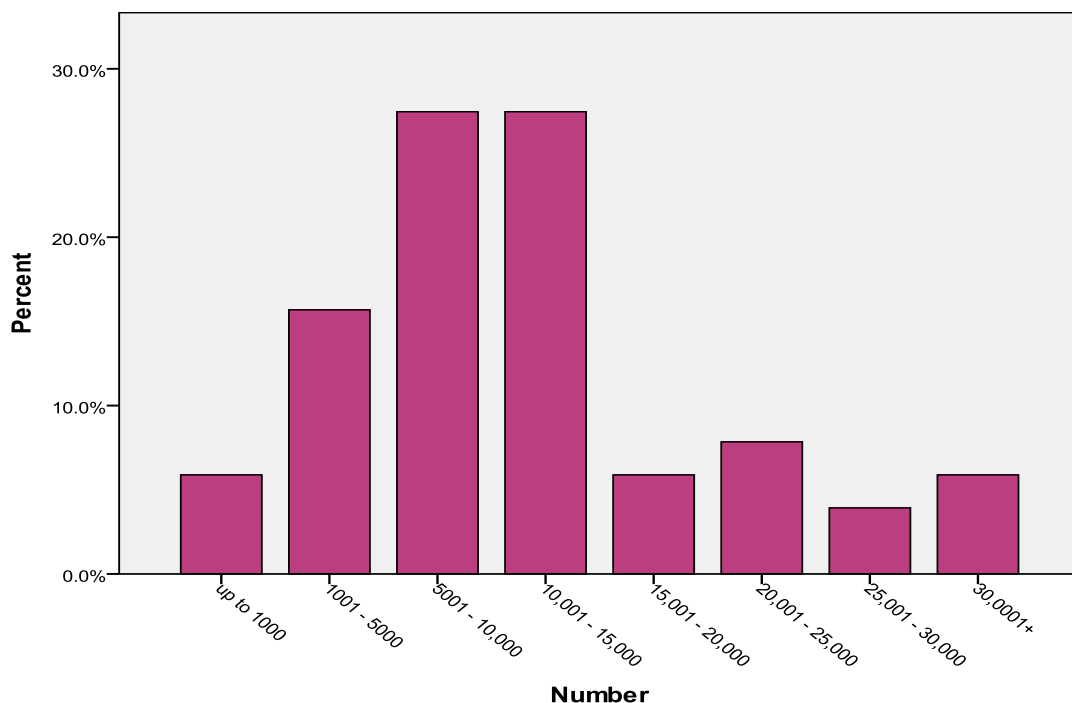
- 66 respondents provided musculoskeletal physiotherapy services, making this the most commonly provided outpatient physiotherapy service.

#### 5.1.1 Number of physiotherapy referrals for year ending 31/03/2011

There were 51 respondents to this question.

	N	Minimum	Maximum	Sum	Mean	Std. Deviation
Number of patients referred	51	368	44,827	595,097	11668.5	9077.52

**Table 10. Number of musculoskeletal new patient referrals 2010-2011**

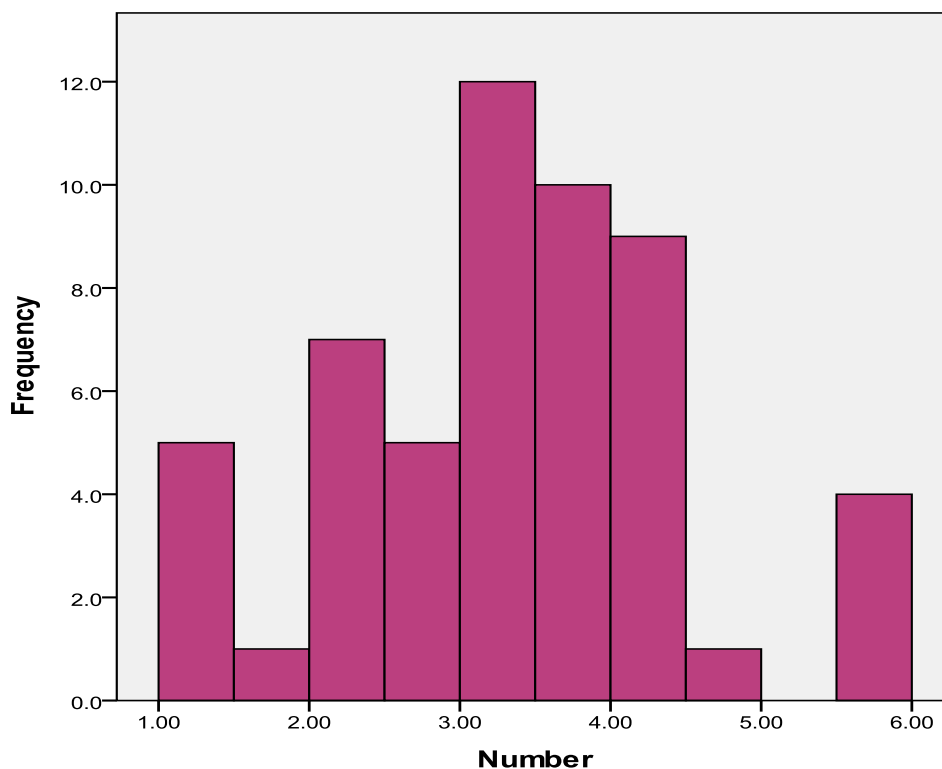


**Figure 24. Number of musculoskeletal new patients referred 2010-2011**

- 51 respondents reported a total of 595,097 patient referrals for outpatient musculoskeletal physiotherapy during the year 2010-2011
- The smallest service reported 368 referrals and the largest 44,827
- The mean number of referrals was 11,669.  
In 2010 the mean number of referrals was 9,693
- In 2009, 36 per cent of respondents reported the majority of referrals in the 5,001-10,000 category, with only 22 per cent reporting the majority of referrals in the 10,001-15,000 category

### 5.1.2 Average number of face-to-face contacts

There were 54 respondents to this question.  
The data is displayed as a histogram.



**Figure 25. Musculoskeletal outpatients average face-to-face contacts**

- The minimum number of physiotherapy treatments was 1, the maximum was 6
- The average number of contacts was 3.31
- The average first to follow-up ratio was 1:2.31  
This compares with the 2009-2010 average first to follow-up ratio of 1:3.41.



### 5.1.3 Did Not Attend (DNA) rate

A DNA is a wasted appointment slot, caused by a patient who does not attend an appointment (whether they cancel or do not turn up on the day) and the appointment slot is unused.

A DNA can be for a first or follow-up appointment.

There were 53 respondents to this question.

	N	Minimum per cent	Maximum per cent	Mean per cent	Mode per cent
DNA rate	53	0	39	9.45	10.0

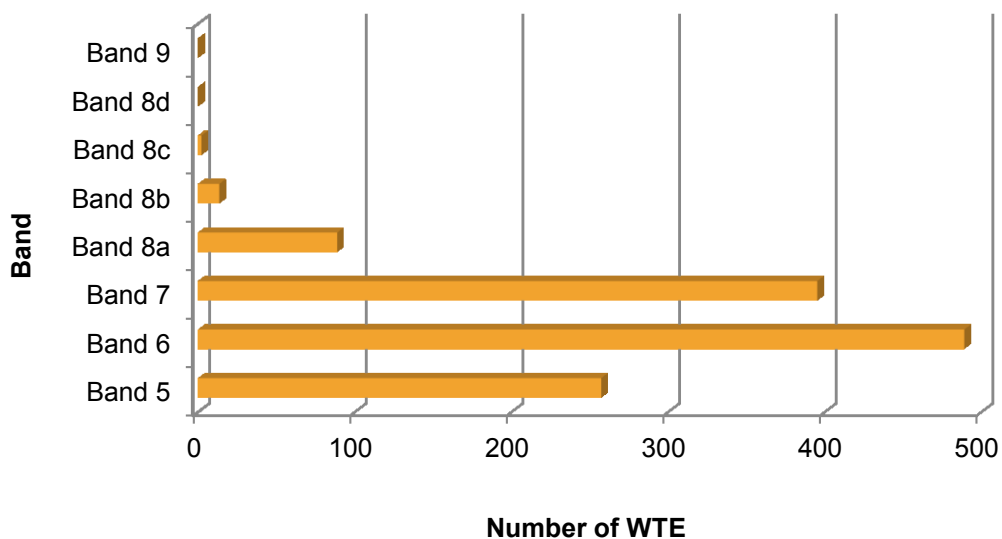
**Table 11. Musculoskeletal DNA rate**

- The lowest DNA rate was 0 per cent
- The highest DNA rate was 39 per cent
- The average DNA rate was 9.45 per cent
- The mode was 10 per cent.

In 2009-2010 the mean DNA was 9.58 per cent, signifying no great change since last year.

### 5.1.4. Clinical workforce: HPC registered staff

There were 57 respondents to this question.



**Figure 26. Musculoskeletal outpatients clinical workforce: HPC registered staff**

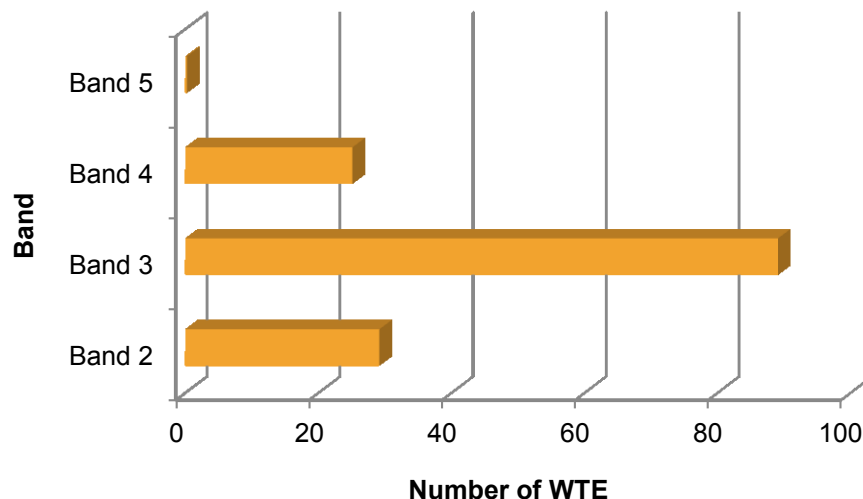
It is difficult to make comparison with 2009-2010, as the number of respondents to this question was small.

However, the band volumes correlate with the greatest proportion of staff being band 6, followed by band 7, band 5, band 8a, and band 8b.

There were no band 8c posts reported in 2010-2011, compared with 6.1 WTE in the previous year. This raises a question about the physiotherapy consultant workforce and whether this band has been downgraded or removed.

### **5.1.5 Clinical workforce: assistants**

There were 57 respondents to this question.



**Figure 27. Musculoskeletal outpatients clinical workforce: assistants**

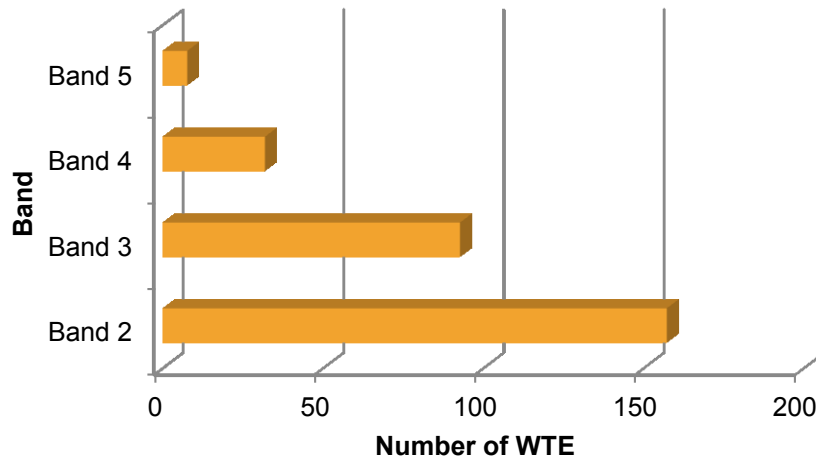
- Band 3 is the most commonly occurring support worker band in musculoskeletal outpatients.
- In 2009-2010 there were twice as many band 3 staff as band 2.
- In 2010-2011 the proportion of band 3 staff to Band 2 had increased, with a slight reduction in the proportion of band 4 staff.

### **5.1.6. Musculoskeletal workforce: administration and clerical**

There were 57 respondents to this question.

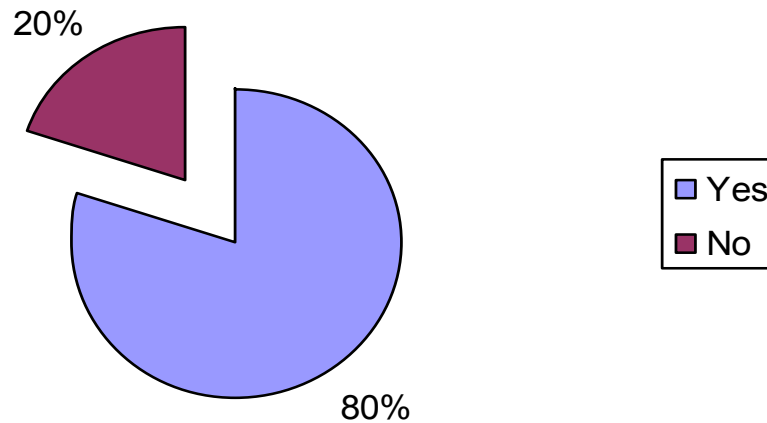
The number of respondents detailing their A&C staffing was lower in 2010-2011, making comparison with 2009-2010 difficult due to low response rate.

As in 2009-2010, band 2 was the largest administrative band.



**Figure 28. Musculoskeletal outpatients clinical workforce: admin and clerical**

### 5.1.7 Standard for new patients per WTE physiotherapist per week



**Figure 29. Standard for new patients per WTE physiotherapist per week**

In 2010-2011 80 per cent of respondents reported that they had a standard set for the number of new patients per week that one WTE physiotherapist should treat.

This compares with 70 per cent in 2009-2010, demonstrating a step change in capacity management.

### 5.1.8 Number of new patients per week by band

14 respondents provided data for this question.

	N	Minimum	Maximum	Mean	Std. Deviation
<b>Band 5</b>	44	0	20	11.54	3.82
<b>Band 6</b>	45	8	25	13.21	3.49
<b>Band 7</b>	40	0	25	12.53	4.55
<b>Band 8a</b>	15	0	20	12.06	4.90

**Table 12. Number of new patients per week by band**

There were differences for each Agenda for Change band. The number of new patients per WTE was similar to 2009-2010.

These figures must be treated with caution due to the very low response rate.

### 5.1.9 Average number of new patients per annum by band

This data is based on the mean number of new patients identified in Table 12 above, multiplied by 41 (the number of weeks JJ Consulting consider a WTE physiotherapist works each year).

Band	Average new patients per annum per physiotherapist
<b>Band 5</b>	471
<b>Band 6</b>	541
<b>Band 7</b>	512
<b>Band 8a</b>	492

**Table 13. Average new patients per annum by band**

## 5.2 Inpatient trauma and orthopaedic services

2010-2011 was the first year for which this data was collected.

- 38 respondents reported that they provided trauma and orthopaedic inpatient services.
- 32 provided data on the number of trauma and orthopaedic beds.

### 5.2.1 Number of trauma and orthopaedic beds

	N	Minimum	Maximum	Mean	Std. Deviation
Number of inpatient T&O beds	32	50	194	74.45	39.32

*Table 14. Number of trauma and orthopaedic beds*

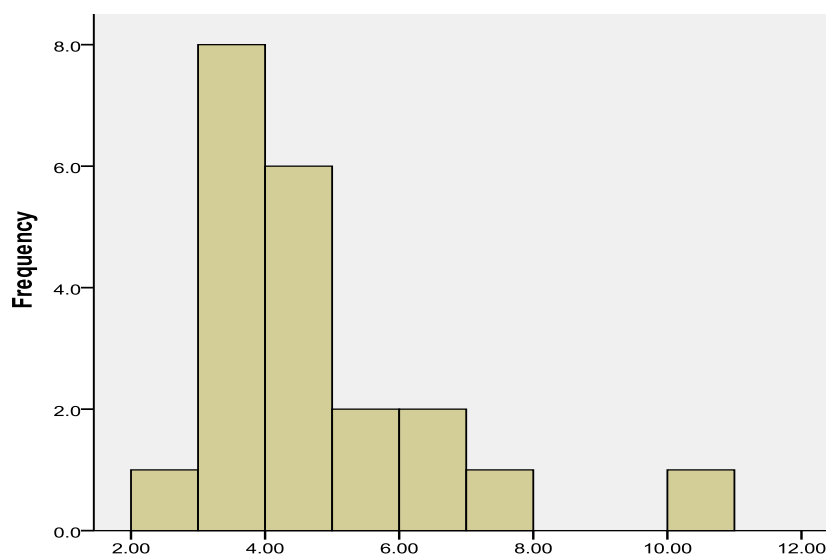
- The mean number of trauma and orthopaedic inpatient beds was reported to be 74.
- The largest unit had 194 beds.

### 5.2.2 Average face to face contacts

*“What are your average physiotherapist total face-to-face contacts for T&O patients?”*

There were 21 respondents to this question.

The data is presented as a histogram.



**Figure 30. Trauma and orthopaedics – average face-to-face contact per patient**

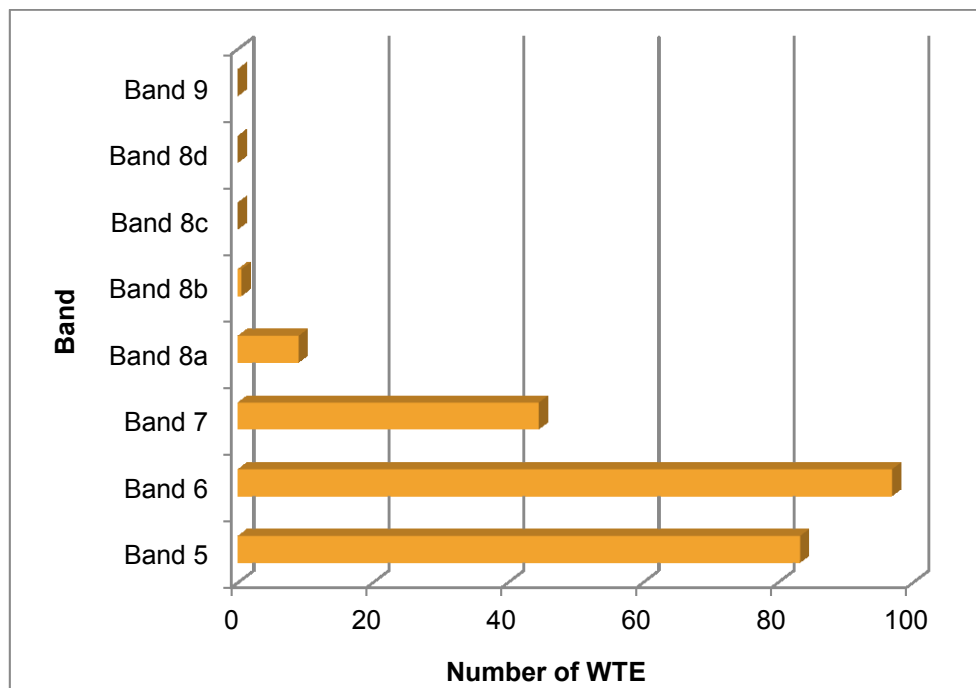
The average number of face-to-face contacts for a trauma and orthopaedic inpatient physiotherapy service was 4.8.

This is the first time that this data has been gathered nationally.

### 5.2.3 Trauma and orthopaedic HPC registered staff – WTE

*“Please indicate the number of Whole Time Equivalentents for each band. (If they provide service for more than T&O, please apportion the approximate WTE input to this service only).”*

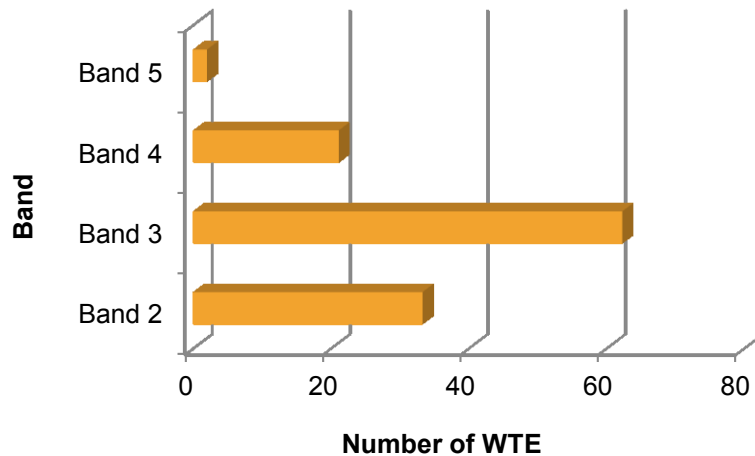
There were 21 respondents to the question.



**Figure 31. Trauma and orthopaedic HPC registered staff – WTE**

- The most common physiotherapist band on trauma and orthopaedic inpatient wards was band 6, followed by band 5.
- There were half as many band 7 staff as there were band 5, with a few band 8a staff.

### 5.2.4 Trauma and orthopaedic assistant staff – WTE



**Figure 32. Trauma and orthopaedic assistant staff – WTE**

Band 2 and 3 assistants combined outnumbered band 5 physiotherapists on trauma and orthopaedic wards.

### 5.2.5 Trauma and orthopaedic weekly service provision

There were 31 respondents to the question asking when the physiotherapy service to T&O was provided.

		Frequency	Per cent
<b>Provision</b>	Monday - Friday only	2	6.5
	Full service - 7 days a week	3	9.7
	7 day service with reduced input Saturday and Sunday	23	74.2
	6 day service with reduced input at the weekend	3	9.7
<b>Total</b>		31	

**Table 15. Trauma and orthopaedic weekly service provision**

- 74 per cent (23) of respondents provided a seven day service - with reduced input at the weekend.
- 10 per cent (3) provided a six day service
- 10 per cent (3) provided a full service seven days a week
- 6 per cent (2) provided a weekday service only.

### 5.3. Stroke services

*“Do you provide a stroke service?”*

In answer to the question there were 67 respondents.

	Frequency	Percent
<b>Yes (community-provided care only - intermediate care and outpatient)</b>	5	8
<b>Yes (inpatient stroke service only)</b>	28	42
<b>Yes (both inpatient care and community-provided care)</b>	11	16
<b>No</b>	23	34
<b>Total</b>	67	100.0

**Table 16. Stroke physiotherapy service**

- 42 per cent provided an inpatient stroke service
- 34 per cent did not provide any physiotherapy for stroke
- 16 per cent provided both inpatient and community stroke services
- 8 per cent provided only a community stroke service.

The majority of respondents provided an inpatient stroke service, with fewer respondents providing a community service.

Only one service provided data on an early supported stroke discharge service - a Royal College of Physicians recommended model of service provision.

#### **5.3.1 Stroke inpatient service**

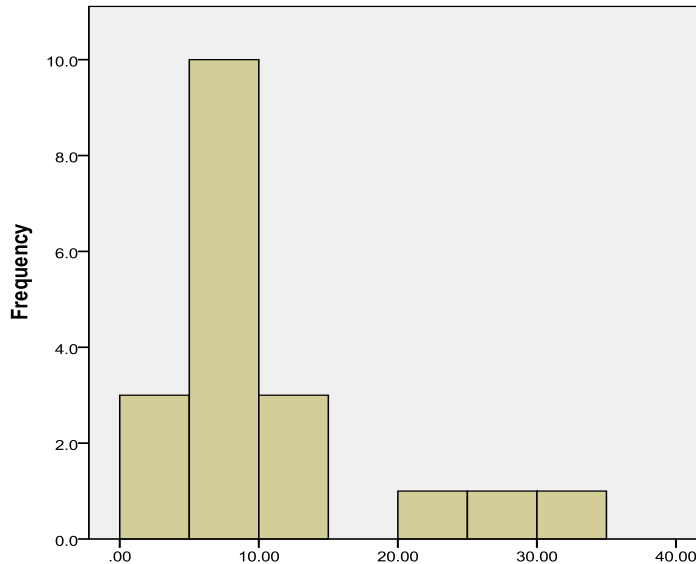
##### **5.3.1.1 Average number of face-to-face contacts**

The data is presented as a histogram below.

The average number of physiotherapist contacts with a stroke patient on an inpatient ward was 10.3.

The average number of beds reported in an inpatient stroke unit was 32.



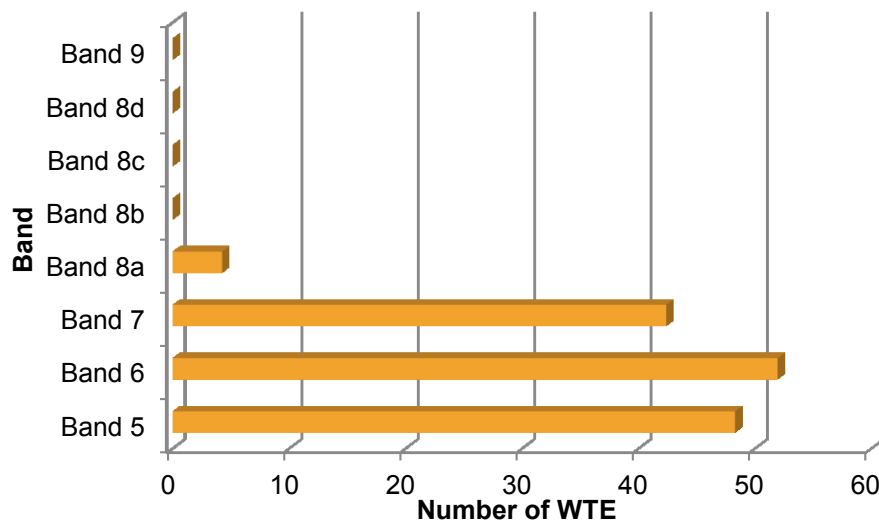


**Figure 33. Stroke inpatient care – average face-to-face contact per patient**

### 5.3.1.2 Stroke inpatient HPC registered staff – WTE

“Please indicate the number of WTE physiotherapists for each band.”

There were 31 respondents to this question.

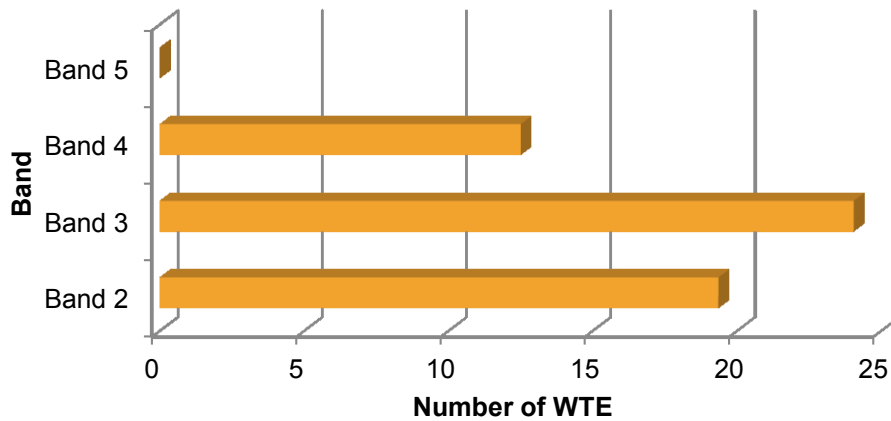


**Figure 34. Stroke inpatient HPC registered staff – WTE**

The inpatient stroke physiotherapist workforce comprises fairly equal numbers of bands 5, 6 and 7, a richer skill mix than trauma and orthopaedics.

### 5.3.1.3 Stroke inpatient assistant staff – WTE

There were 31 respondents to this question.



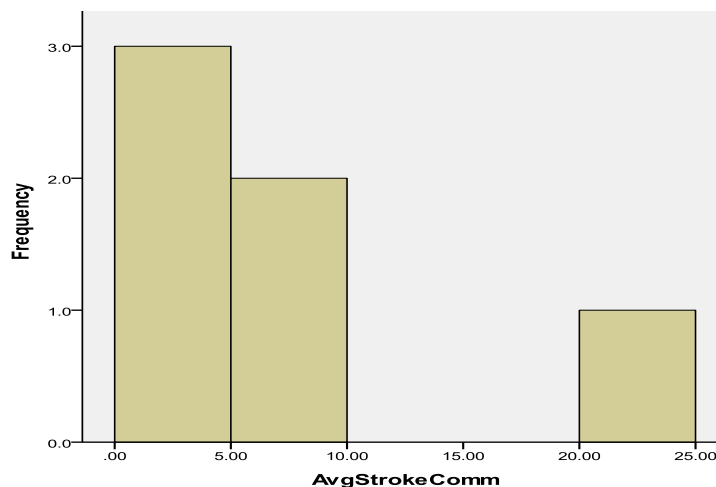
**Figure 35. Stroke inpatient assistant staff – WTE**

The assistant inpatient workforce for stroke is approximately one-third of the registered staffing establishment.

### 5.3.2 Community stroke workforce

#### 5.3.2.1 Community face-to-face contacts

6 respondents provided data on their community stroke activity. The data is presented as a histogram.



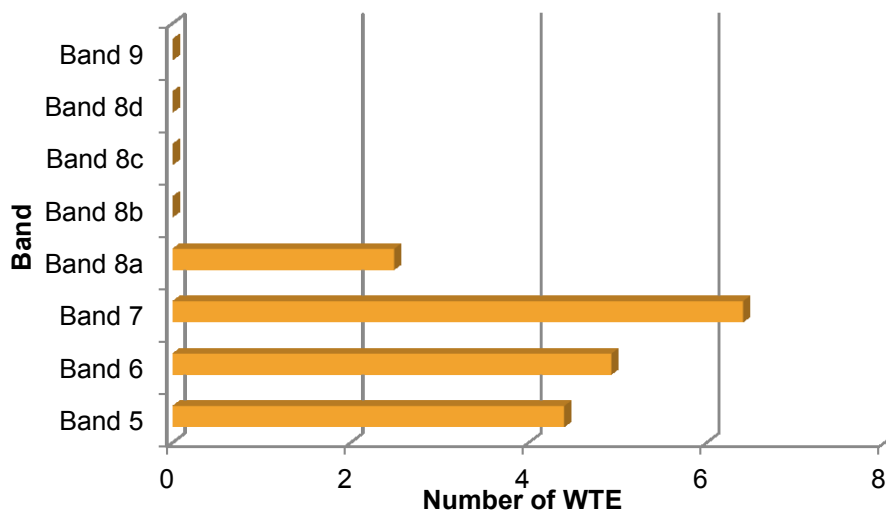
**Figure 36. Community stroke workforce – face to face contacts**

The average number of face-to-face contacts in the community was 7.

Caution should be taken interpreting this data due to the small number of responses.

### 5.3.2.2 Community HPC registered staff – WTE

6 respondents provided data.

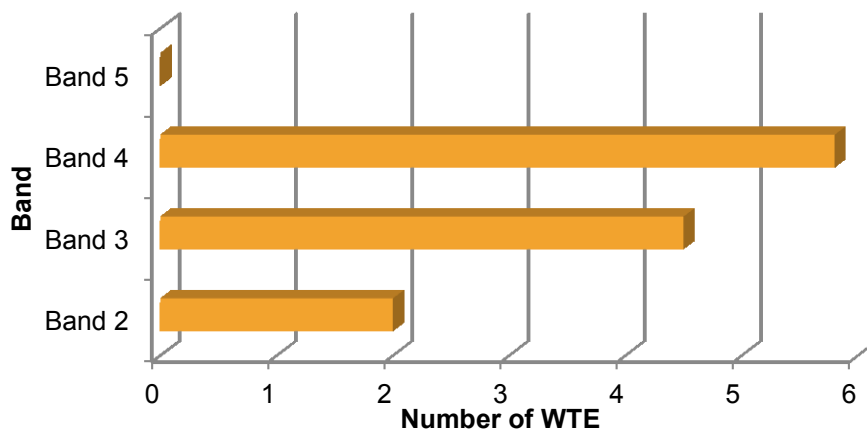


**Figure 37. Stroke community HPC registered staff – WTE**

In the community band 7 was most prevalent. The skill mix appears to be richer than that of the inpatient stroke services.

Caution should be taken interpreting this data due to the small number of responses.

### 5.3.2.3 Community assistant staff – WTE



**Figure 38. Stroke community assistants – WTE**



Community stroke physiotherapy assistants make up a greater proportion of the workforce than in the inpatient service, counterbalancing the more highly banded community physiotherapist posts.

Caution should be taken interpreting this data due to the small number of responses.

## 5.4 Accident and Emergency

*“Do you provide an Accident & Emergency (A&E) physiotherapy service?”*

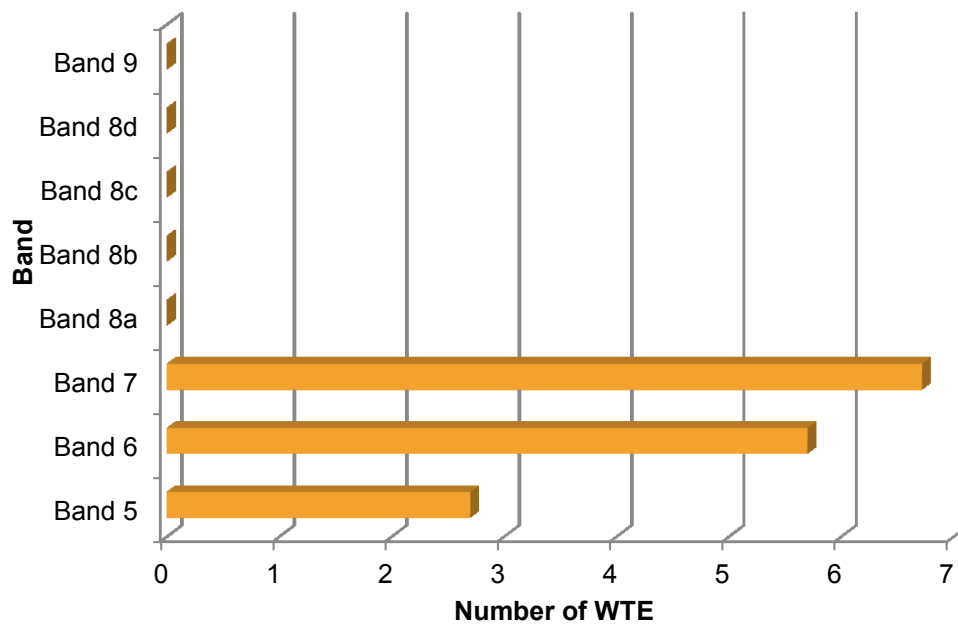
66 respondents answered the question.

- 26 per cent (17) responded Yes
- 74 per cent (49) responded No.

### 5.4.1 A&E WTE

*“Please indicate the number of WTE physiotherapists by band working in A&E”.*

There were nine respondents to the question.



**Figure 39. A&E - WTE**

- Bands 7 and 6 largely make up the A&E physiotherapy workforce, with few band 5 posts.
- There were only 2 assistants reported to be providing A&E physiotherapy.

Caution should be taken interpreting this data due to the small number of responses.

## 5.5. Out-of-hours respiratory service

Out-of-hours respiratory services operate almost entirely in acute settings, 95 per cent of which had an A&E department. So little data was provided for community settings that analysis was not practical.

Out-of-hours respiratory physiotherapy service was provided in the following:

- 64 per cent (28) in acute organisations
- 25 per cent (11) in organisations that provide acute and community services
- 9 per cent (4) in Health Boards (which provide acute and community services)
- 2 per cent (1) in a community-only service which provided a Monday-Friday service

### 5.5.1 Provision of acute hospital out-of-hours respiratory service

36 respondents provided data.

- 92 per cent (33) provided the service 365 days/year
- 8 per cent (3) provided an out-of-hours respiratory service at weekends only.

For the 365-day service:

- 77 per cent used an “on-call” model of provision
- 23 per cent provided an extended day service supplemented by “on-call” overnight.

### 5.5.2 Monthly provision of respiratory on-call

33 respondents provided data.

Hours of on-call/ month	Frequency	Per cent
0 - 19	9	27.3
20 - 39	6	18.2
40 - 59	4	12.1
60 - 79	2	6.1
80 - 99	12	36.4
<b>Total</b>	<b>33</b>	<b>100.0</b>

*Table 17. Monthly provision of respiratory on-call*

- 36 per cent (12) respondents provided a sizeable 80-99 hours of on-call respiratory physiotherapy per month
- 28 per cent (9) provided a small on-call respiratory physiotherapy service of 0-19 hours per month
- The remaining 36 per cent provided intermediate levels of input.

#### ***5.5.3 Breadth of physiotherapy respiratory on-call service***

- 72 per cent provided one on-call rota for one hospital site
- 6 per cent provided one on-call rota for multiple hospital sites
- 22 per cent provided multiple on-call rotas for several hospital sites

#### ***5.5.4 Justification of physiotherapy respiratory on-call service***

37 respondents provided data.

- 19 per cent (7) had been challenged about their on-call service and had been required to justify its continuance
- 24 per cent (9) expected to be challenged to defend the continuance of their on-call service.

## 5.6 All specialties – staffing ratio

### 5.6.1 Ratio of assistants and clerical staff to physiotherapists

For the six services listed below, the number of WTE staff were collated to give an overview of the ratio of HPC registered staff to assistants and admin/clerical staff.

Specialty	Qualified staff	Assistants	Admin/ clerical	Total staff	Percentage assistants to whole workforce	Percentage admin/ clerical to whole workforce
Musculoskeletal outpatients	1245.87	143.64	289.47	1678.98	9	17
Trauma and orthopaedics inpatients	234.16	118.74		352.9	34	
Stroke (inpatient)	146.9	55.92		202.82	28	
Stroke (community-provided care)	18.23	12.3		30.53	40	
Stroke (early supported discharge)	3.0	3.0		6.0	50	
Accident & Emergency	15.12	2.3		17.42	13	

**Table 18. All specialties: ratio of assistants and clerical staff to physiotherapists**

Respondent numbers for the specialties varied considerably, with generally low numbers of respondents, therefore generalisations should not be made based on this data.

- In musculoskeletal outpatients, assistants make up 9 per cent of the workforce and admin/clerical 17 per cent - though the admin/clerical staff often support whole physiotherapy services, not solely outpatients
- In trauma & orthopaedics inpatients, assistants make up 34 per cent of the workforce
- Stroke (inpatient care) assistants make up 28 per cent of the workforce
- Stroke (community-provided care) assistants make up 40 per cent of the workforce
- Stroke (early supported discharge) assistants make up 50 per cent of the workforce
- Accident & Emergency assistants make up 13 per cent of the workforce.





Assistants are an integral part of the physiotherapy workforce in a wide variety of specialties.

Outpatients remains the area where assistants are least deployed.

## **Section Six: Summary of key points and recommendations**

### **6.1 Summary of key points**

This report sets out a range of data and information about physiotherapy waiting times, workforce and caseloads in the four countries of the United Kingdom for the financial year 2010-2011.

The report builds on the database developed in the previous two reports covering 2008-2009 and 2009-2010.

The workforce and caseload elements contain information on:

- Musculoskeletal outpatient physiotherapy services
- Inpatient trauma and orthopaedics
- Stroke services
- Accident & Emergency
- Physiotherapy assistants and administrative and clerical support staff.

In the current environment of the "fiscal ice-age", where there is also infinite demand and finite resources and in which the NHS is undergoing the greatest upheaval, reorganisation and reconfiguration in its history, the information available through this report will be a useful resource for the CSP and its membership.

There was a smaller response to the questionnaire in 2010-2011 than in either of the previous two years; however, data was provided on twice as many physiotherapy departments (401, compared with data on 204 departments in 2008-2009).

The sample population was 220, and responses were received from 109 senior physiotherapy managers and leaders for 141 provider organisations. This represented a response rate of 50 percent for individuals, but 64 per cent of the organisations in the sample.

However, not all respondents answered all the questions, and therefore caution is advised in using some of the information in the report; although, taken with the evidence contained in the first two reports, it contributes to a growing database.

A 64 per cent overall response rate is generally regarded as excellent. The advice received from four university research departments and two national survey organisations was that a 40 per cent return is "excellent" for national surveys. Therefore much of the information can be used with confidence.

The survey indicates average longest waiting times of 6 to 8 weeks compared with 7 weeks in the previous survey, therefore broadly in line with previous results.

A DNA is defined as a wasted slot through the non-attendance of first or follow-up appointments for whatever reason. The DNA data submitted by the respondents was broadly similar to the results for the previous survey, indicating a very small reduction, the average figure for DNA being 9.45 per cent compared with 9.54 percent last year, therefore also broadly unchanged.

The number of provider organisations offering "Choice Appointments" or a variation of this increased from 29 in the last survey to 64. The lowest DNA figure was 0% and the highest outlier reported was 39%.

For self referral, survey responses were low; but of those responding, 54 per cent of provider organisations offered it.

This is an increase in the percentage offering self referral on last year, but based on a smaller sample.

First to follow-up ratios in musculoskeletal outpatient physiotherapy decreased significantly.

In 2009-2010 the survey indicated a first to follow-up ratio of 1 to 3.41, i.e. an average of 4.41 contacts per physiotherapy episode.

This survey shows a decreased average ratio of 1 to 2.31, giving a total average number of face-to-face contacts of 3.31 per episode of physiotherapy.

This is a decrease of 1.1 face-to-face contacts on average compared with last year.

Case load and workforce data was presented in Section Five, but the response rate was low, therefore caution is required in making generalisations.

Nevertheless, the survey is a useful start to establishing a knowledge base on which to build to provide information for the Society, and in time to support managers and leaders in the development of business cases, service planning, performance management and the development of key performance indicators (KPIs).

For the first time data on average numbers of interventions in Trauma and Orthopaedics inpatients (4.8) and stroke inpatients (10.3) was collected on a national sample.

Due to the small number of organisations in Scotland, Northern Ireland and Wales, it was not considered that analysing the data obtained from them separately would change the statistical significance of the results; therefore, aggregate data has been

used throughout the report. However, the data for Northern Ireland, Scotland and Wales will form a valuable baseline.

## **6.2. Recommendations**

The authors were invited in the commissioning of this work to make key recommendations for the CSP to consider:

### **6.2.1 Communication and publicity**

1. Sections of the report are published and circulated widely within the profession, so that the information can be used by physiotherapy managers and leaders as a resource to support their management and service development work.
2. The report is used as a source of information and evidence in a variety of contexts and settings such as lobbying.
3. The CSP ensures that the managers' contact list is kept fully updated on an ongoing basis.
4. Once published, the CSP again allow reference to the report on the authors' JJ Consulting website.

### **6.2.2 Caseloads and workforce**

5. The CSP considers commissioning work on caseloads and workforce in further clinical specialties to be agreed.
6. The CSP considers the development of minimum standards for workforce and caseload requirements using the information from this series of reports and other sources.

### **6.2.3 Waiting times**

7. The CSP continues to raise awareness of the importance of short waiting times for outpatient physiotherapy interventions.
8. The CSP commissions further work to survey waiting times in the four countries of the UK to build on the initial database.

### **6.2.4 Did Not Attend**

9. The CSP continues to strongly support the profession in striving to minimise DNAs in order to improve clinical effectiveness, management efficiency and elimination of waste.



### **6.2.5 Self-referral**

10. The CSP continues to support and promote self-referral to physiotherapy services more widely to commissioners and provider organisations.

### **6.2.6 Information management and technology**

11. The CSP continues to raise awareness as appropriate about the lack of computerised information systems available to physiotherapists in a large number of provider organisations throughout the UK.
12. To support the CSP membership with regard to the mandatory data collection work that commences in England on 1st April 2013, and share experiences from others who have already submitted national data.

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## **Appendix 1: Text of the invitation to participate in the survey**

This invitation was sent to physiotherapy managers and leaders from the Chief Executive of the CSP on 31 May 2011.

Dear Physiotherapy Manager/Lead

The CSP would **strongly encourage all senior physiotherapy managers/leads** to assist in the completion of the enclosed **independent** (and **confidential**) survey of **current physiotherapy waiting times/workforce/workload in the four countries of the United Kingdom**. If you complete the survey by Friday 17<sup>th</sup> June 2011, you will be entered into a draw to **win the latest version of the iPad**.

The Department of Health in England will be collecting (first on a voluntary basis from 2010 and then mandatory from 2012) waiting time data for physiotherapy and other AHPs for the first time and the Welsh Assembly Government already require this data to be collected. It is essential that the profession has an idea of the current base line position on physiotherapy waiting times in order to determine if (at regional and national levels) the state of average waiting times are improving. This is also vital for CSP being able to lobby on behalf of the profession.

The CSP has therefore **commissioned Dr Robert Jones and Fiona Jenkins (JJ Consulting)** to conduct this independent survey, which **needs your help**. The Society has also added 2 sections on out-of-hours working and the effect of the NHS reforms. The information from employing organisations will remain **completely confidential** and none of it will be identifiable. It will be used to form broad regional and national **averages**, which will be useful to managers and decisions makers in judging how much overall progress is being made. Please respond to the survey as soon as possible, your help is very much appreciated.

Click below to access the survey:

[https://www.surveymonkey.com/s/Physio\\_Wait\\_Times\\_2011](https://www.surveymonkey.com/s/Physio_Wait_Times_2011)

Phil Gray  
Chief Executive  
Chartered Society of Physiotherapy



## **Appendix 2: The 2010-2011 survey**