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The extended scope physiotherapist in orthopaedic out-patients – an audit

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ABSTRACT

INTRODUCTION We undertook an audit of the activity of the extended scope physiotherapists (ESPs) in our unit. We assessed their activity against three benchmark data: (i) independent assessment and management by the ESP of 85% of patients seen by them; (ii) no patient to be re-referred to a surgeon with the same problem; and (iii) patient satisfaction rate of 89%.

PATIENTS AND METHODS All new referrals seen by the ESPs over the 6-month period between July 2002 and December 2002 were included in the audit. Patient medical records were reviewed retrospectively. Patients were contacted by telephone 12 months after their initial clinic appointment to obtain patient satisfaction scores.

RESULTS In the 6-month period, 150 patients (75 male, 75 female) were seen. Their median age was 43.5 years (range, 17–85 years). Their main complaints related to the spine (42%), knee (33%), shoulder (18%), or other site (7%). The ESPs saw and managed 82/150 patients (55%) independently. Consultant review was required for 81% of shoulder cases, 34% of knee cases and 11% of back cases. GPs re-referred 4/150 patients (3%). We successfully contacted 126 patients by telephone: 97 (77%) were satisfied with their management by ESPs. Of patients who were dissatisfied, 76% did not see a consultant at any stage in their management.

CONCLUSIONS ESPs fulfilled a useful role in our orthopaedic out-patient clinic particularly in the back clinic. The percentage of independently managed patients was much lower than the figure quoted in the literature. We suspect that the published literature does not reflect modern referral patterns and recommend that time for review of new patients seen by ESPs should be factored into consultant's clinic time. Patients' expectations may be a barrier to achieving greater levels of patient satisfaction.

KEYWORDS
Extended scope physiotherapist – Audit

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Extended scope physiotherapists (ESPs) have emerged amidst growing demands on hospital orthopaedic services. Byles and Ling[1] suggested that 40–60% of all orthopaedic out-patient referrals could be safely treated by a physiotherapist practising independently. Hockin and Bannister[2] reported that a physiotherapist in an out-patient orthopaedic clinic treated 85% of patients independently and reported improvement in 79% of cases. ESPs are regarded as a cost-effective means of reducing hospital out-patient waiting times.[3]

The aim of this study was to audit the activity of ESPs in our hospital. Benchmark standards were set as follows: (i) ESPs should independently assess 85% of patients appropriately referred to them;[2] (ii) the patient satisfaction rate should be 89%;[1] and (iii) no patient should be re-referred to an orthopaedic surgeon with the same complaint.

Patients and Methods

Extended scope physiotherapists

ESPs had at least 5 years' clinical experience post qualification and at least 3 years' experience in the management of orthopaedic and musculoskeletal conditions as recommended by the guidelines produced by the Chartered Society of Physiotherapy.[4] ESPs had been seeing new orthopaedic referrals in clinic for at least 18 months before the period of the audit.

Triage

Based on the recommendations of Durrell,[5] a triage protocol was developed which enabled selection of patients from general practitioner (GP) referral letters. Patients were deemed suitable for ESP consultation if the history

was suggestive of a benign musculoskeletal condition and if immediate surgery did not seem to be indicated. Consultant-to-consultant referrals were excluded, as were lumps and bumps, children under 16 years of age and histories suggestive of complex diagnostic problems.

Following the triage process, consultants reviewed the referrals selected by the ESPs. They made the final decision regarding whether a patient was suitable for the ESP clinic or should be seen in the consultant clinic. When patients were sent to their clinic appointment, it was made clear that they would be seen by a physiotherapist. Both patients and GPs were informed that the patient had the option not to be seen by an ESP and could wait to see the consultant.

Clinic arrangements

ESPs assessed patients in clinic at the same time and in the same clinic area as the orthopaedic consultant. Each patient was allocated 30 min. ESPs were expected to discuss the following with a consultant: radiological investigations, referral to another medical specialist, injection therapy, and listing for an invasive procedure or operation.

Study group

All new referrals seen by ESPs in orthopaedic out-patients over the 6-month period between July 2002 and December 2002 were included in the audit. Patient medical records were reviewed retrospectively in order to determine whether they were re-referred to an orthopaedic consultant with the same complaint. Patients were also interviewed by telephone 12 months after their initial clinic appointment to determine whether they had been re-referred elsewhere and to obtain patient satisfaction scores.

Results

ESPs assessed 150 patients (75 male, 75 female) in the 6-month period between June 2002 and December 2002. Their median age was 43.5 years (range, 17–85 years). Their main complaints related to the spine (42%), knee (33%), shoulder (18%), or other site (7%) (hand, wrist, elbow, and neck).

Rate of independent management

ESPs independently assessed 99/150 patients (66%): 82 were managed independently with advice and out-patient physiotherapy and 17 were referred to the consultant's clinic for further management. Consultant review was required in the remaining 51 cases and outcomes are given in Table 1. Consultant review was required most frequently for shoulder cases with 81% requiring a review (see Table 2). Injections accounted for 11 of the 22 shoulder cases reviewed by a consultant. Of the 50 knee cases seen, 17 (34%) were reviewed by a consultant and the outcome was arthroscopy in 11 cases. A consultant reviewed 11% of back cases.

Re-referral rate

GPs re-referred four patients out of 150 (3%).

Patient satisfaction rate

We successfully contacted 126/150 patients by telephone. Of these 126 patients, 97 (77%) were satisfied with their management and felt the clinic visit was worthwhile, 80 (63%) felt that the treatment and advice given was appropriate, 84 (67%) felt they were given an adequate explanation of their problem, and 97 (77%) were happy that the ESP had the ability to deal with their problem. Of the patients who were dissatisfied with their management, 76% did not see a consultant at any stage in their management.

Discussion

Rate of independent management

Our audit found that 66% of highly selected patients were seen independently by the ESPs and 55% were seen and managed

Table 1 Outcome following consultant review

Advice and out-patient physiotherapy	17
Injection of local anaesthetic and steroid	14
Listed for operative procedure	16
MRI request	4

Table 2 Consultant review by site of pathology

Site of pathology	*n*	Number requiring consultant review	Outcome following consultant review			
			Advice	Injection	List for operation	MRI
Back	64	7 (11%)	4	–	2	1
Knee	50	17 (34%)	5	1	11	–
Shoulder	27	22 (81%)	7	11	2	2
Other	9	5 (56%)	1	2	1	1
Total	150	51	17	14	16	4

independently by the ESPs. This figure was much lower than our standard. We do not believe that this could be accounted for by the 'learning curve' during which ESPs become more familiar with a particular consultant's approach as ESPs had been seeing patients for at least 18 months before the audit was undertaken. We suspect that the widely quoted assertions by Byles and Ling,[1] that up to 60% of all orthopaedic referrals (*i.e.* unselected cases) could be managed independently by a physiotherapist, and by Hockin and Bannister,[2] that 85% of selected cases can be managed independently by a physiotherapist, may be historical and may not reflect modern referral patterns.

Weale and Bannister[3] suggested that ESPs who manage selected orthopaedic referrals independently could be a cost-effective means of reducing hospital out-patient waiting times. Our triage protocol was carefully designed to identify patients who could be managed independently by ESPs. The results of our audit suggest that GP letters may not provide sufficient information for adequate triage of orthopaedic referrals. This suggestion is supported by the study by Jacobs and Pringle,[6] which found deficient content scores in referrals from GPs to orthopaedic departments such that it was not possible to determine the urgency of a referral accurately. The use of a standard referral proforma has been shown to improve the quality of referrals by dental practitioners to a department of restorative dentistry;[7] however, to our knowledge, this has not been shown for musculoskeletal disease.

The rate of independent management was worse in some subspecialties than in others (Table 2). Of the 50 knee cases, 17 required a consultant review and of these, 11 underwent arthroscopy. The same surgeon who decided upon arthroscopy had previously deemed these patients as suitable for independent management by the ESPs on the basis of their referral letters. The threshold for operative intervention was the same when the consultant reviewed the letters and subsequently saw the patients. The reason for the apparent change of management plan was because the referral letters contained inadequate information. Of the 27 shoulder cases, 22 required a consultant review and of these, 11 had injections. Training in injection techniques would improve the independence of ESPs and this is being considered in our hospital.

An important consequence of our audit findings is that consultants should anticipate multiple interruptions and should ensure that they allocate part of their clinic time to reviewing new patients seen by ESPs.

Re-referral rate

Our audit found a 3% re-referral rate which compares favourably with our benchmark standard of 0%. None of the four patients who were re-referred were seen by the consultant before the re-referral. All four had mechanical back pain and in no case did the consultant change the patient's management.

Patient satisfaction rate

Of the patients we were able to contact, 77% were satisfied with their management and felt the clinic visit was worthwhile. This fell short of our benchmark standard of 89%. Our patients were aware that they would be seen by ESPs and were given the option to see a consultant well in advance of their appointment. In spite of this, we found that a greater proportion of dissatisfied patients in the group of patients who were never seen by a consultant when compared with the group of patients who saw a consultant at some stage in their management. Patients' expectations may be a barrier to achieving greater levels of patient satisfaction.

Conclusions

On the basis of the published literature, we developed a protocol that we expected would enable ESPs to see selected orthopaedic referrals independently. We found that although this could be achieved for back referrals, a high proportion of knee, shoulder and other cases required consultant review. Our audit suggests that even with a carefully designed triage protocol, it is unlikely that ESPs will be able to work completely independently. Potential changes to improve independence include better triage with standardised proformas, though here is no evidence that they are effective in musculoskeletal disease, and instruction in injection techniques. The latter is under consideration in our department. Although we did not specifically audit this, it seems likely that time is saved when a patient is first seen by an ESP and a consultant then sees the patient to book an operation or investigation. Consultants should anticipate multiple interruptions and the main impact of our audit has been a shift in our expectations of the independence of ESPs. Consultants now allocate part of their clinic time to reviewing new patients seen by ESPs. We conclude that ESPs fulfil a useful role in the orthopaedic out-patient clinic but that the literature supporting independent management by ESPs may be historical and not reflect modern referral patterns.

References

1. Byles SE, Ling RSM. Orthopaedic out-patients – a fresh approach. *Physiotherapy* 1989; **7**: 435–7.
2. Hockin J, Bannister G. The extended role of a physiotherapist in an out-patient orthopaedic clinic. *Physiotherapy* 1994; **80**: 281–4.
3. Weale AE, Bannister GC. Who should see orthopaedic outpatients – physiotherapists or surgeons? *Ann R Coll Surg Engl (Suppl)* 1995; **77**: 71–3.
4. The Chartered Society of Physiotherapy. *Chartered Physiotherapists Working as Extended Scope Practitioners (ESP): Guidance for Members*. Member Networks and Relations Information Paper No PA 29. London: The Chartered Society of Physiotherapy, 2003.
5. Durrell S. Expanding the scope of physiotherapy: clinical physiotherapy specialists in consultants' clinics. *Man Ther* 1996; **1**: 210–3.
6. Jacobs LG, Pringle MA. Referral letters and replies from orthopaedic departments: opportunities missed. *BMJ* 1990; **301**: 470–3.
7. Djemal S, Chia M, Ubata-Narayange T. Quality improvement of referrals to a department of restorative dentistry following the use of a referral proforma by referring dental practitioners. *Br Dent J* 2004; **197**: 85–8.