



Document type **GUIDANCE PAPER**
Reference **PD039**
Issuing function **PRACTICE & DEVELOPMENT**
Date of issue **FEBRUARY 2009**

Self Referral

Implementation tools



Self referral

Implementation tools

Introduction.....	2
Feedback to the CSP.....	3
1. Making the case for widening access to therapy services.....	4
2. Are you ready for self referral checklist.....	11
3. Data collection tool.....	16
4. Other implementation tools.....	19
Appendix 1 – the Patient-Specific Functional Scale.....	20
Appendix 2 - the EQ-D5 health questionnaire.....	21
Appendix 3 - Using the EQ-D5.....	23
References.....	25



Self referral

Implementation tools

Introduction

Self referral has been made a priority for the NHS in England. The Operating Framework for the NHS 2009/10 sets out that from April 2009, PCTS will be commissioning self referral services. The government is clear about the benefits of self referral when Health Secretary Alan Johnson endorsed its recommendations in the Department of Health report 'Self referral to musculoskeletal physiotherapy and the implications for other Allied Health Professions. (DH, 2008)

"The concept of ringing to get an NHS therapy (AHP) appointment as easily as one at the hairdresser, at a time and place to suit requires a cultural shift for both patients and the service providers - this will not take place overnight" was a comment made by an NHS Commissioner

To support the members considering self referral the CSP has developed a range of 'Implementation tools'. These tools should be used in conjunction with guidance on self referral, developed by Holdsworth & Webster (see references).

The tools, some of which are included in this guidance document, are:

1. Making the case for self referral

This guidance supports members in structuring a dialogue with commissioners. Since self referral does not lead to an increase in activity, services do not need to develop a business case, but rather a service improvement plan. This plan includes being able to assess the new self referral service against key performance indicators such as safety, timeliness, effectiveness, efficiency, equity, co-ordination and patient-centeredness.

2. Are you ready for self referral checklist

This sets out the key steps which services need to complete in order to implement self referral effectively. It is in a question and answer format, and includes recommendations from those with experience of self referral. It contains an extensive section on maximizing marketing and advertising opportunities.

3. Data collection tool

This guidance is based on the experiences of those physiotherapists with expertise in data collection and the development of datasets. It includes a section on recommended baseline data, and what to collect if this data does not exist in the service. Based on the 'vital signs' recommended in the World Class Commissioning guidance, there is a standard data collection proforma for self referral.



The remaining implementation tools, available to download from the CSP website at <http://www.csp.org.uk/director/members/practice/practiceinitiatives/selfreferral.cfm>, include:

4. PowerPoint presentation

This presentation, with accompanying notes, focuses on the benefits of introducing self referral. Physiotherapists and other AHPs to stimulate discussion and generate ideas for local implementation with colleagues and key stakeholders can use this.

5. Patient leaflet and poster

The leaflet is for musculoskeletal services (other specialties will follow). It can be printed onto A3, A4 or A6 paper for a more professional finish.

Feedback to the CSP

We would value your feedback as to how you have used the implementation tools both within this guidance and those highlighted above from the website:

- Have the tools enabled you to introduce self referral?
- Which tool was most useful?
- Which tool was least useful
- Was there anything missing which you would like the CSP to develop?
- Do you have any additional comments? Email tenhover@csp.org.uk

If you have any questions about anything to do with self referral, please contact Ruth ten Hove MCSP at tenhover@csp.org.uk.



1. Making the case for widening access to therapy services

This section will help you make the case for self referral, widening access to services, in particular enabling patients to refer themselves directly

It sets out:

- Historical background, political context and underpinning values
- Important messages to key stakeholders
- Quality framework checklist, developed by the NHS Institute for Innovation and Improvement which includes
 - A service performance tool, including seven criteria to identify impact in key areas
 - A table which enables comparison of self referral with current practice
 - A 'who, what, when and where' table to identify the size of the change which the introduction of self referral would bring
 - Questions to stimulate further ideas for innovation and service improvement

Background, context and underpinning values

For more than thirty years, therapists have been able to practise autonomously and accept referrals from any source, including the patient themselves. Self referral is not a new way of accepting referrals, just a way that has not traditionally happened in many places in the NHS although it is common in private practice. In October 2008, the Health Secretary Alan Johnson gave the most positive endorsement to the national 'roll out' of self referral to therapy services.

Self referral means that: patients are able to refer themselves to a therapist without having to see anyone else first, or without being told to refer themselves by a health professional. This can relate to telephone, IT or face-to-face services (DH, 2008).

This is not fast track access, just an additional method of accessing physiotherapy services. It is not any change in the therapy given or to the waiting times to treatment.

The value of self referral to patients is that:

- It puts the individual in control of their care
- It supports the individual in developing skills in self care and self management. And this 'advice' should be valued as 'real treatment' by both therapists and patients
- It promotes health focused behaviour
- It champions a whole service ethos of *"treat to manage not treat for life"*
- It allows people with complex and long term conditions a simple route in and out of services
- It gives patients an easy route back into the service. Other services eg CATs no longer need to give routine *"see you in 6 weeks"* appointments



And the value to therapy services is that it encourages:

- More engagement and involvement in the whole patient journey
- Enhanced professional practice and a wider range of development opportunities

“Just do it. It’s simple, it works and it’s win win for everyone” was the overwhelming advice from one community hospital. The simplicity, success and the positive patient experiences of self referral won them over.

Key messages to stakeholders

For Commissioners

Results from national self referral to physiotherapy projects in England and Scotland (DH, 2008) have shown it to:

- Be a less expensive model of physiotherapy care than the GP referral route for access to physiotherapy
- Increase user satisfaction
- Reduce the number of other healthcare interventions (MRI, X-Rays)
- Reduce sickness absence time from work
- Be cost effective for service users in terms of their time and commitments
- Streamline other pathways of care
- Promote autonomous decision making about personal health status and need
- Enhance motivation for recovery, enabling speedier return to previous health status
- Have the potential to provide opportunities for targeting particular groups with health needs (eg farmers, minority populations)

For General Practitioners

- Enable best use of GP time – 25% of GP consultations are for people with musculoskeletal problems, so allowing these people to self refer to physiotherapy would free up substantial GP consultation time;
- Reduce associated administration costs
- Afford patients faster access
- GP suggested self referral allows patients to make their own choices
- Patients like it

For employers

- Return employees to normal life as soon as possible. People who self referred to physiotherapy took fewer days off work and were 50% less



likely to be off work for more than one month when compared to the conventional GP referral

- Quick access is key when research indicates early intervention for low back pain in employees enables a return to work up to five weeks earlier and gives a 40% reduction in the recurrence of low back pain in the following year

Defining self referral within a Quality Framework

The underpinning principles that are driving current health care policy are that services will be evidence-based and will build on the quality of the patient journey and experience. In particular that people will have choice and control over the services that they use.

To support these principles and match the public's increasing expectations, World Class Commissioning promotes and encourages the development of innovative practice and service delivery. The guide 'Commissioning to make a bigger difference' (NHSI, 2008) enables a thorough assessment of how innovation can transform services.

Key to its success will be the skills and commitment of frontline clinicians and managers in identifying ideas that will transform services. The next section, taken from 'making a bigger difference' describes a five-step process to take an idea and test it as an innovation. These steps are:

1. Seven dimensions of performance
2. Innovation claim framework
3. The 4Ws table
4. Stimulating further service innovation
5. Summarising your thinking

In this guidance the five steps have been completed for self referral to musculoskeletal (msk) physiotherapy to provide an indication of the positive impact of the introduction of self referral on a service and patient population. The same process is recommended for any AHP service considering the introduction of self referral.



1. Seven dimensions of performance

The seven dimensions of performance and examples of potential things to measure within each dimension are provided in the table below:

Dimension	Type of impact	Positive impact
Effectiveness	Population health/well – being	Yes
	Clinical outcomes	Yes
	Improved functional status	Yes
	Free from complications	No
Efficiency	Cost	Yes
	Consumption of provider time and resources	Yes
	Consumption of time or resources or people who use the service	Yes
Safety	Absence of errors	No evidence of any increased risk
	Prevention of harm	Yes
	Conformance to standards	Yes
	Reliability	Yes
Timeliness	Waiting time	Yes
	Time to service delivery or intervention	Yes
	Time required to complete task	Yes
Equity	Greater access and availability to all	Yes
	Cultural sensitivity	No evidence
	Closing the gap in equalities	Yes
Co-ordination across the whole system	Flow across journey/system	No evidence
	Integration of care plans	No evidence
	Shared information and assessments	No Evidence
People centredness	Ease of use	Yes
	Convenience	Yes
	Portability	Yes
	Influence	Yes
	Choice	Yes
	Ease of understanding	No evidence
	Engagement/involvement in care	Yes
	Self management	Yes



	Fit to lifestyle needs	Yes
	Experience of care	Yes

2. Innovation claim framework

This provides a structure for assessing the degree of innovation an idea has in relation to a specific setting.

By being able to answer yes to a level, you are indicating in what setting the idea is innovative, in comparison with usual practice in that setting.

Level 1	My immediate team, department of service	Yes
Level 2	My local organisation (eg PCT, Trust)	Yes
Level 3	A specific setting eg GP practice, older people services, places with similar populations in my economy	Yes
Level 4	Any setting in my economy	Yes
Level 5	A specific setting across the country	Yes
Level 6	Any setting across the country	
Level 7	A specific setting internationally	
Level 8	Any setting internationally	
Level 9	The world at large, across sectors, industries etc.	

3. The 4Ws table

This guides assessment of the degree of innovation of an idea by providing a side-by-side comparison of existing and innovative practice in relation to:

Who is primarily involved in delivering the intervention?

Where and **When** it is delivered and;

What the people who use the service and their carers experience in the process.

	Typical good approach across PCT for people with msk problems	Self referral for msk problems
Who	<ul style="list-style-type: none"> • GP • Physiotherapist • GP and physiotherapy admin staff 	<ul style="list-style-type: none"> • Physiotherapist • Patient/carer • Physiotherapy admin staff • Referral to other HCP if required
What	<ul style="list-style-type: none"> • Patient is referred to PT following assessment with GP • Patient receives PT assessment, treatment plan, which includes advice and education 	<ul style="list-style-type: none"> • Patient completes self referral form, which includes red flag symptoms. Form assessed by PT, clinical criteria determine urgent or routine appt.



	<p>regarding required lifestyle changes</p> <ul style="list-style-type: none"> • Patient discharged or referred on to other services 	<ul style="list-style-type: none"> • Patient receives PT assessment, treatment plan, which includes advice and education regarding required lifestyle changes • Patient discharged or referred on to other services
When	Normal PT opening hours	Normal PT opening hours
Where	<ul style="list-style-type: none"> • PT treatment setting 	<ul style="list-style-type: none"> • PT treatment setting plus • Shift to patient able to contact service themselves and arrange suitable appt

Key results based on data

- 1.High levels of service user satisfaction and confidence
- 2.More efficient in the use of patients time, expense and effort
- 3.Empowers patients to self-care/self-manage to meet their needs
- 4.Associated with lower levels of work absence
- 5.Does not result in an increased demand on services
- 6.Is well accepted and supported by physiotherapists and GPs
- 7.Is associated with lower NHS costs by up to 40%

4. Stimulating further service innovation

- What has really changed in the system of care as a result of this idea?
- What has been left unchanged?
- What additional new possibilities and opportunities are now created as a result of this change?
- What might be the next big idea that stretches beyond this?

Additional ideas and extensions of self referral:

- Extend self referral to other specialities and AHPs
- Think about key 'hard to reach' groups (eg farmers and ethnic minorities). Is there additional material that could be developed?
- Explore the use of IT, the web and other technology to afford patients even greater access to the service
- Consider reviewing and extending the hours the service is available
- Explore the use of other locations in your local community to offer more choice
- Think about developing the role of the 'expert patient' and champion, with particular reference to improving self care and self management



5. Overall how would you characterise the idea?

Considering how to further develop the service really stretches individuals thinking. This does not diminish the existing idea, but it points to even bigger differences, which could be made. Introducing self referral is an incremental change to the service – patient care remains exactly the same, just the process of accessing the service, which some patients may prefer, has changed. The 4Ws process results in additional innovative ideas for service delivery, commissioning and market development, which lead on to the next round of change.

The next step in the process is to look at whether you are ready, in a practical sense, for the introduction of self referral to your service, using the checklist on the following page.

A box entitled 'points for action' follows each checklist section and this enables the individual to document local implementation action points. There is also a small box next to each headline question to be 'ticked' when that headline area has been addressed



2. Are you ready for self referral checklist

This checklist will help you prepare for self referral by providing you with a checklist of questions and statements, which identify the key areas to consider when developing self referral. The checklist incorporates practical suggestions from the England Department of Health self referral pilot sites.

1. Have you made every effort to bring down your waiting list to meet locally agreed standards?

- Self referral does not lead to an increase in demand for physiotherapy, provided the service is adequately resourced (this has not been tested for other therapy services)
- Rates of referral will initially increase slightly, as is the case with any newly marketed service, these will level out within the first three months
- Knowledge of long waiting lists will discourage patients from referring themselves
- Physiotherapy staff were initially apprehensive about marketing the physiotherapy service in case there was a flood of patients. Once the pilot was properly underway, they were reassured that they would not be overwhelmed with patients

Points for action

2. Do you have a thorough understanding of the demographics of the local population?

- Ensure you know what the referral patterns are from your GPs (Are there pockets of under referral?)
- Consider what are current and future possible demand and capacity

Points for action

3. Have you read existing research evidence and talked to services that already accept patients who self refer?

- Department of Health report (DH, 2008)
- CSP website – dedicated section on self referral, including further implementation tools at patient leaflets and at <http://www.csp.org.uk/director/members/practice/practiceinitiatives/selfreferral.cfm>



- Self referral website including references and further publications - www.selfreferralphysioinfo.com
- Examples from other AHPs

Points for action

4. Have you fully engaged with all key stakeholders

- Get to know your GPs -time invested in getting them on board is time well spent.
- Finding a GP and practice manager champion is worth it
- Seek advice from relevant local patient groups
- Engage fully with managers
- Enter into dialogue with commissioners, using the 'Making a case for self referral' guidance in the above section

Points for action

5. Do you have a Communications and Marketing plan?

Does your plan include?

A conversation with the Communications Lead for your Trust/PCT?

Your Communications Lead can help you with:

- Media handling - proactively placing good news stories, dealing with enquiries and producing media releases
- Advising on links with stakeholders, such as local councils who could assist you in targeting the population
- Advising on links with stakeholders in the local community that you could use to market the new service
- Planning proactive communications around the Trust/PCT
- Getting material onto organisations' websites and other corporate communications tools – eg staff magazine
- Commissioning printing/advertising and patient information
- Assisting in engaging with patient groups
- Advice on best practice for resources in different formats e.g. Braille, large font.

A range of opportunities to optimise marketing via the GP practice?



- Are all the practice staff aware of the change in access to physiotherapy and are they promoting them to patients?
- The fact that leaflets are around in GP waiting rooms means that the service is "OK" and "quality assured" – some patients may collect leaflets for friends and family to use when necessary
- Make the most of the experience of GP practice managers. How about putting a leaflet about the new service and where to pick up a form in every letter and repeat prescription in the practice – a simple and effective way to target a whole population
- Put an article about the new service in the GP practice newsletter or on the GP practice website
- If the GP practice has TV screens in the waiting room, consider making a short video

A range of opportunities to optimise marketing via the Trust /PCT?

- Have you put leaflet/referral form on the Trust/PCT website?
- Have you highlighted self referral in the staff/Trust magazine
- Have you considered putting leaflets/flyers in the main reception of the hospital?
- Have you considered making local patient groups aware of the change in access to physiotherapy? (eg Arthritis Care)

Identifying and targeting patients who would not normally see posters/leaflets in GP practices?

- Have you considered placing an advert in the local paper? Or asking the paper to run an article about the new method of access to physiotherapy
- Placing posters leaflets in shopping centres, community centres, colleges, transport hubs (ie train or bus stations, city car parks), sports centres/gyms/leisure centres, petrol stations, libraries, cycle shops, health food shops.
- Consider linking in promotion of your self referral service to other events that you might be running promotions for e.g. Back Care week, Street Physio.
- Supermarket advertising is OK in theory but in practice it is difficult to make your advert stand out from the crowd and patients do not presently expect NHS services to be advertised in this sort of location



- Also in places where people have already decided to pay for ‘treatment’ – eg hairdressers, dentist, beauty salons, opticians, pharmacies.

Identifying and targeting the population where English is not the first language?

Engaging with community leaders, influential individuals

Procuring translation services so that your poster is available in the most commonly used languages of the practice populations (your communications lead can advise on this)

A system of keeping your materials up to date in all places

Be aware that the more places you have leaflets, the more leaflets you need and someone has to go round and keep them topped up. This can be time consuming. Keep a list of all places where you advertise and check every few months or so to ensure that, where changes need to be made to your promotional materials, new versions are sent to replace the originals in those places.

Points for action

6. Are your monitoring and evaluation processes ready?

- You will need accurate baseline data, which includes information on:
 - Referral rate
 - Access
 - Waiting times
 - Referral source
 - Categorizing/grouping of patients
 - Activity
 - Outcome

If you do not have a sufficient range of baseline data, collect at least three months worth, prior to embarking on self referral

- CSP has developed a standardised data set to support the introduction of self referral (see section 3 below for guidance on data collection)

Points for action



7. Do you have the appropriate support skills within your service?

- Skill mix is key, you must have the right clinical skills in the service and a suitable clinical support structure, that all staff can contribute to
- Ensure someone within the service has the necessary project management and IT skills – you will need to create a database or spreadsheet for monitoring referrals and outcomes

Points for action

8. Are all clinical staff well prepared and signed up to a 3 month run in period?

- Ensure everyone involved knows the parameters – i.e. it is just a point of access not a fast track
- Getting all staff on board takes time, consider a phased approach
- Spend time talking to staff – both clinical and admin
- Have department working or 'clusters' of staff

Points for action

9. How will you demonstrate impact?

- Ensure you have full IT support
- Ensure the database / spreadsheet design is appropriate for the project and optimised for both data capture and data entry
- Agree data definitions and descriptions

Points for action



3. Data collection tool

Introduction

With the current policy emphasis on efficiency, quality and equity there has never been a more important time for services to collect good data to demonstrate their impact and monitor quality, this is particularly the case when a new service such as self referral is introduced. The service must have evidence that it is cost and clinically effective, that standards of care particularly related to access are being met and that it is acceptable to patients.

However before introducing any new service it is imperative to have a good understanding of the existing service, and this should be based on accurate and reliable baseline data. If this baseline data does not exist, services are strongly advised to collect some data, based on the previous three months before introducing self referral.

Baseline data should include

- The total number of patients referred
- A means of grouping of problems which patients have been referred with eg backpain, neurological, womens health etc
- Waiting times
- Activity levels, for most services this will be by the total number of patient contacts
- A measure of outcome – preferably patient generated
- The costs

The dataset set out in this document is recommended for those introducing self referral. It is based on the experiences of physiotherapists who have expertise in data collection and in the development of datasets. It is set out for musculoskeletal patients, but the 'fields' that put the patients into specific categories could be altered to reflect different specialties. The dataset builds on the following key principles:

- a. Simple to use, either electronically or with a paper based system
- b. Includes definitions, descriptions and simple instructions to complete each field, which all personnel should be very familiar with
- c. Cost effective – data collection is costly and therefore all data fields have been scrutinised for the required impact
- d. There should be an effective mechanism for feedback to services. This is so that reports of progress can be generated which monitor progress and demonstrate the potential impact of self referral
- e. Adheres to the 'vital signs' recommended by World Class Commissioning, which include: access, activity levels and patient reported outcomes

The dataset contains two validated outcome measures, however if services are already using other measures e.g. a VAS score, MYMOP etc then they may want to continue using that, as well as or instead of the measures recommend here. This dataset, as well as recommending the collection of common data, is also to encourage services to use common outcome measures



Dataset – Self Referral

1. How the patient was referred

GP Self GPS Other (please select)

2. Date of initial referral (dd/mm/yy)

3. Date of first physiotherapy appointment (dd/mm/yy)

4. Total waiting time (insert numbers) weeks days

5. Condition category

LBP	<input type="checkbox"/>	Neck	<input type="checkbox"/>	Thoracic	<input type="checkbox"/>
Knee	<input type="checkbox"/>	LL	<input type="checkbox"/>	Multi	<input type="checkbox"/>
UL	<input type="checkbox"/>	Shld	<input type="checkbox"/>	Neuro	<input type="checkbox"/>
Urology	<input type="checkbox"/>	Other	<input type="checkbox"/>		<input type="checkbox"/>

6. Total number of contacts (insert numbers)

7. Reason for Discharge

Treatment complete Failed to complete

Referred on to other Health Care Practitioner

Condition resolved on 1st assessment Other (

8. Outcome measures

a. Patient Specific Functional Scale

[Initial total score*]	<input type="text"/>
[Final total score*]	<input type="text"/>
[Overall change]	<input type="text"/>

b. EuroQol EQ-5D

	Mobility	Self care	Activity	Pain	Anxiety
Initial	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Final	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Overall health VAS rating, initial score

Overall health VAS rating, final score



Guidance for completing the dataset

The fields of this dataset should be completed **AFTER** the patient has had their **initial assessment**. The fields related to outcome measures should also be completed **AFTER** the patient’s **final assessment**.

1. Source of Referral

- a. GP referred - self explanatory
- b. Self referred - Patient self referral is a system of access that allows patients to refer themselves to a therapist directly, without having to see or be prompted by another healthcare practitioner. This refers to telephone, electronic technology or face to face services
- c. GPS – The GP sees the patient and suggests they refer themselves to therapy.
- d. Other – This will drop down menu gives three options: Consultant, Nurse Practitioner, and other health professional.

2. Date of initial referral – this is the date which the GP/other first saw the patient about their particular problem. Self referred patients; this date should be on the self referral form which the patient completes

5. Condition category (Abbreviations). This has been set out for musculoskeletal physiotherapy. However other services should develop their own categories, which would then replace those in this dataset.

LBP	Low back pain
Neck	Neck spinal pain
Thoracic	Thoracic spinal pain
Knee	Any condition related to the knee
LL	Any condition related to the lower limb that does not include the knee
Multi	Where more than one body area is referred for treatment at the same time eg LBP/LL
UL	Any condition related to the upper limb that does not include the shoulder
Shld	Any condition related to the shoulder
Neuro	Any neurological condition
Urology	Any urological condition
Other	Any condition not included, please provide details



6. Total number of contacts. This is the total number of patient contacts contained within the full episode of care. Record only the number of contacts that you have with patients on a face to face basis

7. Reason for discharge

- a. **Treatment complete** - Patient discharged by therapist with no other indication for further therapy intervention
- b. **Failed to complete** – Patient failed to attend for last therapy appointment and has not communicated with the service for a minimum of seven days
- c. **Referred on to other Health Care Practitioner** – Further therapy intervention not indicated, however referral to other healthcare professional appropriate
- d. **Condition resolved on 1st assessment** – At the initial contact the presenting signs and symptoms have been resolved to the extent where they do not require physiotherapy intervention
- e. **Other**- Patient discharged from physiotherapy due to a reason NOT described by any of the alternative categories, record reason.

8. Outcome measures

a. The patient specific functional scale is a useful questionnaire to quantify activity limitation and measure functional outcome for the patient with any condition requiring rehabilitation. The clinician should read and complete the measure at the first assessment and then after the final assessment.

b. EQ-5D is a standardised instrument for use as a measure of health outcome. It comprises two areas of assessment, which must be used together

- 5-digit health state classification to build a composite picture of the respondent's health status
- VAS self rating of health quality of life

The full format of these outcome measures and accompanying notes are available in Appendices 1, 2 and 3 of this document.

4. Other implementation tools

The remaining implementation tools – PowerPoint presentation, Patient leaflet and poster - are available to download from the CSP website at <http://www.csp.org.uk/director/members/practice/practiceinitiatives/selfreferral.cfm>

Created: February 2009

Author: Ruth ten Hove, Professional Adviser



Appendix 1 – the Patient-Specific Functional Scale

CLINICIAN TO READ AND FILL IN BELOW: Complete at the end of the history and prior to physical examination.

- Initial assessment

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem. Today are there any activities that you are unable to do or having difficulty with because of your _____ problem?

(Clinician - show scale to patient and let the patient rate each activity)

- Final assessment

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list at a time). Today, do you still have difficulty with _____? (Clinician - read activities and have patient score each activity in the list against the scale as before)

Patient – specific activity scoring scheme (Point to one number):

0	1	2	3	4	5	6	7	8	9	10
Unable to Perform Activity										Able to perform activity at the same level as before injury or problem

(Date and Score)

Activity	Initial score	Final Score
1.		
2.		
3.		
Additional		
Additional		

On the data form the total score* at the initial assessment and the total score* at the final assessment should be recorded.

***Total score = sum of the activity divided by the number of activities**

Subtract initial score from final score for overall change.

Minimum detectable change (90%CI) for average score = 2 points

Minimum detectable change (90% CI) for single activity score = 3 points

PSFS developed by: Stratford p, Gill C, Westaway M and Binkley J (1995).

Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada 47, 258 – 263

Reproduced with permission of the authors



Appendix 2 - the EQ-D5 health questionnaire

English version for the UK
(validated for Ireland)

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed



EQ VAS

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

**Your own
health state
today**

Best
imaginable
health state

100

90

80

70

60

50

40

30

20

10

0

Worst
imaginable
health state



Appendix 3 - Using the EQ-D5

This comprises two areas of assessment which must be used together

- 5-digit health state classification to build a composite picture of the respondent's health status
- VAS self rating of health quality of life

Descriptive System

At both initial and final assessment the patient is asked to indicate his/her health state by ticking in the box against the most appropriate statement in each of the **5 dimensions**. This decision results in a one-digit number [1,2 or 3, 1 being the least severe and 3 being the most severe of the three available options in each heading] expressing the level selected for that dimension. The digits for five dimensions can be combined in a five-digit number describing the respondent's health state, eg 22321. It should be noted that the numbers 1-3 have no arithmetic properties. Further details for interpreting results can be found at www.euroqol.org

Although self-explanatory instructions are provided within the text, the following may be helpful. A patient may sometimes find that the number of levels is too limited. For example, for the mobility question, a respondent in a wheelchair is not 'confined to bed', but he/she may find 'some problems in walking about' appears to under-estimate their level of difficulty. The therapist should stress the instruction: 'please indicate which statements best describe your own health state today'. **It is the respondent's personal evaluation that is required and on no account should a prompt be given.**

EQ VAS

This generates a self-rating of health-related quality of life, and should be completed at both initial and final assessment. The patient rates his/her health state by drawing a line from the box marked "Your health state today" to the appropriate point on the EQ VAS.

Sometimes, respondents tend to rate their health state by placing a mark on the thermometer instead of drawing a line. There is no reason why this could not be interpreted as a valid response.

It is important to ensure that the patient is not prompted in any way by the therapist and that it is the patient's own rating of health-related quality of life that is being recorded.

In order to achieve comparable results, it is necessary to adhere to the standard text and instructions and layout of EQ-5D. This is especially relevant for EQ VAS as this is a graphical representation of the value of health (it is important for example that the scale should be a standard 20 cms). A three-digit number



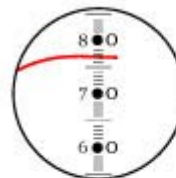
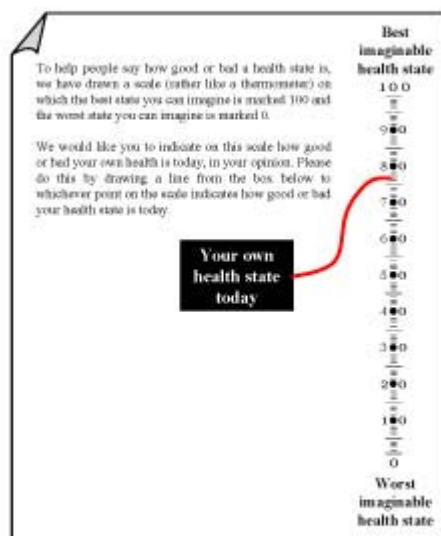
between 000 and 100 is read off the thermometer, from the exact point where the line crosses the scale, for example, 046 or 069.

For comparative purposes, we recommend that:

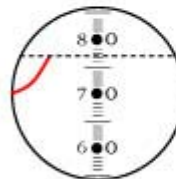
- missing response is coded as '999'
- ambiguous response is coded as '888'

Scoring the EQ VAS

The EQ VAS should be scored as follows:



For example this response should be coded as 77



Even though the line does not cross the VAS this response can still be scored by drawing a horizontal line from the end point of the response to the VAS. In this example the response should be coded as 77

Missing values should be coded as '999'.

Ambiguous values (e.g. the line crosses the VAS twice) should be treated as missing values.



References

Department of Health (2008) Self referral to musculoskeletal physiotherapy and the implications for other Allied Health Professions. DH; London.

Holdsworth L and Webster V (2006) Patient Self Referral, a guide for therapists (Allied Health Professions - Essential Guides). Radcliffe Publishing Limited: Oxford.

NHS Institute for Innovation and Improvement (2008) Commissioning to make a bigger difference. NHSI; London.

Stratford p, Gill C, Westaway M and Binkley J (1995). Patient-Specific Functional Scale: Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada 47, 258 – 263