

**An audit of the Outcome of
Physiotherapy Intervention for
Outpatients with cervical spine pain and
dysfunction**

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The Report

Introduction

Clinical audit since the publication, in 1989, of the NHS circular (GEN29) has had an unprecedentedly high profile in the Health Service which has been endorsed by the Government, as well as all health profession associations. The Department of Health's definition of clinical audit (DOH 89) serves as a useful statement on which to base audit activity and has served as an underlying ethos on which to base this current report.

"Clinical audit is the systematic critical analysis of the quality of clinical care including the procedure used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient/client." (DOH 89)

With the publication of the Government White Paper, 'The NHS modern and dependable' (1997), issues of accountability and clinical governance are now in the forefront of practice. With the Government's directive that proper systems and processes are set in place to ensure continuous improvement in clinical standards, backed by the new statutory duty for quality in NHS trusts.

Physiotherapy is a relatively young profession and has gathered momentum in recent years in terms of research activity and in the measurement of clinical effectiveness. As with other professions engaged in healthcare, physiotherapists pursue activities within a variety of specialities. For physiotherapists, one of the core areas of specialism is the management of musculoskeletal dysfunction, most commonly dealt with in out patient physiotherapy departments within the NHS Hospital Trusts, but also in the private sector, in private hospitals and in private practices.

In the full report, 'The Development of the Mid Kent and University of Brighton Outcome Measurement Tool for Physiotherapy Out Patient Services' (Moore 1996), cervical spine dysfunction was present in 17% of the total patient population undergoing physiotherapy treatment during the one year pilot period described in the full report. Cervical spine dysfunction therefore was chosen as the topic for the second audit in the series, stimulated by the original outcome report (Moore 1996).

The cervical spine with its anatomical biomechanical and pathological complexity presents a considerable challenge to the physiotherapists. Symptomology ranging from cervical headaches, symptoms of sympathetic irritation as well as joint stiffness, muscle weakness, muscle imbalance and importantly pain, are manifested by the cervical pathologies which affect the cervical spine. These in themselves, range from rheumatoid arthritis, congenital abnormalities, arthrosis, trigger points, neuralgia, cervical spondylosis, post traumatic pain and facet impingement (Bogduk 1994). There are also many symptoms associated with cervical headaches alone. These can be considered as nausea, vomiting, phono/photophobia, dizziness, tinnitus, throat symptoms, hearing deficits, blurred vision, eyelid oedema, tearing and redness of the eye (Jull 1994). Additionally there are cranial symptoms which may arise after cervical injury or secondary to upper cervical arthrosis. These include sub-occipital neck and yoke area pains, unilaterally or bilaterally, with bouts of frontal headache which may be periodic and transient or remain as a dull and background ache, facial and anthro-lateral throat pain, patches of subjective facial numbness, otalgia, retro-orbital pain, sometimes paratheseae in the eye, subjective laryngeal disturbances with compulsive clearing of the throat, upper pectoral and axillary pain, feelings of instability and disequilibrium with sometimes a tendency to list to one side, disturbances of hearing and/or vision, depression with feelings of fatigue and a belief in personal neurosis, irritability, insomnia and light headedness.

Together, this series of symptoms can create a maze which a physiotherapist needs to confidently negotiate to enable them to respond to the patients identified problems with accurate, efficient and appropriate treatment. It has been in the spirit of the quest for improvement in quality of care that this audit has been carried out.

Background to the Audit

In 1995, East Kent Health Authority funded the first year of a 3 year project to develop models of care from the assessment of appropriate physiotherapy treatment methods in relation to clinical outcome. Physiotherapists across South East Kent collaborated to develop clinical guidelines in 5 areas of physiotherapy: outpatients, care of the elderly, orthopaedics, respiratory care and neurology.

The project floundered after the first year due to lack of funds. From 1993, Mid Kent Healthcare Trust funded consultant support from the University of Brighton, Department of Occupational Therapy and Physiotherapy, now the School of Healthcare Professions to establish a tool to measure the effects of physiotherapy intervention in the general outpatient setting and to gather data on current practice. An outcome measurement tool was developed in liaison with patients and staff by the consultant and was piloted over a 15 month period in 3 outpatient physiotherapy departments within Mid Kent Healthcare Trust. The outcome measurement tool together with a full report of its development was published by the University of Brighton in collaboration with Mid Kent Healthcare Trust (Moore 1996), and the measurement tool was integrated into the day to day practice of physiotherapists working in outpatient departments throughout Mid Kent Healthcare Trust and has also been adapted for use in other areas of physiotherapy practice within the Trust. The tool has been adopted by other physiotherapy departments throughout the Country, either in its entirety or in a modified form. In essence, the original tool consisted of a data sheet (discharge summary sheet) consisting of 31 items requiring a response from the physiotherapist (see appendix 1) together with a codings list.

In the published report (Moore 1996), low back pain was identified as the most common reason for patient referral to the outpatient department in the Mid Kent Healthcare Trust. Therefore low back pain was chosen as a topic for further audit work and a programme entitled 'An audit of physiotherapy intervention for outpatients with low back pain against pre-set clinical standards' was designed.

The notion of an audit of low back pain was discussed in the autumn of 1996 within the Mid Kent Healthcare Trust. At this stage, it was intended that 7 physiotherapy outpatient departments across the South Thames region would take part using the Mid Kent and University of Brighton's outcome measurement tool which could be audited against East Kent's clinical standards.

The Director of Physiotherapy at Kent and Canterbury Hospital and the then Physiotherapy Manager from Mid Kent Healthcare Trust were identified as joint clinical leaders for the low back pain audit project.

In November 1996, a bid for funding for the project was submitted to the clinical audit programme management group, South Thames region and funding was approved and confirmed in December 1996. In mid December 1996, the first planning meeting of the low back pain audit group met. The group included:

Janet Fry - Director of Physiotherapy Services, Kent and Canterbury Hospital and joint clinical leader
Carol Groom - Physiotherapy Manager, Mid Kent Healthcare Trust and joint clinical leader

Jane Woodward - Audit Manager, Audit Department, Mid Kent Healthcare Trust

Professor Ann Moore - Consultant to the project from the University of Brighton's School of Healthcare Professions

Dr Jean Richards - West Kent Public Health Department was appointed by the South Thames Audit Committee to monitor the project's progress.

As previously stated the initial plan was to use 7 physiotherapy departments in the South Thames region in the audit programme. In the event, 10 trusts entered the audit and contributed data to the overall audit process. The participating units for the low back pain audit were:

Dartford and Gravesham Hospital
Frimley Park Hospital
Kent and Canterbury Hospital
Mid Kent Healthcare Trust
Queen Elizabeth the Queen Mother Hospital
Richmond Rehabilitation Unit
St Georges' Hospital
Thames Link
William Harvey Hospital
Worthing Hospital

At the first meeting of the audit management group, the audit topic was refined. Participant roles were clarified. A plan for the audit was established, and a list of units that would be asked to participate was drawn up. Procedures for the analysis of results were also established.

In February 1997, a further meeting of the audit group took place to define the audit topic, agree standards to be audited against and discuss the relevance and make minor modifications to the original outcome measurement tool for the low back pain audit. The meeting was also used to establish the population size for the audit. It was anticipated that 200 patients from each unit would be included in the audit, giving a proposed total audit population of 2000 subjects from 10 sites.

In May 1997, workshops took place within the participating units to explain the audit process, the outcome measurement and the project as a whole.

Feedback from the workshops provided valuable information, which contributed to the final codings, used in the discharge summary sheets for audit purposes (see appendix 2).

In July and August of 1997, each unit trialled the discharge summary sheet and returned the pilot data to Mid Kent Healthcare Trust for inputting in order for any discrepancies in data to be identified and for further support to be provided if necessary to the participating units. At this stage, 80 data sets were analysed for conformity.

The main audit commenced in September 1997 following a variable response by units to the pilot audit work.

By the end of November 1997, less than 10% of the anticipated number of discharge summary sheets had been received. However, further data was received in January bringing the total number of data sets to, at that stage, 335.

In February 1998, a meeting was held with the project management group, and representatives from each of the participating units. By this stage, 414 data sets had been received. Some content issues were identified in relation to the discharge summary sheets and some areas, in particular, were identified which would need consideration for any further work. Units were urged this time, to speed up the rate of data collection and the speed of return of completed data sheets.

Constraints and problems affecting the audit activities within the trusts were identified by representatives from each of the trusts units:

1. Some discharge summary sheets that had been completed by 2 trusts had not been received centrally. The reason for this was uncertain.
2. Units required clearer instructions with regard to cut off and response dates.
3. Turnover of staff and staff rotations presented difficulties with consistency of audit form completion and return.
4. Patients treated in General Practices had not been included by some units due to the time constraints. Therapists based in General Practices found it hard to justify the extra time required to complete the summary sheets to fundholders.

In some units, patients had been excluded from the audit if their therapist had left the unit before their treatment had been completed, despite another therapist taking the patient on to their list. It was agreed that the tool would be modified at a later stage to include information about the number of therapists who had been involved in the management of the patient.

Final data sheets were received for the low back pain audit at the end of February and the audit officer entered data and downloaded the data analysis according to the requirements discussed with the audit management group and the representatives of the unit.

The data was then handed to the University of Brighton consultant at the end of March 1998 for detailed professional analysis and report writing. The final report was published in early October 1998.

Whilst the writing of the low back pain report was underway, plans for a further audit programme were developed. In the published full report (Moore 1996), pain and dysfunction of cervical spine origin was found to be the second most common body site treated by physiotherapists in outpatients in Mid Kent Healthcare Trust, with 17% of the physiotherapy patient workload attributed to this body site. It was decided on discussion therefore that an audit of the physiotherapy intervention of cervical spine dysfunction be the next audit programme carried out, and a bid for funding was made to South Thames Clinical Audit programme once more. Confirmation of funding was received in October 1998 (Moore 1998).

In the early part of 1998, meetings had been set up to set and agree standards for the cervical spine audit programme. Also during the early part of 1998, it had been decided to modify the original outpatient physiotherapy outcome measurement tool, and that which had been used in the low back pain audit and make it more specific to spinal dysfunction. This was done by the consultant to the project under discussion with representatives from the 10 trusts. For the discharge summary sheet and the codings used for the cervical spine dysfunction audit, please see appendix 3.

Funding for the cervical spine audit, approved in October 1998, enabled the audit to be fully resourced. The resources required for the audit project were identified as follows:

1. Personnel with experience in the 2 base projects were to be used as they had depth of knowledge of the subject area. This decision was made in the light difficulties in recruiting a suitable researcher with necessary skills.
2. Clinical skills for time lost in providing workshops and on-going support by 2 physiotherapists from the 2 base sites.
3. Clinical support for inputting data.
4. Audit expertise to monitor and provide final data for analysis.
5. University of Brighton consultant time to analysis and write the report.
6. Clinical leads from the 2 base sites.
7. Travel costs, stationery and photocopying.

Timetable for the cervical spine audit

Early April 1998	Project team meeting to define and agree programme
April – May 1998	Series of half-day workshops in participating departments.
June 1998	Commencement of a 2 week pilot of data collection.
July 1998	Checking of pilot data and revisiting of sites.
August – November 1998	Four month study on all sites.
Dec. 1998 – February 1999	Data entry and data downloading.
February – April 1999	Analysis of data and production of report.
June 1999	Final meeting of the project team to discuss the final report.

The Audit

Audit topic

Cervical spine pain and dysfunction.

Patients presenting with central cervical pain with or without referral of symptoms into the head, upper and lower extremities were included in the audit.

Audit locations

Sixteen NHS trusts in the South Thames region participated in the audit. They were:

Ashford and St Peters NHS Trust
Chichester Hospital
Dartford and Gravesham NHS Trust
Frimley Park Hospital
Hastings and Rother NHS Trust
Kent and Canterbury NHS Trust
Kent and Sussex NHS Trust
Mid Kent Healthcare Trust
Richmond, Twickenham and Roehampton NHS Trust
St Georges'
South Kent Hospitals NHS Trust
Thames Link
University Hospital, Lewisham
Woking Community NHS Trust
Worthing and Southlands NHS Trust

Audit Team

Ms Maria Yeomans – Programme Manager
Mrs Carol Groom – Clinical leader, Mid Kent Healthcare Trust
Mrs Jane Woodward – West Kent Health Authority
Professor Ann Moore – Academic and professional consultant to the team, University of Brighton
Ms Diane Collyer – Workshop facilitator, Mid Kent Healthcare Trust (latterly William Harvey Hospital)
Ms Ann Heywood – Administrative support, Mid Kent Healthcare Trust
Ms Kathleen Antony – Administrative support, Mid Kent Healthcare Trust
Mrs Jackie Langford – Assistant to Professor Ann Moore
Mr Alan Hough – Technical support to Professor Ann Moore

Audit venues

Physiotherapy outpatient departments within 15 trusts in the South Thames region took part in the audit.

The audit base for data collection was Maidstone Hospital (Mid Kent Healthcare Trust).

Type of audit

A number of elements of structure, processes and outcomes were audited in a prospective audit of cervical spine dysfunction management by physiotherapy services.

Sample size

The actual sample size was 674 patients. Eight of these were excluded from the final analysis as they had no information relating to the patients outcome recorded and were thus not valid to enter the study. A total of 464 were discharged normally, ie fully completed physiotherapy treatment.

Sampling

All patients suffering from cervical spine pain and dysfunction were admitted to the study by each participating physiotherapy department. All appropriate patients therefore had an equal chance of being admitted to the audit.

Audit tool

Following the incorporation of Mid Kent and University of Brighton's outcome tool into everyday practice in Mid Kent Healthcare Trust's physiotherapy department and the successful use of the tool in the 12 month pilot study, the measurement tool was considered to have face and content validity for the low back pain audit even though it was designed as a general tool for outpatient use, and not for specific use with low back pain sufferers. Since the original work had been carried out, funding had not been available to test the inter- and intra- reliability of the tool. However, for the low back pain audit, the original outcome measurement was adapted slightly in several ways.

An episode section was added to determine whether the patient was suffering from a first episode or a recurrent problem. The reason for referral section was removed as it was specific to local units' needs. The physiotherapist identification section was removed in order to maintain individual therapists' confidentiality. Some minor additions to section codings were made to treatment details, other factors, body codings and referral source to reflect some local units' needs.

The outcome measurement tool discharge summary sheet used for the low back pain audit is included in appendix 2. The tool consisted of 27 items to be completed by the physiotherapist in charge of the patient care in conjunction with the patient. It consisted of a summary sheet which detailed items for response and allowed the addition of coded responses. The remainder of the tool consisted of a criteria for coding used for completion of each item as appropriate.

For the cervical spine audit, it was decided that the original tool which had been designed to cover a multiplicity of patient conditions entering physiotherapy outpatient departments from hyperventilation syndrome to skin disorders and musculoskeletal syndromes should be refined to make it more specific for use with patients with spinal dysfunction. The following sections were added to the original tool. (See appendix 3)

1. A section for rating the condition as acute or chronic.
2. A general diagnosis/aetiology section was added with a section for specific diagnosis if it had been provided and a physiotherapy diagnosis statement was incorporated.
3. A section relating to the tissue origin of symptoms was added in addition to a section inviting therapists to comment on the symptomatic spinal level involved.
4. The weighting of psychosocial and physical factors section was changed in order for a possible 5 responses to be made.
5. A section was added to enable units to record how many therapists had been involved in the patients' treatment.
6. A section was added on improvement of quality of life rating.

When comments were invited from representatives from trusts on the new tool and how it had worked in practice, it was felt that the new tool had been easier to use than the first and was more clinically relevant and sensitive to needs. There was less ambiguity and generally the tool was found to be user friendly.

Explanation of the tool

Unit location of outpatient physiotherapy department – The unit locations of the participating outpatient physiotherapy departments were all randomly coded for inclusion into the audit. Unit location codings are not offered in this report for purposes of anonymity.

Occupation – Occupations were classified using a modified version of the employment department group, Office of Population, Census and Surveys: Structure and definition of major, minor and unit groups (COPCS 1990).

Episode – Episode was classified either as first episode or recurrent episode to give some idea of chronicity.

Acute or chronic – Acute was defined as less than 6 weeks duration and chronic as more than 6 weeks duration.

General diagnosis/aetiology – Responses in this section were classified according to the general nature of the problem necessitating treatment ranging from traumatic, degenerative, inflammatory, congenital, pathological, postural, aetiological origin, spontaneous onset or psychogenic cause.

Specific diagnosis – Specific diagnosis related to the nature of the problem being treated. eg. soft tissue injury, cervical rib, disc lesion etc. In addition, the physiotherapist could record their individual physiotherapy diagnosis in up to 62 characters. eg. they could state “facet joint impingement” if they believed this to be the problem.

Body site codes – Up to 4 body site codes could be recorded, specific codes were offered to reflect spinal areas and potential referral areas relating to the spine.

Origin of referred symptoms – This section enabled the physiotherapist to indicate whether they felt the problem was of neural or other origin.

Symptomatic level – Physiotherapists were given the opportunity to indicate a maximum of three symptomatic spinal levels found on palpation or to state that there were multiple segments involved.

Laterality of symptoms – Symptoms were recorded either as bilateral or unilateral.

Waiting times – Referral dates and dates of commencement of treatment were recorded for administration purposes, but also to calculate the length of patient wait from first contact with present problem with their GP/Consultant to time of referral to physiotherapy in weeks. Additionally, the length of wait was recorded for the time patients were required to wait in weeks, from referral date by their GP/Consultant to commencement of treatment within the physiotherapy service.

Weighting of psychosocial and physical factors affecting the physiotherapy process – This item was based on the Wirral formula (Ball et al 1993). Categorisation took place of the problem necessitating consultation, communication/sensory difficulties, mobility problems, other conditions and social circumstances, and these problems were each rated on a scale of 1-5. Scores range from 1 = No difficulty to 5 = severe difficulty. When rating a problem, physiotherapists were asked to give an indication of the severity of the problem, ie in terms of the pathology and/or dysfunction.

For communication/sensory issues, the physiotherapist was asked to give an indication of the severity of the communication or sensory difficulties, eg. inability to communicate, hearing impairment, co-existing central nervous problem or language problem. For mobility, the physiotherapist was asked to give an indication of any co-existing mobility problems, eg. problems with sitting, necessity for a walking aid for an allied or co-existing problem, and/or transportation difficulties. For social circumstances, the physiotherapist was asked to give an indication of the severity of any social circumstances which may have impacted on their

treatment strategy. These could include, for example, if a patient was a single parent, bereavement, financial problems or unemployment.

Other conditions – In this section, the physiotherapist could give an indication of the severity of other conditions which might impact on the management of the patient, eg. patient with a heart condition, respiratory condition and/or any other co-existing medical or orthopaedic problem.

Functional, physical and subjective outcomes – These items related to the initial assessment of functional, physical and subjective outcomes, the assessment of expected functional, physical and subjective outcomes and the actual functional, physical and subjective outcomes. The score was rated on a scale of 1-10 and related to severity, irritability and nature of the problem, range of motion, participation in work, leisure and social activities and reliance on drug therapy for pain relief.

Outcome of referral – Outcome of referral allowed the recording of, not only patients who were discharged normally (attended for physiotherapy treatment as prescribed by their physiotherapist and who were discharged from treatment by the physiotherapist), but also the incidence of non-attendance, transfers inside and outside the district and inappropriate referrals.

Treatment details – Physiotherapists could record up to 4 treatment modalities used in the management of the patient. It was understood that the treatment details would reflect the combined use of modalities in many cases and not necessarily simply a progression of treatment.

Total effort scores – The effort scores were based on those introduced by Ball et al (1993), and originally incorporated into the Wirral formula. An activity/treatment modality or administrative activity, eg. letter writing, was scored in terms of the time taken to carry out the task and the degree of effort required in achieving the task successfully. Class taking, for example, was scored according to the formula shown in appendix 3. Effort was graded on a scale of 1-10 taking into consideration the application of the task, physical and mental exertion required, strength required, concentration required, conviction and the motivation of others necessary to complete the task. Effort was recorded at the end of each contact period and the total effort score for the whole treatment period recorded on the discharge summary sheet.

Goal achievement at discharge – Goal achievement was assessed jointly by the therapist and the patient based on goals set at commencement of treatment. Six categories allowed the choice ranging between worse/no goals achieved to goals exceeded. Each category was given a series of descriptors in respect of range of movement, function, pain relief and the ability to work, and scored in terms of the number of treatments necessary to achieve that particular rating. Numbers of treatments were categorised as either 1-6 treatments, 7-12 treatments, 13-18 treatments or 19+ treatments. (See appendix 3 for details)

Other factors influencing outcome – Factors included in this item included anything which might have influenced the outcome of physiotherapy intervention which were beyond the therapists control eg. other medical interventions, lifestyle influences or ceasing to attend etc.

Number of treatments – The number of treatments were recorded in terms of the number of contacts made.

Physiotherapy grade – The grading of the physiotherapist carrying out the treatment was recorded. Where there was more than one physiotherapist involved in the treatment of the patient, up to three grades could be entered.

Patient perceived pain, function and ability to work – In each case, the patient was asked to indicate their level of pain, functional ability and ability to work before treatment commenced and when treatment was terminated. In order to improve the reliability of this outcome measure, it was important that all patients were asked the information in the same

way. The following statement was made by all therapists in respect of each patient that they assessed.

“In order to monitor the effectiveness of your treatment, it is important that we find out about your levels of pain, your level of functional ability and your ability to work at the present time. Please choose a number on the scale of 0-10 which indicates:

- 1) Your present level of pain when it is at its worse, where 0 = the least amount of pain you could envisage and 10 = the worst pain you could imagine.
- 2) Ability to work where 0 = complete absence of ability to work and 10 = working normally.
- 3) Functional ability where 0 = total absence of ability to carry out functional tasks at home, and in the social setting and 10 = maximum or normal ability to carry out functional tasks.”

These questions were all asked again on completion of physiotherapy treatment.

Referral source – Please see appendix 3 for details.

Improvement of quality of life – It was felt that a section should be added on monitoring the patients' perceived improvement or otherwise in their quality of life. Patients were asked to determine their overall improvement or decrease in their quality of life following treatment taking all their personal factors and physical factors into consideration, eg. their pain levels, ability to work, their social life, their sexual activity and general participation in leisure and sporting activities. They were then asked to rate these on a scale of 0-100% in terms of improvement. If 0% was the least improvement they could achieve and 100% was the most they could expect to have achieved, where would they rate themselves on a scale of 0-100 at this time. Patients were allowed to respond with a negative figure if this was more appropriate.

Data entry

All data was entered directly from original discharge summary sheets by administrators at Mid Kent Healthcare Trust and was sampled for conformity by the audit consultant.

Audit results

Management of audit data

The data was analysed and downloaded in 3 ways.

Firstly, all data was described and/or tallied for each variable recorded on the discharge summary sheets.

Then cross tabulation was carried out between the variables, which had been suggested by unit representatives to be of particular interest to them.

Data in this report is presented in its complete form with missing data excluded. The actual numbers on which statistics are based are given in each section.

Finally it should be noted that detailed analysis of outcomes has been carried out, for some variables, only on those data sets of patients who were normally discharged, ie who completed physiotherapy treatment and were discharged by their physiotherapist in the normal way. A detailed breakdown of outcome of referral indicates why patients were not discharged normally and were therefore lost to the physiotherapy service.

Throughout the text, outpatient department unit locations are identified only by number (randomly allocated) to ensure anonymity.

Analysis of data

Data analysis was performed using Minitab, Excel and Epi 6 statistical packages.

Results

Audit population

The total number of patients referred with cervical dysfunction and included in the audit was 674. The number of patients who entered the audit and were discharged normally was 464.

Patients distribution by unit location

The numbers of patients entering the audit attributed to each physiotherapy unit location are shown in Table 1a.

Unit 4 made a nil return to the audit but were initially involved in the initial workshop training sessions.

Unit 6 returned the largest proportion of data sets (13.5%) closely followed by unit 14 (12%) and unit 8 (11.4%). Units 1 and 12 returned very small numbers of data sets for the audit.

The total numbers of patients discharged normally by each physiotherapy unit location, are shown in Table 1b, Unit 14 returned the largest frequency of patients discharged normally (14.2%) followed by unit 11 (12.5%) and unit 8 (12.1%).

Age groups of patients referred with cervical spine dysfunction

The age groups of all patients referred with cervical spinal dysfunction are shown in Table 2a. the most frequently referred age group was the 40-49 age group (22.5%) with a fairly symmetrical distribution throughout the age ranges 0-9 and 80-89.

Higher frequencies in the over 40's are indicative of normal degenerative changes (spondylosis) in the 40 -50 year olds and late arthrosis occurring the 50-60 year old age group.

The frequency of ages of those patients experiencing normal discharge are shown in Table 2b. Again, the 40-49 age group showed the greatest frequency of normal discharges, and the frequency of referrals by age group showed a similar pattern to that demonstrated by all referrals. The mean age of all patients referred was 49.5 years and the mean age of those normally discharged was 51.2 years.

Gender

Tables 3a and 3b show the frequency of referral by gender for all referrals and those discharged normally. In each case, there was a higher frequency of female patients than males.

Age group and gender

Table 4a shows the frequency of gender by age group for all referrals and Table 4b, the frequency of all those normally discharged.

The highest frequency for female patients in the all referral category was found in the 40-49 age group, and there was an equally large frequency in the 40-49 and 50-59 age groups for males. For those normally discharged, the largest group of females were again in the 40-49 age bracket, but the larger proportion of males were found in the older age groups (50-59, 60-69 and the 70-79 ranges).

Occupation

The frequencies of occupational groups for all those referred to physiotherapy for cervical spine pain and dysfunction are shown in Table 5a and for patients discharged normally in Table 5b.

In each case, the retired occupational group was by far the largest group represented with associate professional and clerical secretarial the next most highly represented groups.

Occupation by physiotherapy location

The occupations of patients by physiotherapy location for all those referred are shown in Table 6a, and for those discharged normally shown in Table 6b.

The distribution of occupations by location, largely reflected the same trends within the all referral group and those who were normally discharged.

Nature of recurrency

The frequency of referrals by episode for all referrals is shown in Table 7a, and for patients discharged normally in 7b.

In both cases, the slightly larger majority of patients were suffering their first episode. However, the frequency of recurrency is quite alarming, particularly in those who were normally discharged.

Chronicity of the problem

The frequency of referrals by chronicity for all referrals is shown in Table 8a, and for patients discharged normally in Table 8b.

Of concern was that of all referrals and those discharged normally, over 70% were in a state of chronicity. Perhaps giving some indication of the complexity of the problems being presented to physiotherapists in their clinics.

General diagnostic aetiology

The frequency of referrals by general diagnostic aetiology for all referrals is shown in Table 9a, and for those normally discharged in Table 9b.

The most frequently presented aetiological / diagnostic category was in each case, degenerative, which is consistent with the represented age groups. Traumatic aetiology was the second largest group presented.

Specific diagnosis

The frequency of referrals by specific diagnosis for all referrals is shown in Table 10a, and for those normally discharged in Table 10b.

In each case, spondylosis was the most common problem presenting followed by whiplash and joint dysfunction.

Physiotherapy diagnosis

Physiotherapists were able to incorporate their own physiotherapy diagnosis into the discharge summary sheet using a text field of up to 62 characters, and the results of this section are shown in appendix 4. Of note, is the diversity of descriptions applied to the presenting syndromes and detailed analysis showed that descriptions were often idiosyncratic to particular therapists. This must raise the question of quality in terms of communication between therapists. The obvious way forward would be a standardised glossary of terms and/or syndromes.

Body site affectation

The frequency of referral by primary body site for all referrals is shown in Table 11a (1), and for those discharged normally in Table 11b (1), indicating that cervical spine affectation with pain or symptoms referred to the shoulder was the most common primary body site, with central cervical spine symptoms the next most common site.

For all those referred 253 patients, and for those normally discharged 175 patients had a second problematic area. These are shown in Tables 11a (2) and 11b (2). In each case, the upper thoracic spine was the most commonly represented body site.

Sixty of all the patient referrals and 44 of the normally discharged patients had a third area involved. In both cases, the referral to the shoulder and secondly to the wrist were noted. See Table 11a (3) and Table 11b (3).

Sixteen of all referrals and 10 of those normally discharged exhibited a fourth body site involvement. In both cases, the highest representation was referral to the hand. See Table 11a (4) and Table 11b (4).

Tissue origin of symptoms

The frequency of tissue origin for all referrals and for patients discharged normally are shown in Tables 12a and 12b.

Nerve root origin was the most frequently cited problematic tissue in both groups.

Laterality of symptoms

The frequency of laterality of symptoms for all those referred and for those discharged normally are to be found in Tables 13a and 13b respectively.

Unilateral symptoms were the most frequently described in both situations.

Symptomatic levels

The most common response by therapists to primary spinal levels affected was multiple levels, which was consistent with the traumatic and degenerative changes noted. C5/6 and C6/7 were the most commonly identified individual segmental levels. The same distribution was noted in those patients who were discharged normally, as is shown in Tables 14a (1), and Table 14b (1).

Where more than 1 segmental level was identified, C6/7 and C7/T1 were the most common levels identified, (see Table 14a (2)), and where a third level was identified, C5/6, C6/7 and T1/2 were the most frequency cited symptomatic levels (see Table 14a (3)).

Waiting time in weeks from consultation with GP to referral to physiotherapy

The median waiting time for all referrals was 2.0 weeks (SIQR 4) and a mode waiting time of 0 weeks. 50% of patients were referred within 2 weeks and 80% were referred to physiotherapy within 11 weeks of consulting their GP. For details, see Table 15a,

For those normally discharged, the median waiting time was 2.0 weeks (SIQR 4) and a mode of 0. For details see Table 15b, which shows that 51.5% were referred within 2 weeks of consultation and 81.9% were referred within 11 weeks of consultation.

Waiting time in weeks from referral by GP to commencement of physiotherapy

The frequency of the length of wait in weeks from referral by the General Practitioner to commencement of physiotherapy for all referrals is shown in Table 16a. The figures show a median wait of 3.0 weeks (SIQR 3) and a mode score of 1 week and 42% of patients commenced physiotherapy treatment within 2 weeks. The figures for those discharged normally are shown in Table 16b where the median wait was 3.0 weeks (SIQR 3) and a mode wait of 1 week. 43.5% commenced physiotherapy within 2 weeks and 90.9% commenced physiotherapy within 11 weeks of being referred.

The frequency of banded length of wait from referral to commencement of physiotherapy for all patients referred and those discharged normally are shown in Tables 17a and 17b. The most commonly occurring length of wait in each case, was 0-2 weeks.

Psychosocial and physical factors impacting on therapy

The frequency of the severity of factors impacting on therapy, such as the problem itself, communication problems, mobility problems, social problems and other problems for all those referred for treatment are shown in Table 18a (1-5) and for those discharged normally in Table 18b (1-5).

As can be seen in both cases, the actual problem necessitating referral in the majority of cases (41.4%) was rated as moderate, although 24% of all referrals (20% of normal discharges) were rated as quite severe. Less than 12% had communication problems, around 24% had mobility problems, 37.6% of all referrals had social problems and 34.2% of all referrals had other problems. Only 34% of those discharged normally had social problems and 33.4% had other problems to deal with.

Frequency of outcome of referral

The frequency of outcome of referral is shown on Table 19 for all referrals. 70.9% of all patients were discharged normally following completion of physiotherapy treatment. 15% were lost to the service through non-attendance at some stage during their treatment period. There were only 7 inappropriate referrals, but 6.6% were referred back to their GP/Consultant presumably due to a worsening condition or one which was not responding to physiotherapy.

Other factors influencing outcome

Table 20 shows the frequency of other factors influencing the outcome of physiotherapy treatment for all referrals. There were no other factors in the largest proportion of patients but lifestyle influences were thought to have influenced the outcome in 11.6% patients, and interestingly 7.8% ceased to attend for treatment, having previously commenced treatment.

Use of treatment modalities

Therapists were encouraged to list up to 4 treatment modalities used with each patient. These modalities may have been applied in combination through a number of treatment sessions, and therefore do not necessarily reflect treatment progression.

Treatment choices are shown in Tables 21, 22, 23a and 23b. The most popular modalities utilised were the Maitland concept, mobilisations, active exercises, advice on self-management and education and advice.

The combination of treatment modalities for all referrals is given for information in appendix 5. Commonly, 4 modalities were utilised and these are shown in their entirety. SNAGS were used in 17.5% of cases, and traction in 16.5% of cases. 40.3% of patients received some form of electrotherapy. The most popular form of the electrotherapy modality was ultrasound. Only a small number of therapists appeared to use the McKenzie approach. Interestingly, all patients referred, who commenced treatment, received 3 modalities. A further 39.7% received a fourth modality.

Treatment modality by hospital location

In trusts 2, 3, 6, 13, 26 and 4 advice re self-help was the most popular modality chosen. Whilst in trusts 5, 7, 8, 9, 11, 12, 14 and 15 the Maitland concept was the most frequently used modality. In trust 16 active exercises was the most commonly used modality.

Modality preference by grade of physiotherapist

Junior physiotherapists preferred advice and self-care as a modality, followed closely by active exercises. Senior II staff preferred to use Maitland mobilisations followed by advice and self-care. The same preferences were shown by Senior I staff. Only 1 patient returned was treated by a student. Only 2 patients were seen by Superintendent I's. Acupuncture was the preferred modality of Superintendent II's but this was only shown in 7 patients. Maitland mobilisations was the most frequently chosen modality in Superintendent III's, but for Superintendent IV's advice and self-care was the most frequently chosen modality.

Total effort scores

The frequencies of total effort scores obtained for all referrals are shown in Table 24 for the whole cohort. There was a minimum score of 1 and a maximum of 126 with a mode of 24 and a median of 23 (SIQR 17) indicating reasonably low effort scores considering the potential complexity of many of the traumatic cervical spine lesions.

Number of treatments

The mean number of treatments received overall was 5.3 (SD 3.147) with a mode of 4. For the frequencies and number of treatments received for all referrals, see Table 25a and for those discharged normally see Table 25b.

Numbers of treatments banded in groups of 6 are shown in Table 25c.

Frequency of referral by grade of physiotherapist

Table 26 shows the distribution of numbers of patient treatments by grade of physiotherapist. Senior II's showed the highest contact frequency for all those referred and those discharged normally, with Superintendent III's and Superintendent IV's showing slightly higher numbers of normally discharged patients and Junior's slightly lower numbers.

In some instances patients were treated by more than 1 physiotherapist. The frequency of grade of the first physiotherapist to have contact with the patient is shown in Table 26, with Senior II grades taking the highest referral load in the first instance followed by Senior 1's.

When a second physiotherapist is used, Senior 1's are the most heavily utilised followed by Senior II's and superintendent III's in equal proportions (See Table 27).

Table 28 shows the frequency of number of physiotherapists involved in patient treatments. 90.2% of patients were treated by 1 sole physiotherapist, 8.1% by 2 physiotherapists and only 1.7% of all referrals were treated by 3 physiotherapists or more.

Referral source

The frequency of the referral source for all those referred is shown in Table 29, with General Practitioners showing themselves to be the most frequent referral sources of patients with cervical spine dysfunction (82.5%).

Functional assessment

For details of the functional assessment criteria, see appendix 3, items 20, 21 and 23 of the discharge summary sheet and relevant criteria.

On initial assessment of functional ability, patients scored a mode of 3.0 and a mean score of 5.38 (SD 2.040). For frequencies see Table 30.

At initial assessment, an assessment of expected of functional outcome was made, and frequencies of scores of expected functional outcome are to be found in Table 31, with a mode score of 9 and a mean of 8.3 (SD 1.5).

The actual functional outcome scores for all referrals are shown in Table 32. Again there was a mode score of 9 and a mean of 8.2 (SD 1.89) showing a strong relationship between the assessment of expected outcome and actual functional outcome.

Patient perceived pain

For all patients referred, and for those discharged normally, perceived pain at examination and on discharge were recorded using a digital analogue scale, ie 0 - 10. Scores are shown in Tables 33a and 33b for scores prior to treatment for all referrals and for those discharged normally and in Tables 34a and 34b for scores on completion/leaving physiotherapy.

For all patients referred, pain prior to commencement of treatment showed a median score of 6.0 (SIQR 1.5) and a mode score of 8. On completion of treatment, a median score of 2.0 (SIQR 1.5), with a mode score of 1 was obtained showing a profound decrease in pain levels for the whole cohort.

For those normally discharged, there was a median pain score of 6.0 (SIQR 1.5) prior to commencement of physiotherapy with a mode score of 8, and at discharge a mean score of 1 (SIQR 1.5) and a mode score of 1. Again showing a profound decrease in pain levels during the treatment time.

Frequencies of change in pain levels after physiotherapy for all patients referred and those discharged normally are shown in Tables 35a and 35b. For all normally discharged, the

range was from –6 to 10 with a median score of 3 (SIQR 1.5) and a mode score of 3. The minus figures indicating worsening pain levels in some patients.

Functional ability

For all those referred, functional ability scores prior to commencement of physiotherapy ranged from 0 to 10 with a median score of 7 (SIQR 1.5) and a mode score of 5, and following physiotherapy ranged from 0 to 10 with a median score of 9 (SIQR 1) and a mode score of 10.

The functional ability scores for all those referred for physiotherapy and those discharged normally prior to commencing physiotherapy are given in Tables 36a and 36b, and for scores on completion of physiotherapy or normal discharge in Tables 37a and 37b.

The functional ability scores indicated reasonably high levels of functional ability prior to commencement and a good restoration towards normal levels of functioning after physiotherapy intervention.

For all those normally discharged, scores before physiotherapy commenced ranged from 0 to 10 with a median score of 7 (SIQR 2) and a mode score of 5, and after physiotherapy scores ranged from 0 to 10 with a median score of 9 (SIQR 1) and a mode score of 10. Generally showing an increase in functional ability across the patient cohort during the intervention period.

The frequencies of change in functional ability for the whole cohort and for those discharged normally are shown in Tables 38a and 38b. Patient perceived change in functional ability levels for all those discharged range from –10 to 10 with a median score of 1 (SIQR 1.5) and a mode score of 0, indicating that some patients perceived a reduction in functional ability. For those discharged normally, the range was from –10 to 10 with a median score of 2.0 (SIQR 1.5) and a mode of 0.

Change in functional ability by grade of physiotherapist

For details of change in functional ability by grade of physiotherapist, see Table 39.

There was little difference in the proportion of patients achieving various levels of functional restoration in relation to the grade of therapist treating their condition. The nature of the patient problem, its chronicity and motivation patterns of the patient would all have contributed to recovery rates and levels of recovery. No conclusions could be drawn from the data. However, clustering of levels of increase in functional levels 2/3 occurred in Junior grades, Senior II and Senior I grades who treated the majority of patients.

Change in patient perceived functional ability by hospital location

For details of change in functional ability by hospital location, see Tables 40 and 41.

There was a clustering of functional scores 2/3 by physiotherapy location. Location 11 demonstrated consistently higher scores but this could be attributed to the nature of the patient population as well as other factors, such as therapist speciality, experience and motivation.

Trusts 14 and 9 showed the highest proportion of patients who had perceived worsened functional ability.

Trust 4 made no returns.

Trust 10 showed the highest proportion of patients who perceived no change.

Trust 1 showed the highest proportion of patients who perceived improvement in functional scores but only 3 patients details were returned.

All Trusts showed a larger proportion of patients with increased or improved functional improvement than those who felt worse or remained unchanged.

Ability to work

The frequencies of patients perceived abilities to work, prior to commencement of physiotherapy for all those referred and for those discharged normally are shown in Tables 42a and 42b.

Scores following physiotherapy are shown in Tables 43a and 43b.

For all referrals, scores for ability to work prior to commencing physiotherapy ranged from 0 to 10 with a median score of 7 (SIQR 2.5) and a mode score of 10. On leaving physiotherapy, scores ranged from 0 to 10 with a median score of 10 (SIQR 1) and a mode score of 10.

For those normally discharged, scores ranged before commencing physiotherapy from 0 to 10, a median score of 7 (SIQR 2) and a mode of 10 and following physiotherapy ranged 0 to 10 with a median score of 10 (SIQR 1) and a mode score of 10.

However, the scores for all those referred should be seen in the context of missing data re ability to work, where 42.6% were retired (See Table 44).

Improvement in quality of life

When making responses to the quality of life section, 5.2% of all those referred indicated that there had been a worsening of their quality of life. 94.8% noted an improvement in their quality of life. For details see Table 45a.

Of the normal discharges, 98.9% noted an improvement in their general quality of life. For details see Table 45b.

Scores for improvement in quality of life for all referrals are shown in Table 46a and for those discharged normally in Table 46b.

Noting in each case a generally high return of improvement in quality of life scores amongst the patient population.

Goal achievement

The frequencies of goal achievement for all referrals and for those discharged normally are shown in Tables 47a and 47b. The mode score for all referrals was 5 for both cohorts (goals fully achieved in 1-6 treatments). For those normally discharged, 69% significantly fully achieved or exceeded their set goals within 1-6 treatments. Less than 4% of all referrals did not achieve goals, were worse, or were inappropriate for treatment. Only 1.7% of those normally discharged failed to achieve goals. No one was worse after treatment. For details of goal achievement by numbers of treatments, see Table 47c.

For goal achievement by the number of weeks between referral to physiotherapy and commencement of physiotherapy, see Table 47d, showing that the largest number of those who fully achieved goals in 1-6 months waited the shortest time, 0-2 weeks.

Patients with trauma as their specific diagnosis

153 patients had trauma as their aetiology. The specific diagnoses for patients within this group are shown in Table 48. Of these, whiplash was the most common syndrome treated with 68.6% of the total being dedicated to whiplash injuries.

The number of treatments given to the traumatic cohort ranged from 1-19 with a median number of treatments of 5 (SIQR 2) and a mode number of treatments of 5. See Table 49 for details.

The total effort scores for patients with traumatic lesions ranged from 6 to 153 with a median effort score of 24 (SIQR 22) and a mode score of 12.

Patients suffering from whiplash syndrome had a range of 1-19 treatments. The median number of treatments of 5 (SIQR 2.25) and a mode number of treatments of 3. This was remarkable considering the complexity of so many whiplash syndromes (see Table 50).

78.3% of patients with whiplash syndrome were receiving treatment following their initial injury. 21.7% were being treated for recurrent symptoms (see Table 51).

Of the recently injured group of whiplash patients, the numbers of treatments ranged from 1-19 with a mode score of 3 (see Table 52).

Effort scores for the patients with whiplash syndrome ranged from 7 to 120 with a median effort score of 24.5 (SIQR 10) and a mode score of 12 indicating that physiotherapists found this group no more challenging than other traumatic patients.

Physiotherapists treating whiplash syndromes were in the main, Senior II's who treated over 50% of the cohort and Senior I's who treated over 25%.

Factors influencing the outcome of whiplash patients treatment

Factors influencing the outcome of whiplash patients treatment are shown in Table 53. Interestingly 14% chose to cease to attend, 46% had no other factors, and only 1% needed to change grade of physiotherapist.

Spondylotic patients

For patients with a diagnosis of spondylosis, the number of treatments ranged from 1-16 with a median number of treatments of 5 (SIQR 1.5) and a mode of 4 (see Table 54).

Over 50% of patients of patients with spondylosis scored their actual functional outcome as being 8 or more on the 10 point scale (see Table 55).

The most common modalities used in the treatment of spondylosis were mobilisations (Maitland concept), advice and self-care, active exercises, education and advice

Achievement of standards

The standards set at the commencement of the audit were:

- Pain levels will be reduced by 4 or to 0, ie no pain at discharge, in 80% of patients.
- Functional ability will have increased by 2 or to full function at discharge in 95% of patients.
- 60% of patients will fully achieve or exceed their agreed goals within 6 treatments.

All referrals

Pain levels will be reduced by 4 or to 0, ie no pain at discharge, in 80% of the patient population

83.6% of all those referred had their pain reduced by 4 or to 0 at discharge. Therefore the standard was achieved.

Functional ability will have increased by 2 or to full function at discharge in 95% of the patient cohort.

82.5% of patients showed an increase of 2 in functional ability or full functional ability at discharge. Therefore the standard was not achieved.

60% of patients will fully achieve or exceed their agreed goals within 6 treatments

61% of patients fully achieved or exceeded their goals by discharge. However, only 48.3% achieved this within 6 treatments. Therefore the standard was not achieved.

Patients discharged normally

Pain levels will be reduced by 4 or to 0, ie no pain at discharge in 80% of patients.

69.7% of patients had their pain reduced by 4 or to 0 at discharge. Therefore the standard was not achieved.

Functional ability will have increased by 2 or to full function at discharge in 95% of the patient cohort.

86.4% of those normally discharged increased their functionally by 2 or reached full functional ability at discharge. Therefore the standard was not achieved.

60% of patients will fully achieve or exceed their agreed goals within 6 treatments.

72.7% of patients will fully achieve or exceed their agreed goals at discharge. In the normal population only 55.5% of patients achieved this within 6 treatments. Therefore the standard was not achieved.

Comments from Trusts on the Audit Tool and the Audit Process

Comments were invited from representatives of the participating trusts on the new tool and how it had worked in practice and also on the general process of the audit. These comments were made at a joint meeting held in February at the University of Brighton in 1999.

1. The second tool; the South Thames audit of physiotherapy intervention for spinal problems tool was easier to use than the original tool as it was found to be more clinically relevant and sensitive.
2. There was less ambiguity in the second tool than the first.
3. Section 19 – this section proved to be difficult to use with patients who did not speak English. It was noted that it had been decided that an ethnicity box would not be included when designing the tool, which would have helped an interpretation of section 19.
4. The tool was generally found to be user friendly.
5. It was felt that 'patients perceived pain function and ability to work' section should be placed nearer the beginning of the audit form.
6. It was felt that the 'improvement in quality of life' section should be moved further towards the beginning of the summary sheet and it was also felt that the 'referral source' should be at the beginning of the summary sheet.
7. The end date for physiotherapy intervention should be moved to the end of the discharge summary sheet.
8. It was noted that the original tool had been designed to cover as many needs as possible from the perspective of administrators, clinicians, patients and managers. The second tool was found to be more clinically biased. Discussions took place as to whether more clinical standards should be developed as there is now a significant amount of information provided when using the current tool, which is not measured by any of the standards which have been set to date.
9. A number of areas were identified for further research throughout the meeting, one such area has been researched by a University of Brighton undergraduate student this year, which is an investigation into the 'Non-attendance' of patients referred to physiotherapy in two of the participating trusts.

General comments on the process related to the issues relating to tracking of forms. There seem to be in some instances, insufficient time for forms to be completed. This issue is currently being addressed at trust level. One trust felt that they had not completed enough forms by the due date and therefore fast-tracked patients with cervical spine dysfunction who were awaiting physiotherapy treatment in order to complete more audit forms by the due date. It was felt that this showed considerable commitment by the physiotherapy managers concerned.

Future directions

Several trusts have already utilised information from the low back pain audit and used them in their strategic planning. Several trusts are also considering using the recommendations and developing their own standards for future use.

Future work of the group will be to look to see how the audit can fit in to the continuous monitoring of competence and on standardising the basic levels of treatment that should be offered.

The project group is committed to staying together to allow recommendations to be actioned and to organise re-auditing when it is felt appropriate. Standards can now be re-written to an appropriate level. The project group, in the light of changes to the South Thames region, is now termed the Trans Regional Audit Forum group and may also be used in the future to raise research questions which could be addressed in multiple site research locations.

Commentary/Recommendations

1. The number of patient data sets returned by several trusts was disappointingly low. All trusts at the outset expressed enthusiasm for taking part in the audit. It was therefore surprising that such small returns were made by some. The reasons of this should be established. It may well relate to:
 - a. The management of the audit
 - b. Local staff issues
 - c. Staff training in the use of the tool
 - d. Perceived applicability and relevance of the tool to local practice
 - e. Patient throughput
 - f. Time needed to complete audit documentation
2. The highest age frequency of patients attending for treatment was found in the 40-49 age group indicative of a working age group. This group also showed the highest frequency of normal discharges. In view of the high proportion of non-attendees (see item 6), it would be important to ensure that the service caters for the needs of those in employment, who may well find difficulty in attending for appointments between 9 to 5. It is known that some departments already offer evening/early morning clinic appointments.
3. The highest frequency of recurrency of symptoms in patients was alarming. Recurrency however, may indicate patients who have suffered a recurring syndrome before seeking help from their GP or it may be that patients have had physiotherapy treatment before and that symptoms have recurred. Patients suffering cervical syndromes, and particularly those with traumatic aetiology may sometimes present with complex clinical manifestations involving sensory motor and sympathetic dysfunction, which may not always be apparent immediately after initial injury. It would be important therefore to ensure that all physiotherapy staff are acquainted with the rarer forms of clinical manifestations, eg. posterior cervical sympathetic syndrome, in order to comprehensively offer self-help and advice in the management and treatment of the presenting syndromes, to ensure that the recurring frequency is not due to ineffective physiotherapy management. It is also important and essential that patients with cervical spine symptoms are referred to physiotherapy as early as possible, and early referral by GP's is evident from the statistics given in the audit report. It may however, be a case for education of the potential patient population to recommend early consultation with their General Practitioner in respect of cervical spine orientated symptoms, in order to prevent or lower levels of chronicity exhibited within this cohort.
4. The diversity of physiotherapy diagnostic descriptions used by the participants in the audit was surprising. The descriptions often appeared idiosyncratic with particular therapists and with particular localities. This raises the question of ease of communication between physiotherapists, firstly in the same department but also within therapists between trusts and at a national and international level. This issue probably needs to be addressed urgently, at a local level initially, and possibly points to the need for a small working party to be set up, to establish a glossary of physiotherapy diagnostic terms, in an attempt to standardise terminology across the region. Actions should therefore be discussed by the audit team at its next meeting.
5. The waiting times for referral by General Practitioners to physiotherapists was low in the majority of cases, with a mode score of 0 and a median wait of 2 weeks, and patients waited, on average, only 3 weeks to see a physiotherapist, which was lower than expected. This may reflect the priority given, particularly to patients with

traumatic aetiology, although these figures were comparable to the waiting times seen in previous audit of low back pain.

6. Fifteen percent of patients were lost to the service through non-attendance of some kind. This figure is less than the percentage found in the previous audit of low back pain, however it is still high and obviously impacts on the effectiveness and efficiency of physiotherapy services. Trusts are encouraged to investigate locally, the reasons for non-attendance. Some pilot work has already been carried out by Wood & Moore (1999), and further trusts should consider instigating possible action plans to reduce non-attendance levels.
7. Consistency was shown in the choice of treatment modalities between physiotherapists and physiotherapy location. Some choices reflected obvious clinical speciality within the locality. The modality of preference by grade of physiotherapist was interesting in that Juniors tended to use more patient orientated modalities, ie advice and self-care, in preference to more passive modalities, eg. mobilisations. This may have reflected the type of patient allocated to junior staff. Perhaps the more complex cases being referred to more senior staff, or perhaps a shift in educational philosophy in institutes of higher education, or perhaps, even the reluctance of some junior staff to use other forms of treatment. This would be an interesting issue for local teams to look into.
8. The mode number of treatments of four appeared to show good efficiency of working within the service generally.
9. It was gratifying to note that expected function and actual functional outcome scores showed a strong relationship. Functional restoration scores generally improved, pain levels generally reduced and ability to work levels improved. There were however, some issues of data recording and the potential for inclusion of abhorrent data, with the 1-10 scores for functional ability, pain levels and ability to work. There appears to be examples in some returns where patient perceived scores of functional ability indicated a 10 point worsening of this ability. This may possibly have been the correct score but would have indicated a very unsatisfactory result for physiotherapy and it is more likely perhaps, that the scores were reversed. Comparable results were not evident in the ability to work scores. There is therefore an issue here for therapists who participated in the audit to ensure that their data entry is correct. Difficulties in interpretation of handwriting was noted in some instances, particularly in the physiotherapists diagnostic text field, where data inputters obviously had some difficulty in interpreting the correct terms.
10. Quality of life scores showed a minimal number of patients indicating a worsening of quality of life. This would equate with the 6.6% who were referred back to their GP or Consultant, and may also reflect worsening functional ability. Interestingly however, in the measurement of goal achievement, no patient was returned as being worse in this section.
11. Goal achievement generally was good with 69% signifying full achievement, or the exceeding of goals set within 1-6 treatments.
12. In terms of achievement of standards, the standards were not achieved in the patients who were normally discharged. Of note, is that 72% of patients were described as having a chronic problem, and it is therefore not surprising that standards were not achieved in this group. Additionally, there was little previous work available on which to base the standard setting, and it is therefore probable that the standards for this audit were set at too high a level. This audit data, however, now offers information on which to base more realistic standards for future audits.

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Table 1a Frequency of referrals to each physiotherapy unit - All referrals

OPD location	Number	Percent
1	5	0.7%
2	42	6.2%
3	21	3.1%
5	18	2.7%
6	91	13.5%
7	34	5.0%
8	77	11.4%
9	40	5.9%
10	73	10.8%
11	74	11.0%
12	8	1.2%
13	28	4.2%
14	81	12.0%
15	24	3.6%
16	58	8.6%
Total	674	100.0%

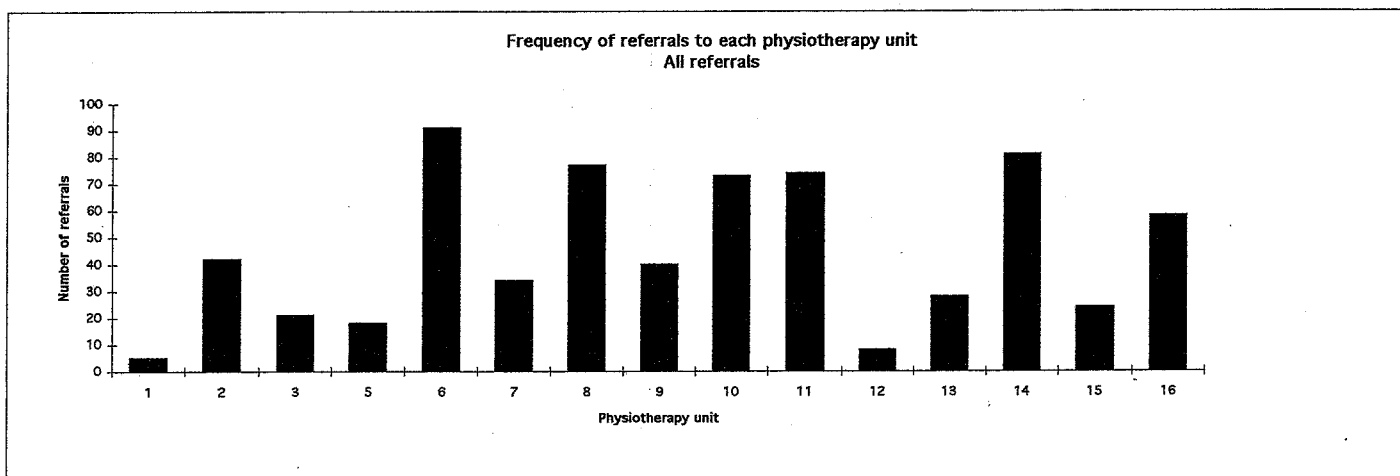


Table 1b Frequency of referrals to each physiotherapy unit - Patients discharged normally

OPD location	Number	Percent
1	3	0.6%
2	27	5.8%
3	10	2.2%
5	16	3.4%
6	48	10.3%
7	22	4.7%
8	56	12.1%
9	33	7.1%
10	47	10.1%
11	58	12.5%
12	4	0.9%
13	18	3.9%
14	66	14.2%
15	14	3.0%
16	42	9.1%
Total	464	100.0%

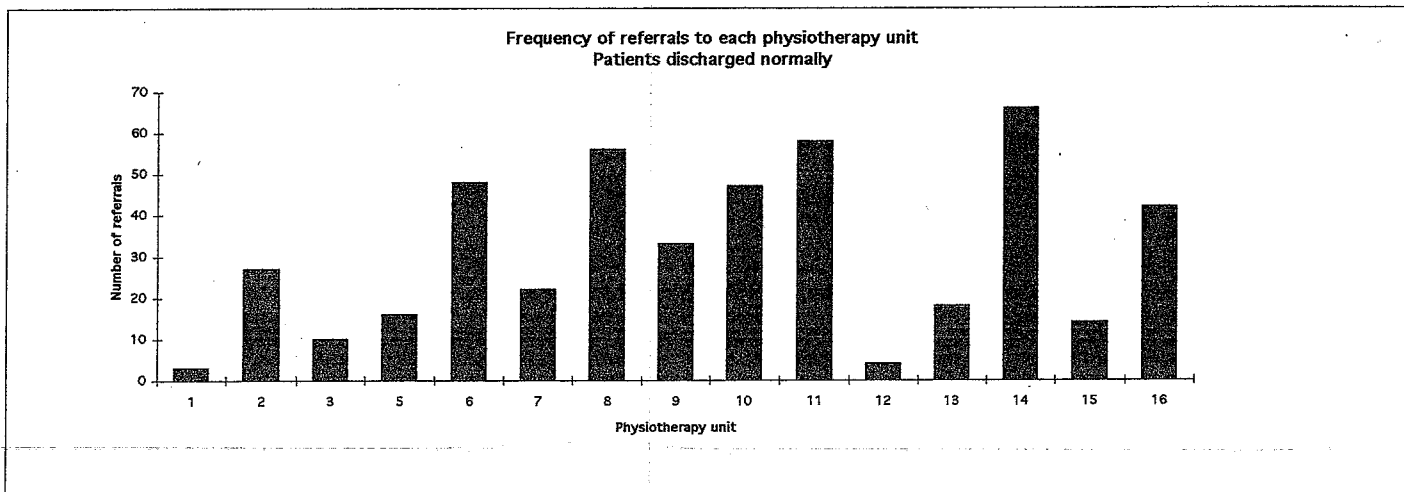


Table 2a Frequency of referrals by age group - All referrals

Age group	Number	Percent
0-9	9	1.4%
10-19	16	2.4%
20-29	54	8.2%
30-39	117	17.8%
40-49	148	22.5%
50-59	124	18.8%
60-69	97	14.7%
70-79	73	11.1%
80-89	21	3.2%
Total	659	100.0%

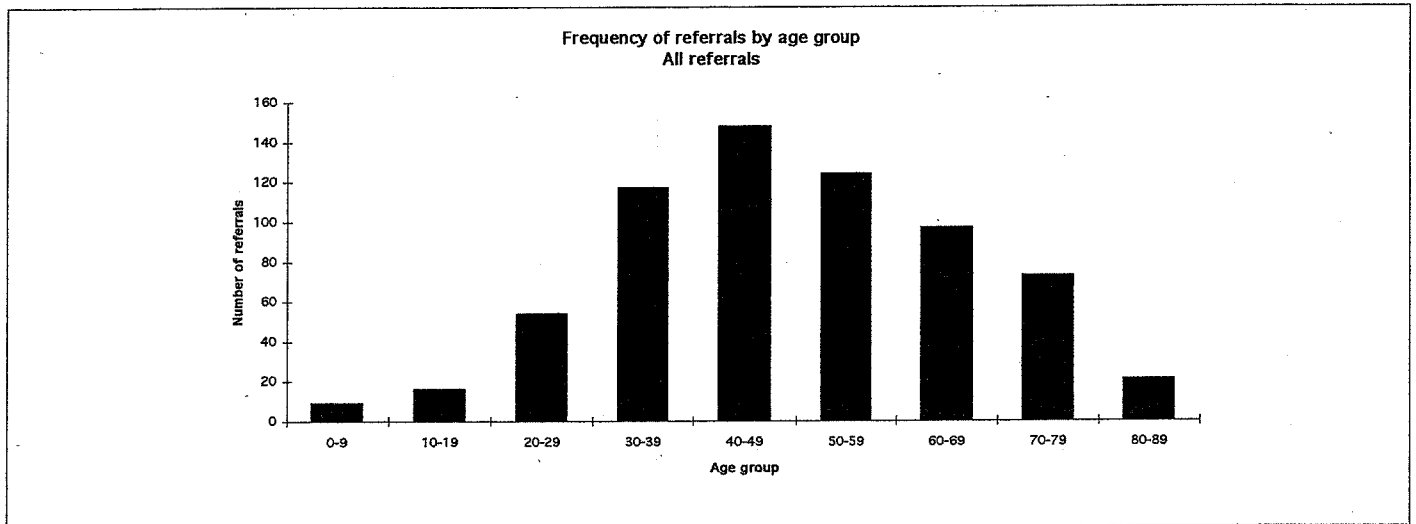


Table 2b Frequency of referrals by age group - Patients discharged normally

Age group	Number	Percent
0-9	2	0.4%
10-19	11	2.4%
20-29	36	7.8%
30-39	73	15.9%
40-49	98	21.3%
50-59	93	20.2%
60-69	72	15.7%
70-79	58	12.6%
80-89	17	3.7%
Total	460	100.0%

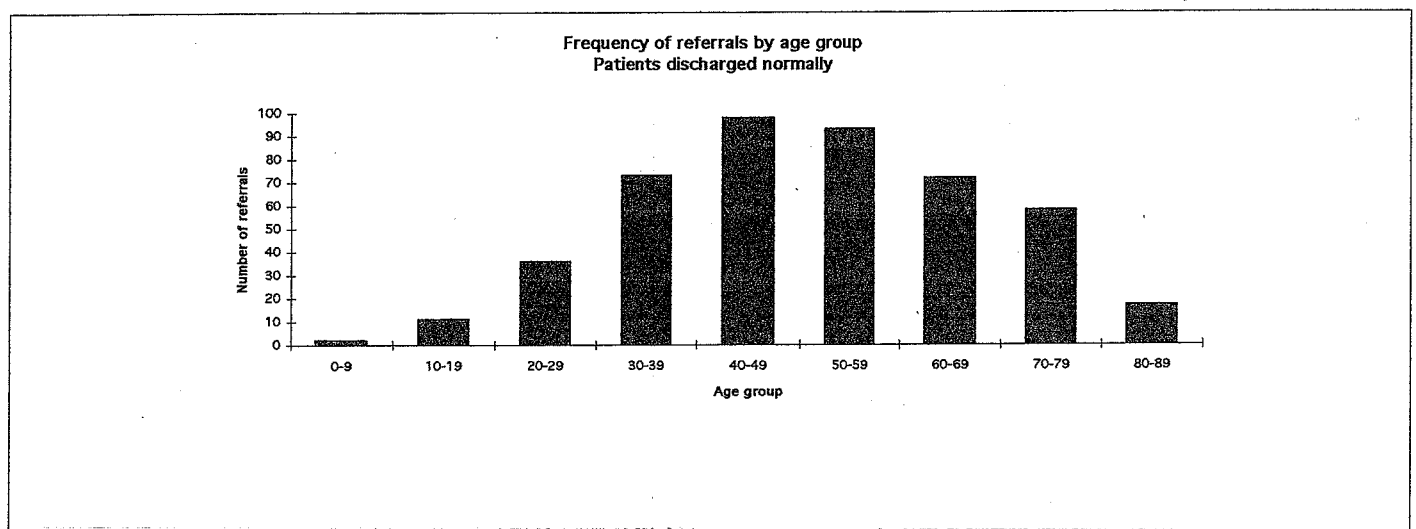


Table 3a Frequency of referrals by gender - All referrals

Gender	Number	Percent
FEMALE	421	63.6%
MALE	241	36.4%
Total	662	100.0%

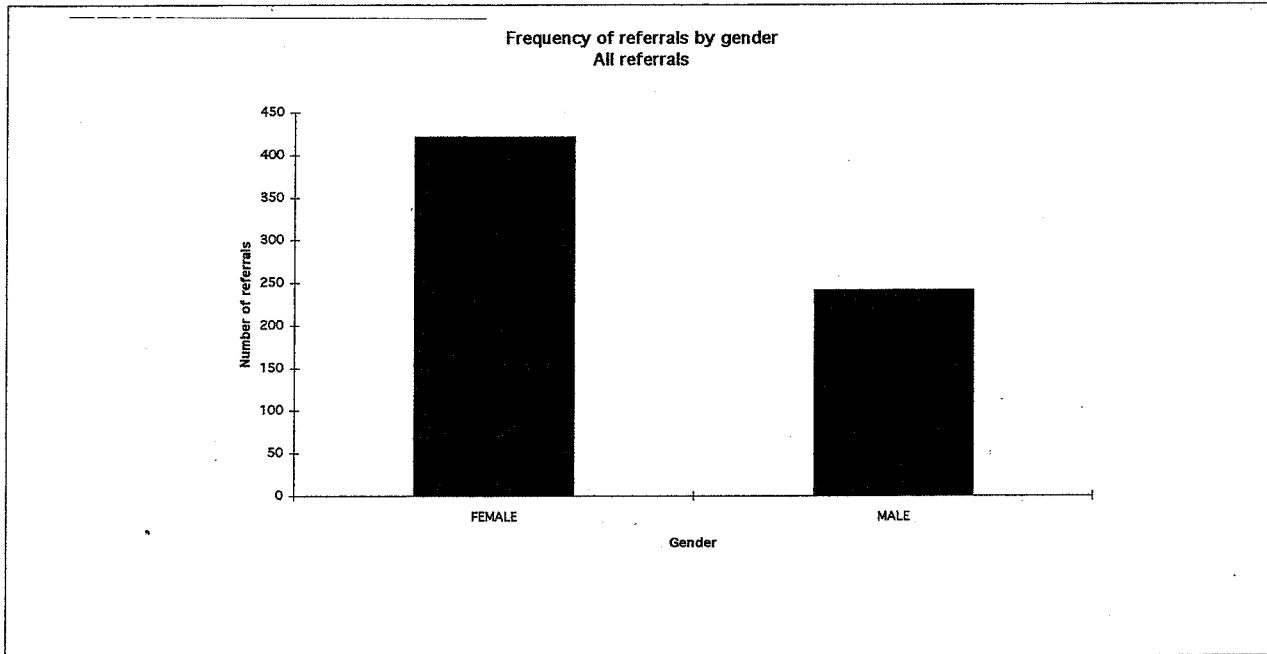


Table 3b Frequency of referrals by gender - Patients discharged normally

Gender	Number	Percent
FEMALE	291	63.1%
MALE	170	36.9%
Total	461	100.0%

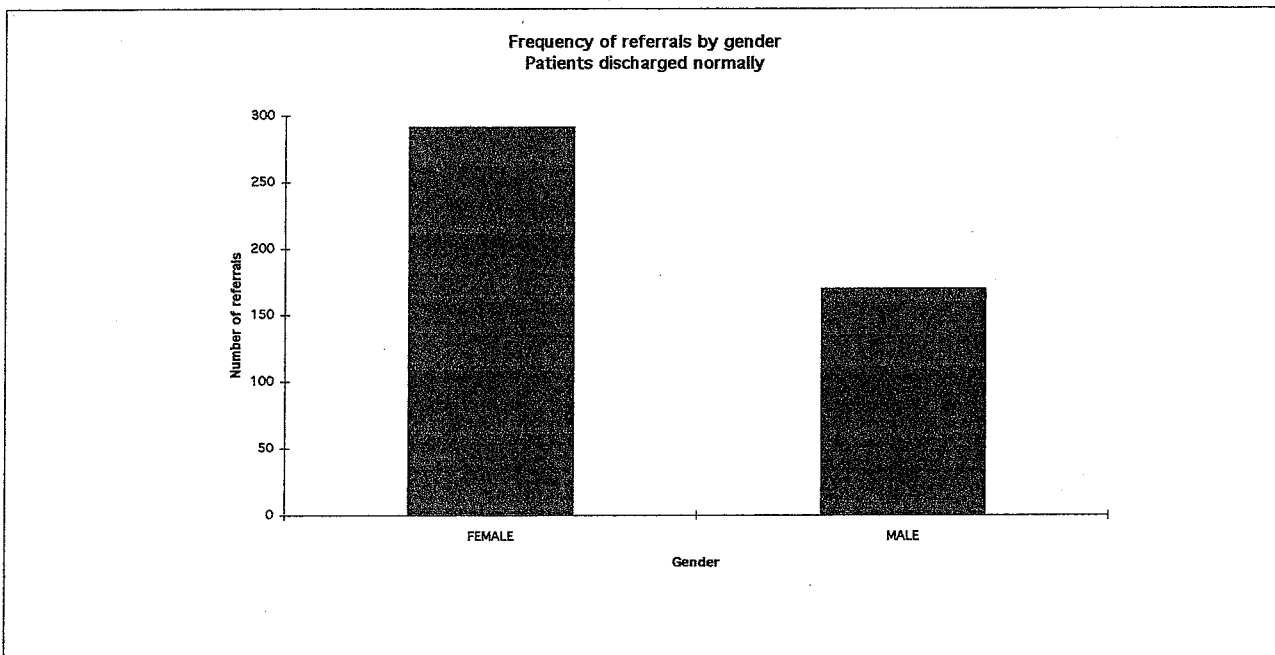


Table 4a Frequency of referrals by gender and age group - All referrals

Age group	Female	Male	Total
0-9	5	4	9
10-19	12	4	16
20-29	37	17	54
30-39	82	33	115
40-49	99	47	146
50-59	77	47	124
60-69	57	40	97
70-79	36	37	73
80-89	11	10	21
Total	416	239	655

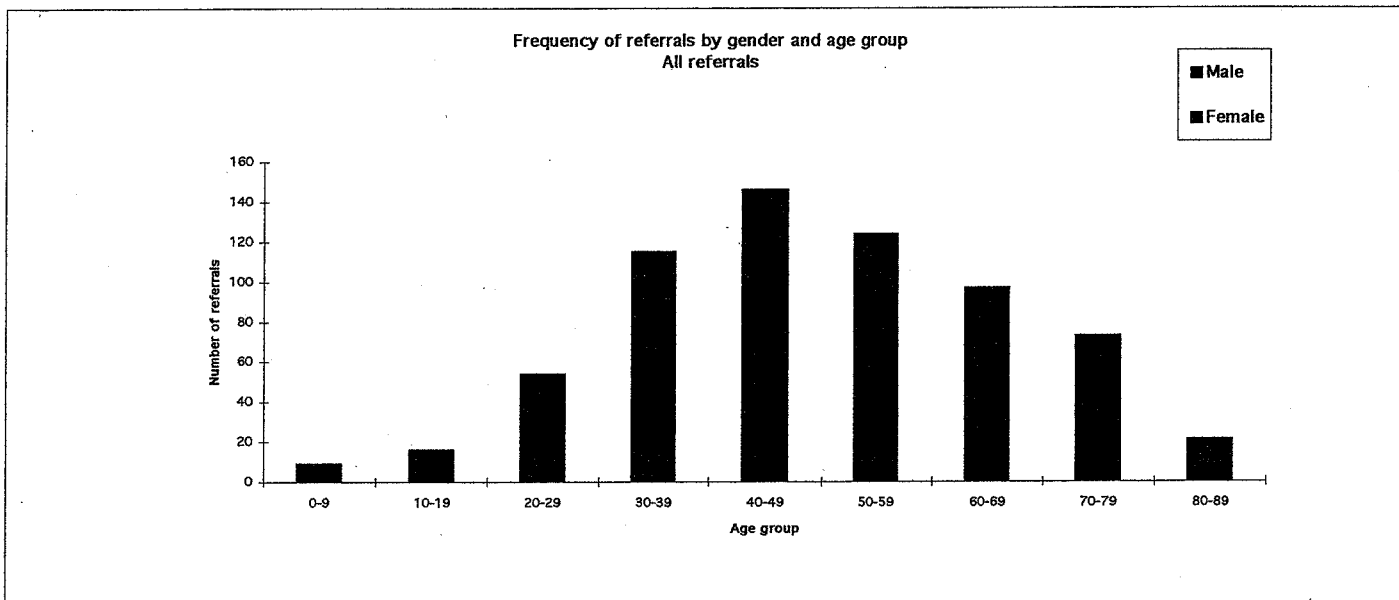


Table 4b Frequency of referrals by gender and age group - Patients discharged normally

Age group	Female	Male	Total
0-9	1	1	2
10-19	8	3	11
20-29	23	13	36
30-39	52	20	72
40-49	70	26	96
50-59	59	34	93
60-69	39	33	72
70-79	28	30	58
80-89	8	9	17
Total	288	169	457

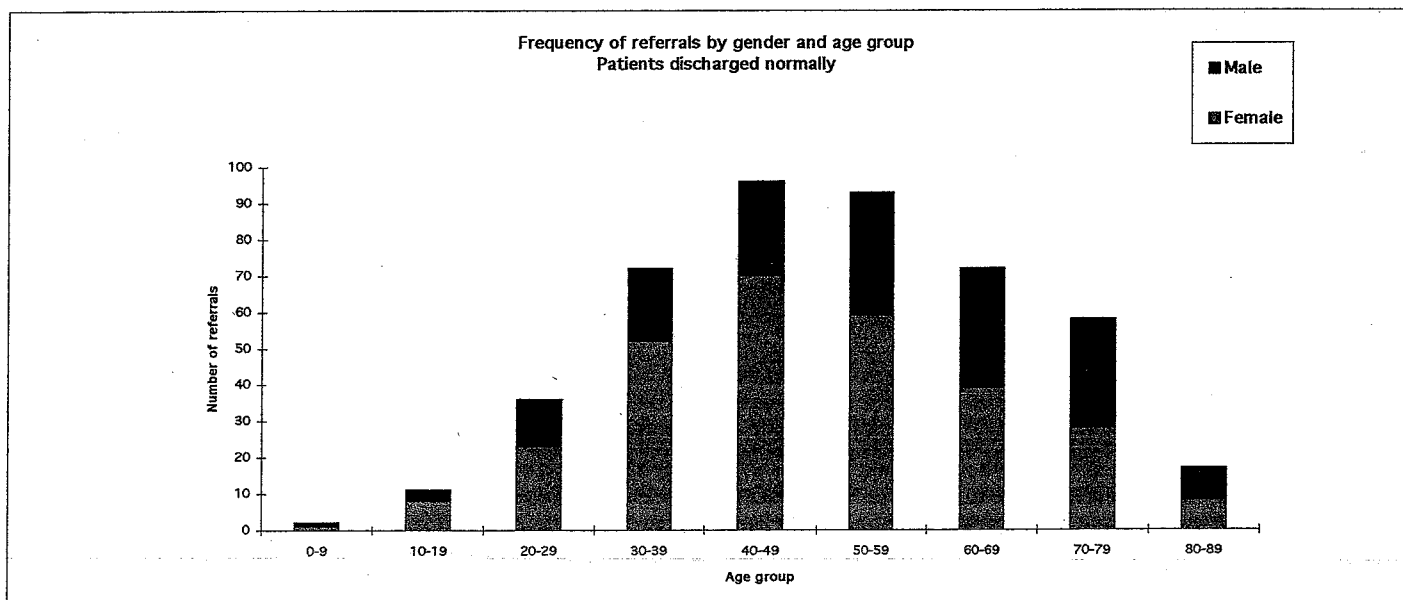


Table 5a Frequency of referrals by occupation - All referrals

Occupation	Number	Percent
Associate Professional	64	10.5%
Clerical/ Secretarial	74	12.2%
Craft & Related	39	6.4%
Houseperson> 2 years	61	10.0%
Manager/Administrator	34	5.6%
Other	42	6.9%
Plant/Machine Operator	19	3.1%
Professional	36	5.9%
Retired>2yrs	139	22.9%
Sales	27	4.4%
School Person	6	1.0%
Service	37	6.1%
Student HE/FE	7	1.2%
Unemployed >2 years	23	3.8%
Total	608	100.0%

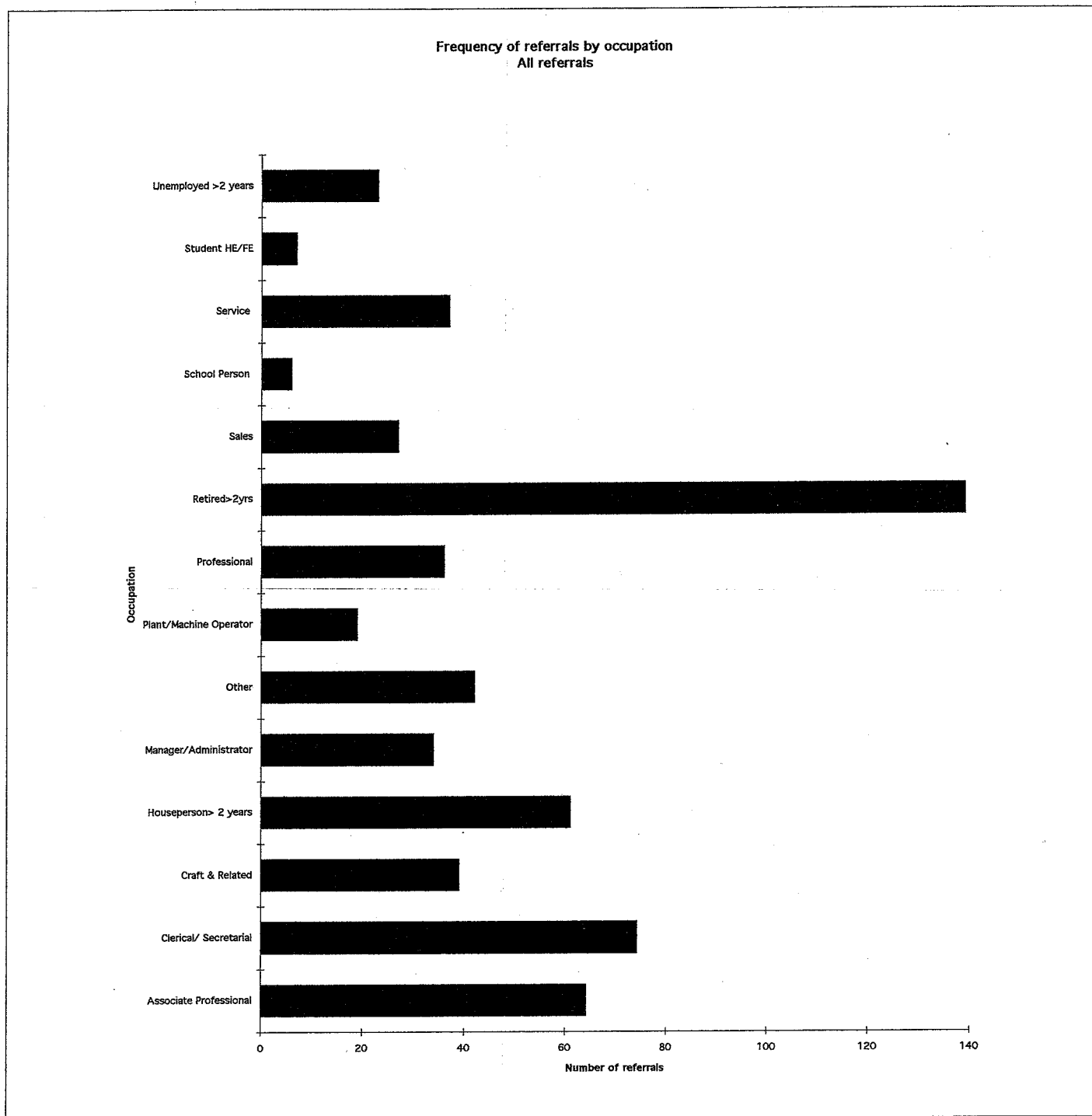


Table 5b Frequency of referrals by occupation - Patients discharged normally

Occupation	Number	Percent
Associate Professional	48	11.1%
Clerical/ Secretarial	57	13.2%
Craft & Related	20	4.6%
Houseperson> 2 years	41	9.5%
Manager/Administrator	25	5.8%
Other	31	7.2%
Plant/Machine Operator	15	3.5%
Professional	27	6.3%
Retired>2yrs	105	24.3%
Sales	16	3.7%
School Person	6	1.4%
Service	24	5.6%
Student HE/FE	4	0.9%
Unemployed >2 years	13	3.0%
Total	432	100.0%

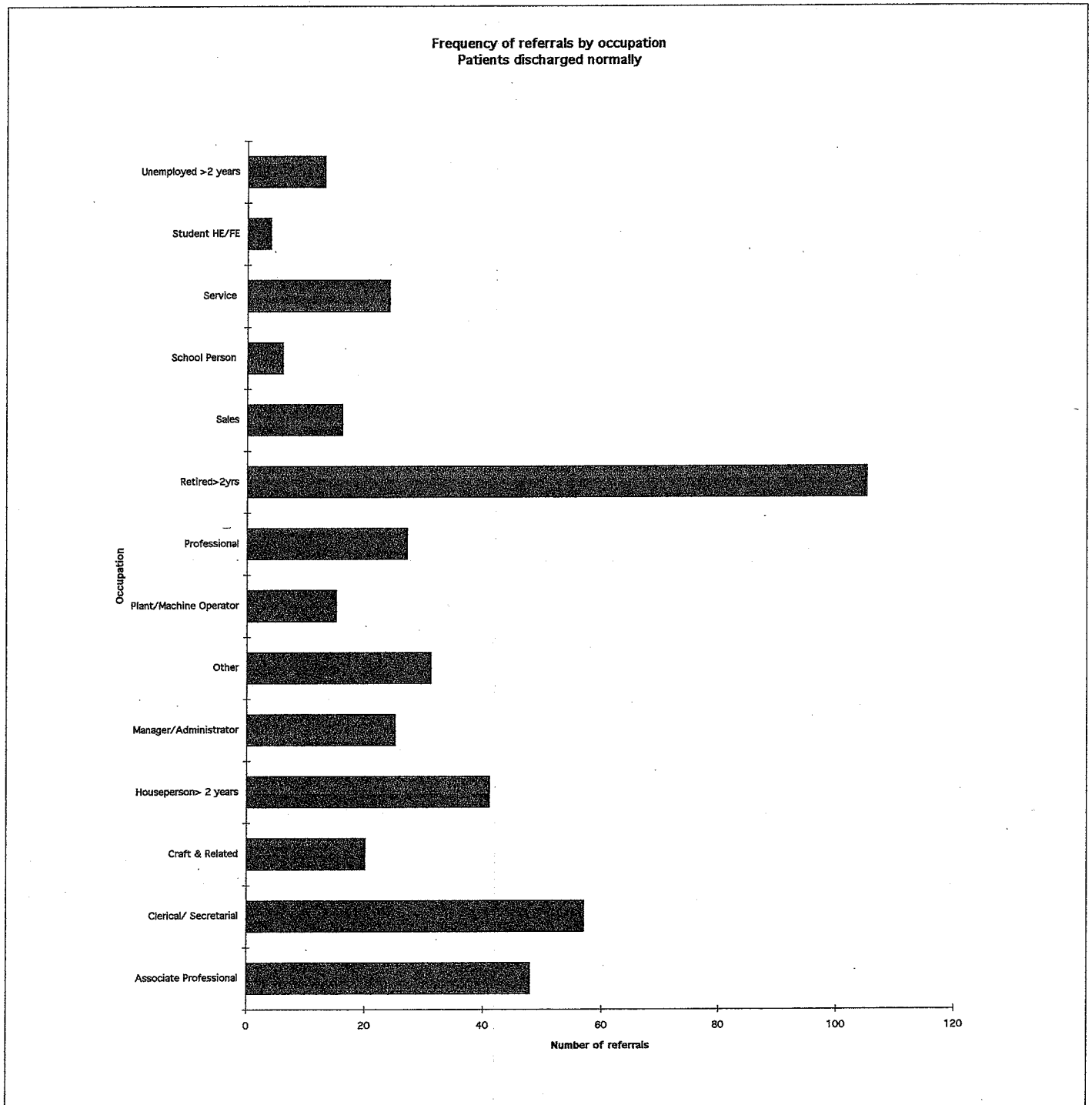


Table 6a Frequency of referrals by occupation and physiotherapy location - All referrals

OCCUPATION	OPD LOCATION																Total
	1	2	3	5	6	7	8	9	10	11	12	13	14	15	16		
Associate Professional	1	6	2	2	12	3	8	4	3	5	1	4	5	3	5	64	
Clerical/ Secretarial	2	2	0	2	10	4	10	3	9	10	1	1	11	6	3	74	
Craft & Related	1	1	2	1	3	2	5	2	7	6	0	2	3	1	3	39	
Houseperson> 2 years	0	7	2	1	5	4	13	1	9	6	3	2	8	0	0	61	
Manager/Administrator	0	2	0	0	6	1	4	2	3	3	0	1	7	1	4	34	
Other	0	1	2	1	3	4	5	4	6	2	1	3	1	3	6	42	
Plant/Machine Operator	0	3	1	0	4	0	1	0	3	3	0	0	3	1	0	19	
Professional	0	2	2	0	7	0	5	2	4	4	1	2	6	0	1	36	
Retired>2yrs	0	8	3	5	14	9	13	14	10	19	1	6	17	5	15	139	
Sales	1	0	1	1	4	3	2	1	4	2	0	1	5	0	2	27	
School Person	0	0	0	0	1	0	0	0	1	0	0	0	2	0	2	6	
Service	0	2	0	0	3	0	4	3	7	8	0	2	4	2	2	37	
Student HE/FE	0	0	0	1	2	1	0	1	1	0	0	0	1	0	0	7	
Unemployed >2 years	0	3	1	0	1	0	5	1	4	5	0	2	1	0	0	23	
Total	5	37	16	14	75	31	75	38	71	73	8	26	74	22	43	608	

Table 6b Frequency of referrals by occupation and physiotherapy location - Patients discharged normally

OCCUPATION	OPD LOCATION																Total
	1	2	3	5	6	7	8	9	10	11	12	13	14	15	16		
Associate Professional	1	4	1	2	9	1	7	3	3	4	0	3	4	3	3	48	
Clerical/ Secretarial	2	2	0	2	6	4	10	3	6	9	0	0	8	2	3	57	
Craft & Related	0	0	0	1	2	2	3	1	2	4	0	1	3	0	1	20	
Houseperson> 2 years	0	5	1	0	3	2	8	1	8	5	2	0	6	0	0	41	
Manager/Administrator	0	1	0	0	4	1	4	2	2	2	0	1	6	0	2	25	
Other	0	0	1	1	2	3	3	4	4	2	1	1	1	3	5	31	
Plant/Machine Operator	0	3	0	0	3	0	0	0	3	3	0	0	2	1	0	15	
Professional	0	1	2	0	4	0	3	2	3	3	0	2	6	0	1	27	
Retired>2yrs	0	7	2	5	9	5	9	12	5	16	1	4	14	3	13	105	
Sales	0	0	1	1	1	1	2	1	0	2	0	1	4	0	2	16	
School Person	0	0	0	0	1	0	0	0	1	0	0	0	2	0	2	6	
Service	0	2	0	0	0	0	3	2	4	4	0	2	4	1	2	24	
Student HE/FE	0	0	0	0	1	1	0	0	1	0	0	0	1	0	0	4	
Unemployed >2 years	0	1	1	0	0	0	2	1	4	3	0	1	0	0	0	13	
Total	3	26	9	12	45	20	54	32	46	57	4	16	61	13	34	432	

Table 7a Frequency of referrals by episode group - All referrals

Episode	Number	Percent
1ST EPISODE	340	53.5%
RECURRENT	296	46.5%
Total	636	100.0%

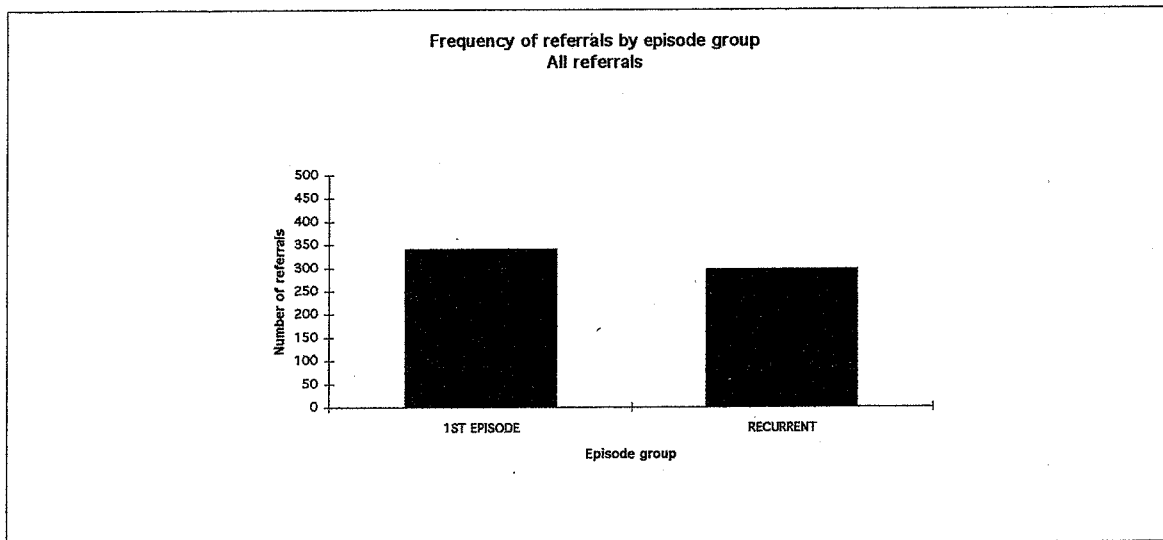


Table 7b Frequency of referrals by episode group - Patients discharged normally

Episode	Number	Percent
1ST EPISODE	239	52.2%
RECURRENT	216	47.5%
Total	455	100.0%

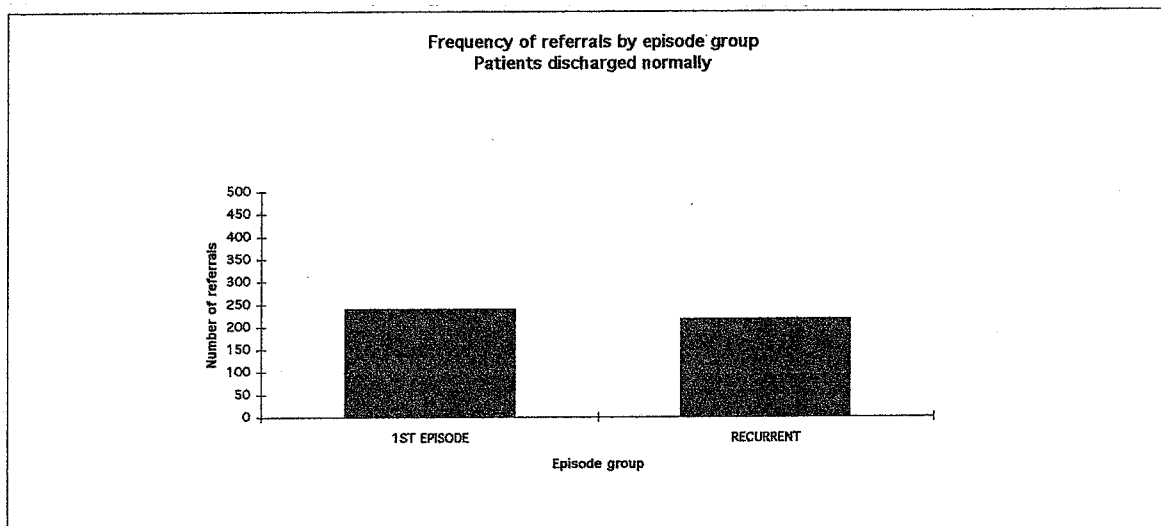


Table 8a Frequency of referrals by chronicity - All referrals

Chronicity	Number	Percent
Acute	177	27.7%
Chronic	461	72.3%
Total	638	100.0%

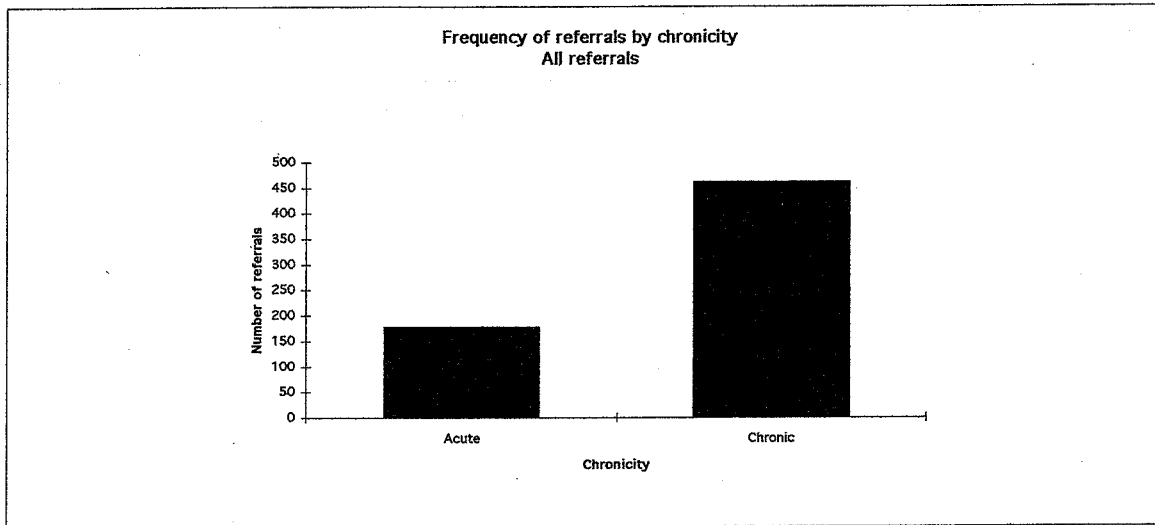


Table 8b Frequency of referrals by chronicity - Patients discharged normally

Chronicity	Number	Percent
Acute	125	27.5%
Chronic	330	72.5%
Total	455	100.0%

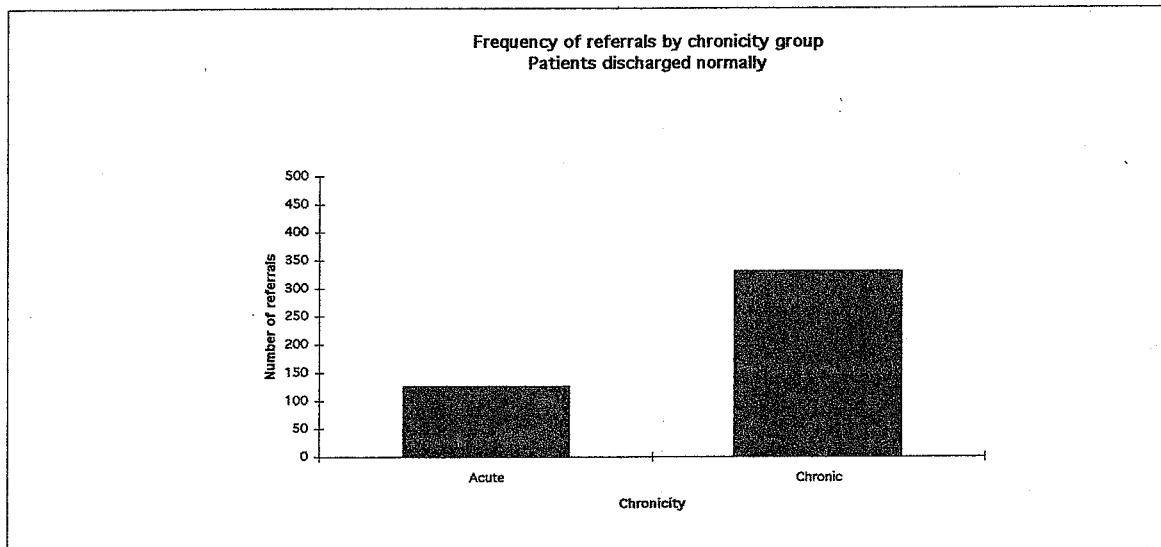


Table 9a Frequency of referrals by general diagnostic aetiology - All referrals

General diagnosis aetiology	Number	Percent
CONGENITAL	3	0.5%
DEGENERATIVE	273	42.1%
INFLAMMATORY	36	5.5%
PATHOLOGICAL	9	1.4%
POSTURAL	104	16.0%
PSYCHOGENIC	1	0.2%
SPONTANEOUS ONSET	69	10.6%
TRAUMATIC	154	23.7%
Total	649	100.0%

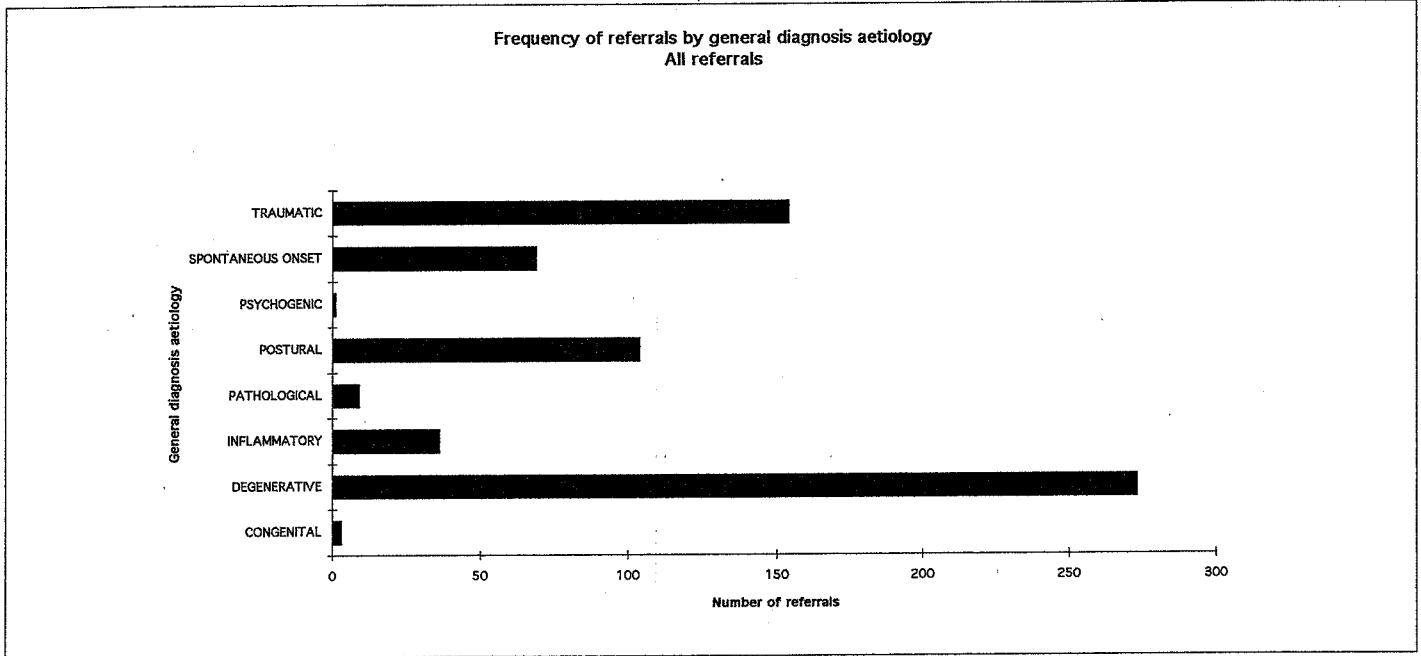


Table 9b Frequency of referrals by general diagnosis aetiology - Patients discharged normally

General diagnosis aetiology	Number	Percent
CONGENITAL	1	0.2%
DEGENERATIVE	213	45.9%
INFLAMMATORY	21	4.5%
PATHOLOGICAL	4	0.9%
POSTURAL	72	15.5%
SPONTANEOUS ONSET	46	9.9%
TRAUMATIC	107	23.1%
Total	464	100.0%

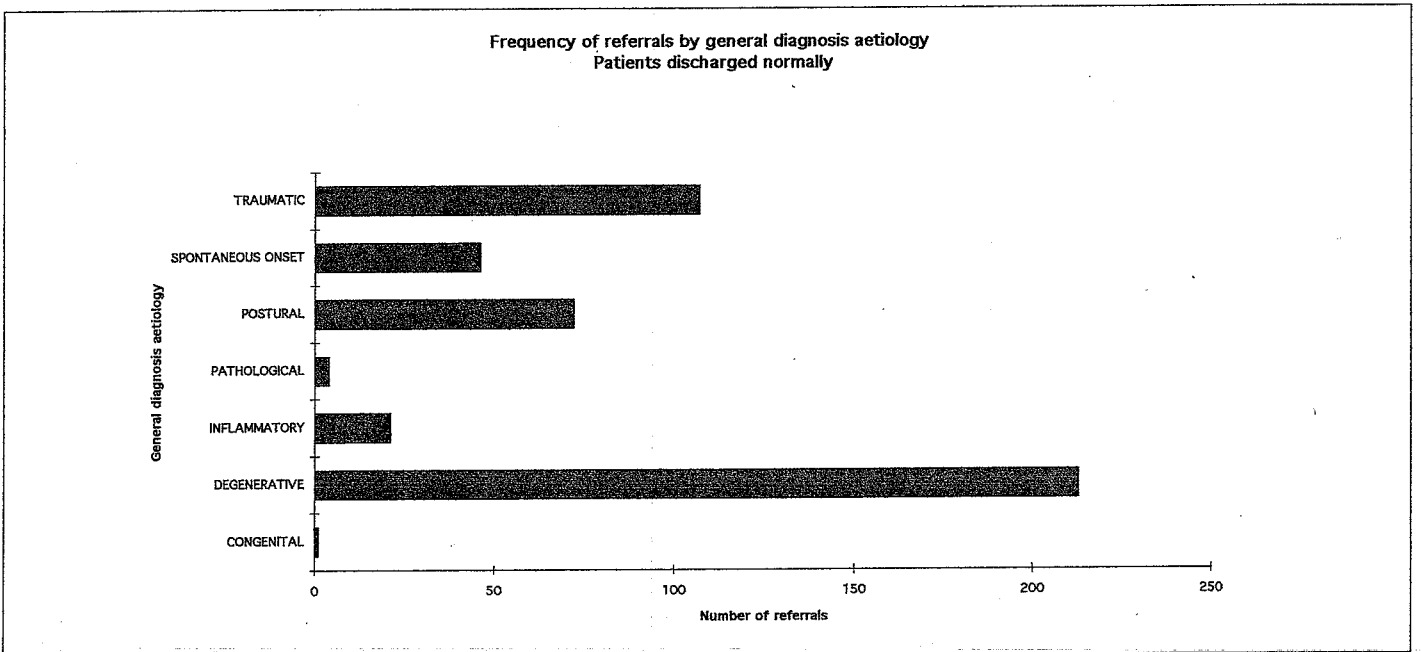


Table 10a Frequency of referrals by specific diagnosis - All referrals

Specific diagnosis	Number	Percent
ACUTE TORTICOLLIS	17	2.6%
ARTHROSIS	14	2.2%
BONY INJURY	4	0.6%
CERVICAL RIB	3	0.5%
DISC LESION	8	1.2%
DISC LESION AND NEURO	16	2.5%
INSTABILITY	4	0.6%
JOINT DYSFUNCTION PAIN	98	15.1%
JOINT INJURY	3	0.5%
KYPHOLORDOSIS	3	0.5%
KYPHOSIS	6	0.9%
MUSCLE DYSFUNCTION PAIN	57	8.8%
NERVE IMPINGEMENT	50	7.7%
NERVE INJURY	2	0.3%
NEURODYNAMIC PROBLEM	17	2.6%
OSTEOPOROSIS	2	0.3%
OTHER TRAUMA	8	1.2%
RHEUMATOID ARTHRITIS	14	2.2%
SCOLIOSIS	1	0.2%
SOFT TISSUE, JOINT & BONE	9	1.4%
SOFT TISSUE INJURY	12	1.9%
SPONDYLOSIS & ARTHROSIS	64	9.9%
SPONDYLOLITHESIS	1	0.2%
SPONDYLOSIS	124	19.2%
WHIPLASH	110	17.0%
	647	100.0%

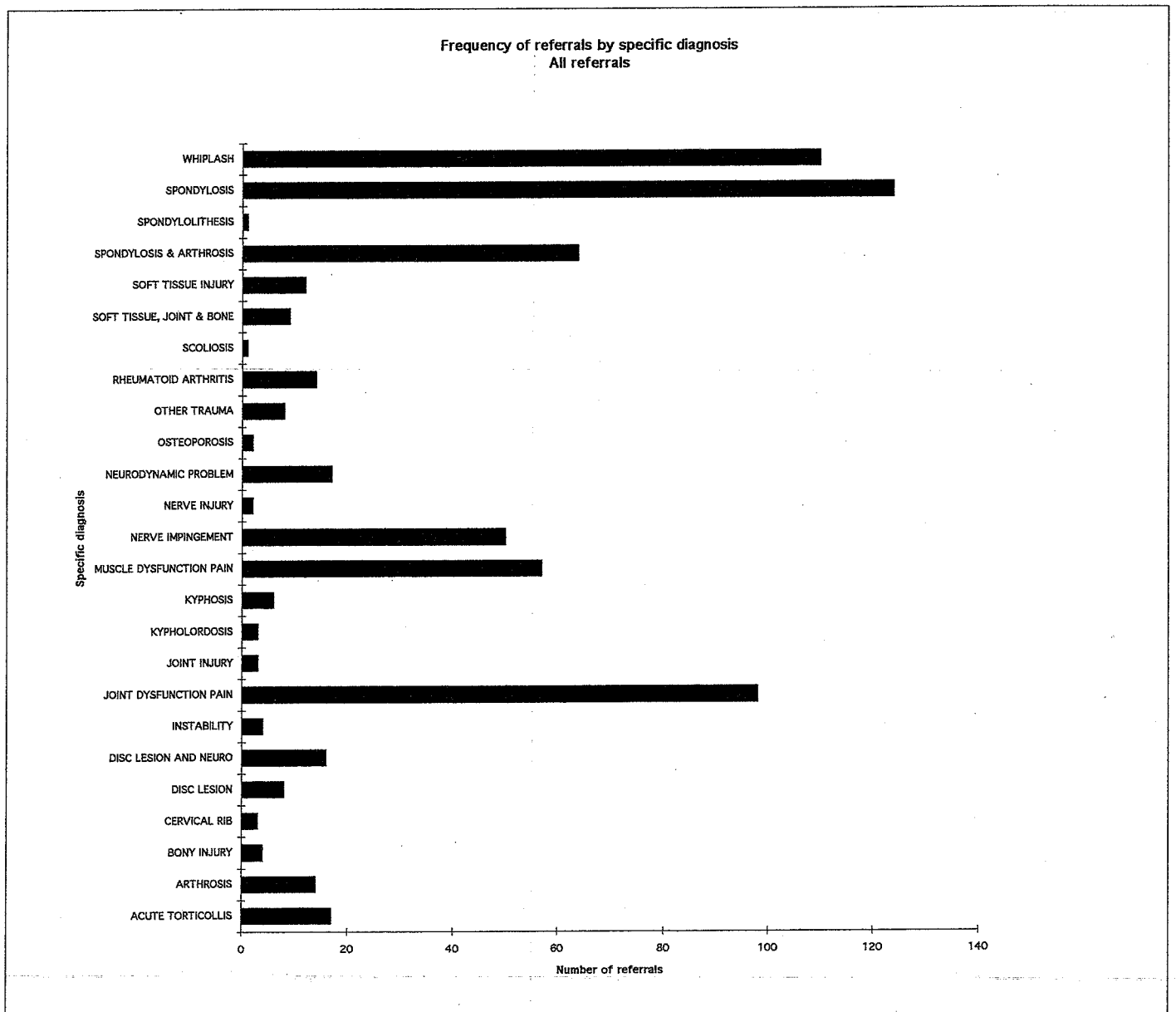


Table 10b Frequency of referrals by specific diagnosis -Patients discharged normally

Specific diagnosis	Number	Percent
ACUTE TORTICOLLIS	14	3.0%
ARTHROSIS	11	2.4%
BONY INJURY	3	0.6%
CERVICAL RIB	1	0.2%
DISC LESION	5	1.1%
DISC LESION AND NEURO	13	2.8%
INSTABILITY	3	0.6%
JOINT DYSFUNCTION PAIN	71	15.3%
JOINT INJURY	2	0.4%
KYPHOLORDOSIS	1	0.2%
KYPHOSIS	3	0.6%
MUSCLE DYSFUNCTION PAIN	44	9.5%
NERVE IMPINGEMENT	34	7.3%
NEURODYNAMIC PROBLEM	13	2.8%
OSTEOPOROSIS	2	0.4%
OTHER TRAUMA	4	0.9%
RHEUMATOID ARTHRITIS	8	1.7%
SCOLIOSIS	1	0.2%
SOFT TISSUE, JOINT & BONE	5	1.1%
SOFT TISSUE INJURY	12	2.6%
SPONDYLOSIS & ARTHROSIS	45	9.7%
SPONDYLOLITHESIS	1	0.2%
SPONDYLOSIS	92	19.9%
WHIPLASH	75	16.2%
Total	463	100.0%

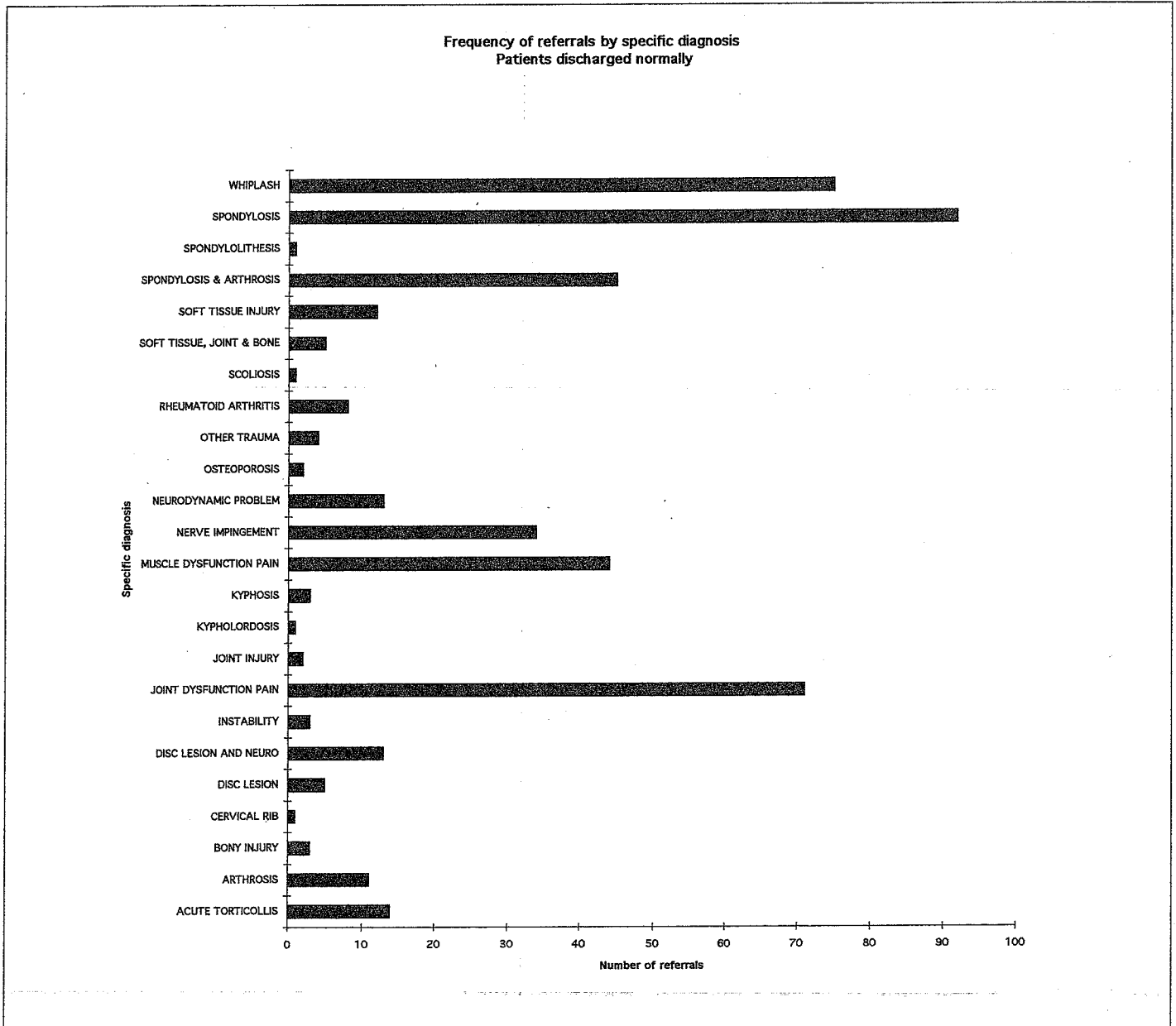


Table 11a(1) Frequency of referrals by body site (1) - All referrals

Body site	Number	Percent
CERV. SPINE + REF. ELBOW	24	3.7%
CERV. SPINE + REF. HAND	124	19.2%
CERV. SPINE + REF. HEAD	31	4.8%
CERV. SPINE + REF. SHOULDER	214	33.1%
CERV. SPINE + REF. WRIST	25	3.9%
CERVICAL SPINE	137	21.2%
OCCIPITAL	40	6.2%
OCCIPITO-FRONTAL	9	1.4%
PARIETAL	4	0.6%
TEMPORAL	10	1.5%
UPPER THOR. + REF. THORAX	4	0.6%
UPPER THOR. + REF.UPPER LIMB	12	1.9%
UPPER THORACIC	13	2.0%
Total	647	100.0%

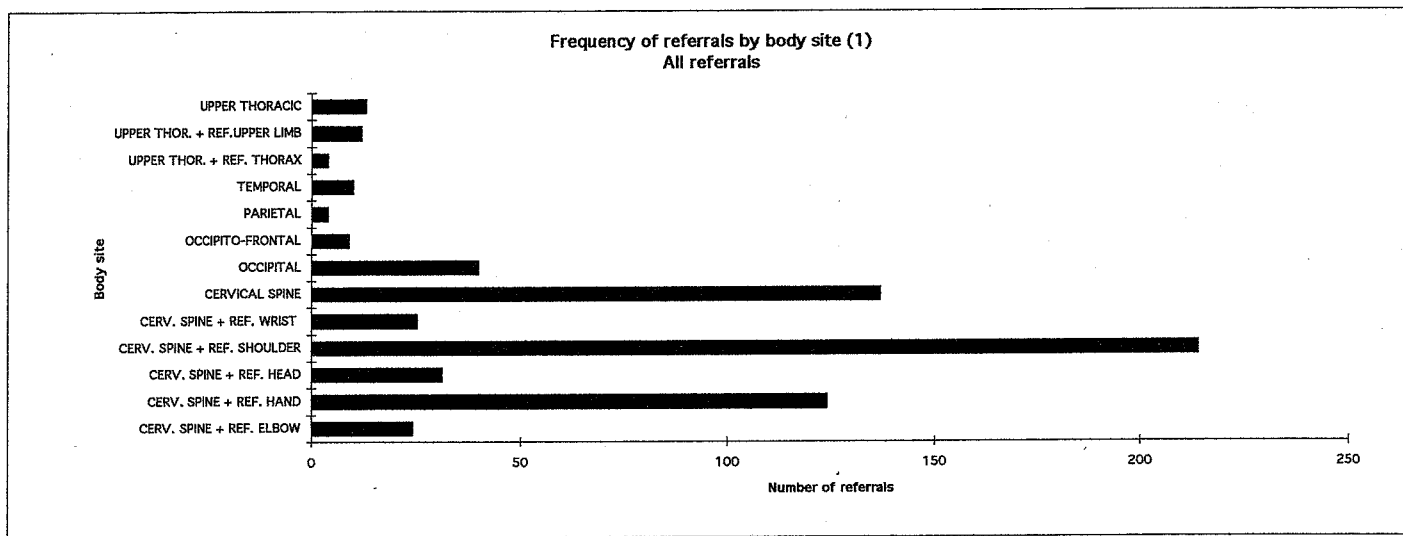


Table 11b(1) Frequency of referrals by body site (1) - Patients discharged normally

Body site	Number	Percent
CERV. SPINE + REF. ELBOW	13	2.8%
CERV. SPINE + REF. HAND	87	18.9%
CERV. SPINE + REF. HEAD	24	5.2%
CERV. SPINE + REF. SHOULDER	160	34.7%
CERV. SPINE + REF. WRIST	17	3.7%
CERVICAL SPINE	101	21.9%
OCCIPITAL	29	6.3%
OCCIPITO-FRONTAL	6	1.3%
PARIETAL	3	0.7%
TEMPORAL	8	1.7%
UPPER THOR. + REF.UPPER LIMB	7	1.5%
UPPER THORACIC	6	1.3%
THORACIC + REFERRAL	6	1.8%
Total	461	100.0%

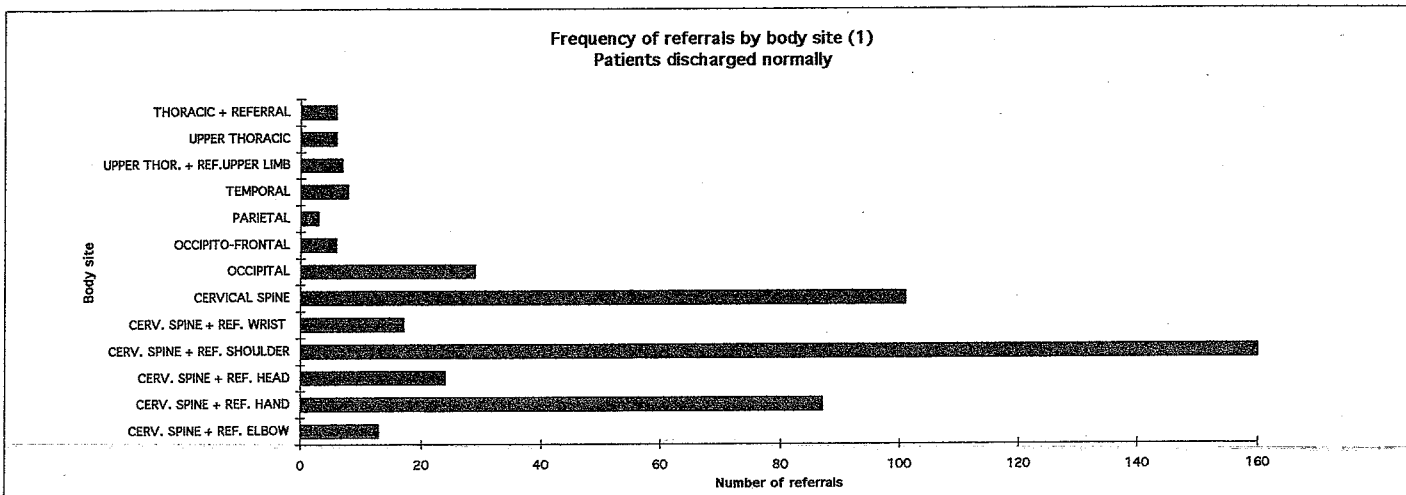


Table 11a(2) Frequency of referrals by body site (2) - All referrals

Body site	Number	Percent
CERV. SPINE + REF. ELBOW	15	5.9%
CERV. SPINE + REF. HAND	24	9.5%
CERV. SPINE + REF. HEAD	26	10.3%
CERV. SPINE + REF. SHOULDER	27	10.7%
CERV. SPINE + REF. WRIST	9	3.6%
CERVICAL SPINE	23	9.1%
LUM. SPINE + REF. BUTTOCK	2	0.8%
LUM. SPINE + REF. FOOT	1	0.4%
LUM. SPINE + REF. THIGH	3	1.2%
LUMBAR SPINE	5	2.0%
MANDIBULAR	1	0.4%
OCCIPITAL	15	5.9%
OCCIPITO-FRONTAL	12	4.7%
PARIETAL	5	2.0%
TEMPORAL	14	5.5%
UPPER THOR. + REF. THORAX	7	2.8%
UPPER THOR. + REF. UPPER LIMB	13	5.1%
UPPER THORACIC	51	20.2%
Total	253	100.0%

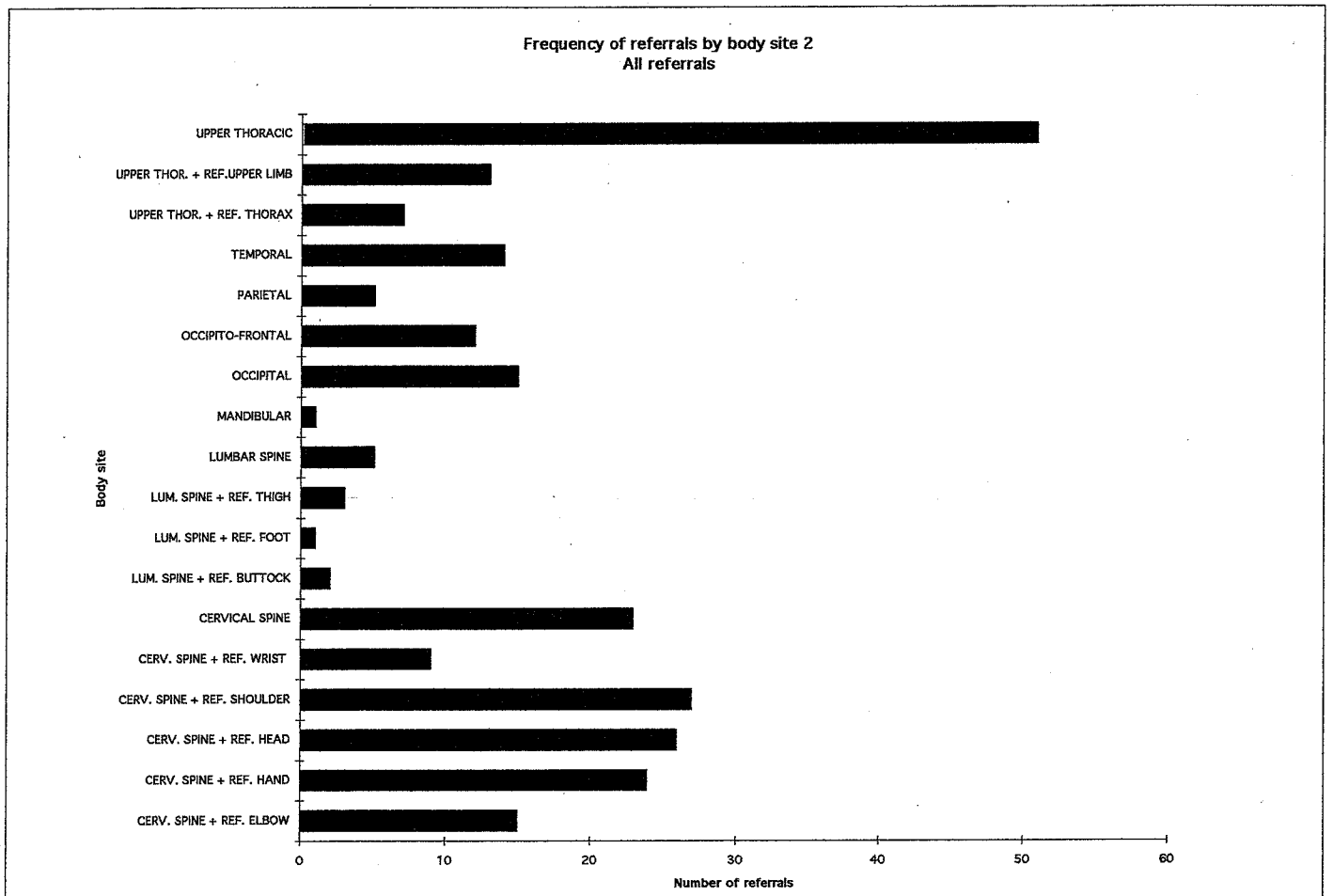


Table 11b(2) Frequency of referrals by body site (2) - Patients discharged normally

Body site	Number	Percent
CERV. SPINE + REF. ELBOW	11	6.3%
CERV. SPINE + REF. HAND	14	8.0%
CERV. SPINE + REF. HEAD	20	11.4%
CERV. SPINE + REF. SHOULDER	20	11.4%
CERV. SPINE + REF. WRIST	7	4.0%
CERVICAL SPINE	15	8.6%
LUM. SPINE + REF. THIGH	1	0.6%
LUMBAR SPINE	4	2.3%
MANDIBULAR	1	0.6%
OCCIPITAL	9	5.1%
OCCIPITO-FRONTAL	9	5.1%
PARIETAL	2	1.1%
TEMPORAL	13	7.4%
UPPER THOR. + REF. THORAX	6	3.4%
UPPER THOR. + REF. UPPER LIMB	8	4.6%
UPPER THORACIC	35	20.0%
Total	175	100.0%

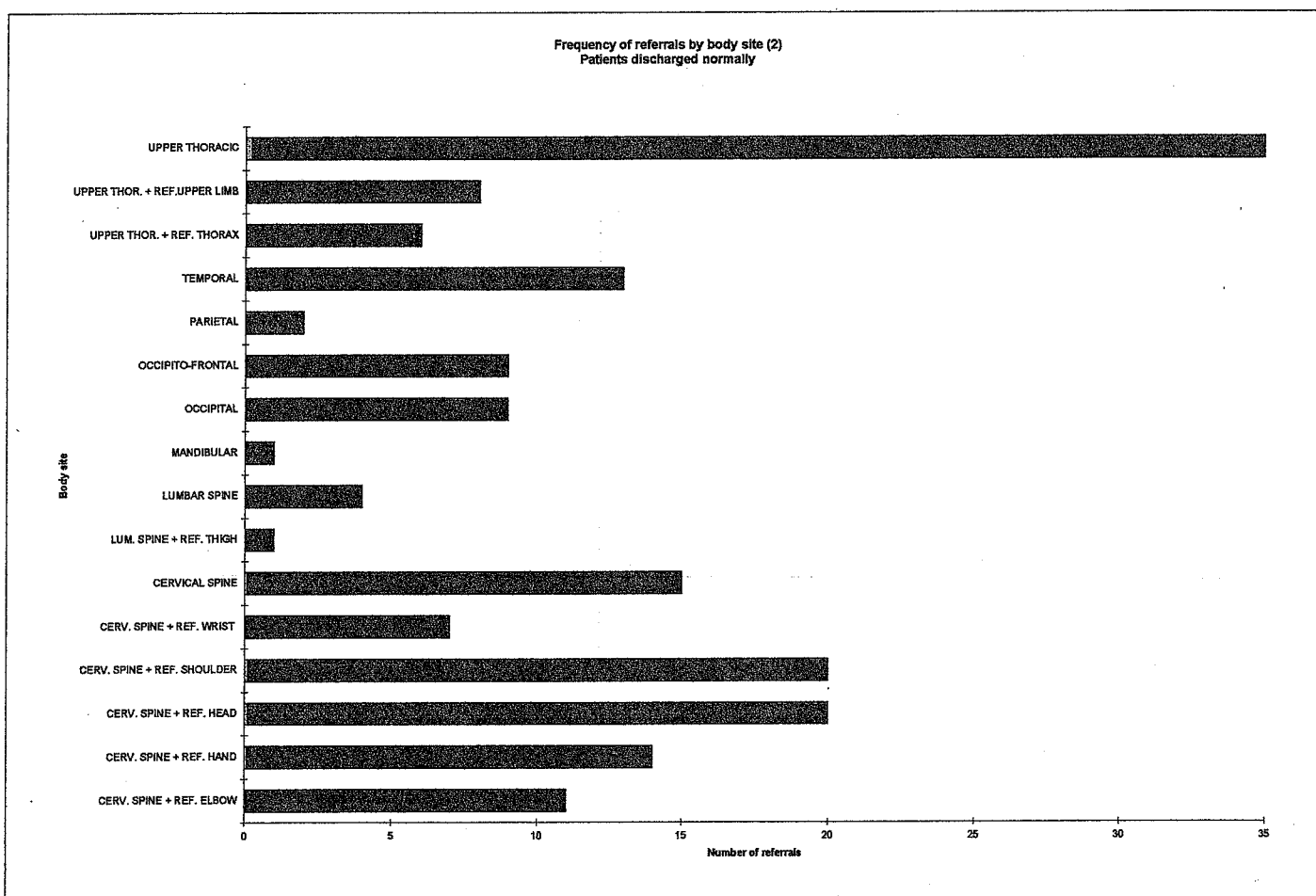


Table 11a(3) Frequency of referrals by body site (3) - All referrals

Body site	Number	Percent
CERV. SPINE + REF. ELBOW	4	6.7%
CERV. SPINE + REF. HAND	5	8.3%
CERV. SPINE + REF. SHOULDER	9	15.0%
CERV. SPINE + REF. WRIST	9	15.0%
CERVICAL SPINE	3	5.0%
LUM. SPINE + REF. BUTTOCK	2	3.3%
LUM. SPINE + REF. FOOT	3	5.0%
LUM. SPINE + REF. KNEE	1	1.7%
LUMBAR SPINE	5	8.3%
OCCIPITAL	3	5.0%
OCCIPITO-FRONTAL	2	3.3%
TEMPORAL	5	8.3%
UPPER THOR. + REF. THORAX	3	5.0%
UPPER THORACIC	6	10.0%
Total	60	100.0%

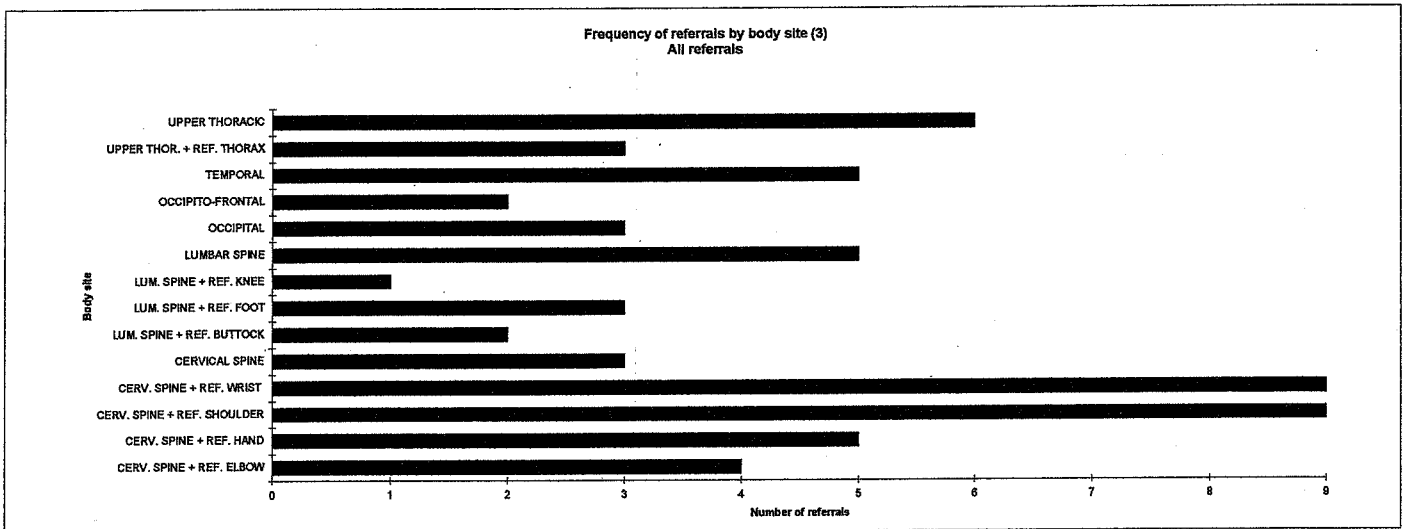


Table 11b(3) Frequency of referrals by bodysite (3) - Patients discharged normally

Body site	Number	Percent
CERV. SPINE + REF. ELBOW	4	9.1%
CERV. SPINE + REF. HAND	4	9.1%
CERV. SPINE + REF. SHOULDER	8	18.2%
CERV. SPINE + REF. WRIST	6	13.6%
CERVICAL SPINE	2	4.5%
LUM. SPINE + REF. FOOT	2	4.5%
LUM. SPINE + REF. KNEE	1	2.3%
LUMBAR SPINE	5	11.4%
OCCIPITAL	2	4.5%
OCCIPITO-FRONTAL	1	2.3%
TEMPORAL	3	6.8%
UPPER THOR. + REF. THORAX	1	2.3%
UPPER THORACIC	5	11.4%
Total	44	100.0%

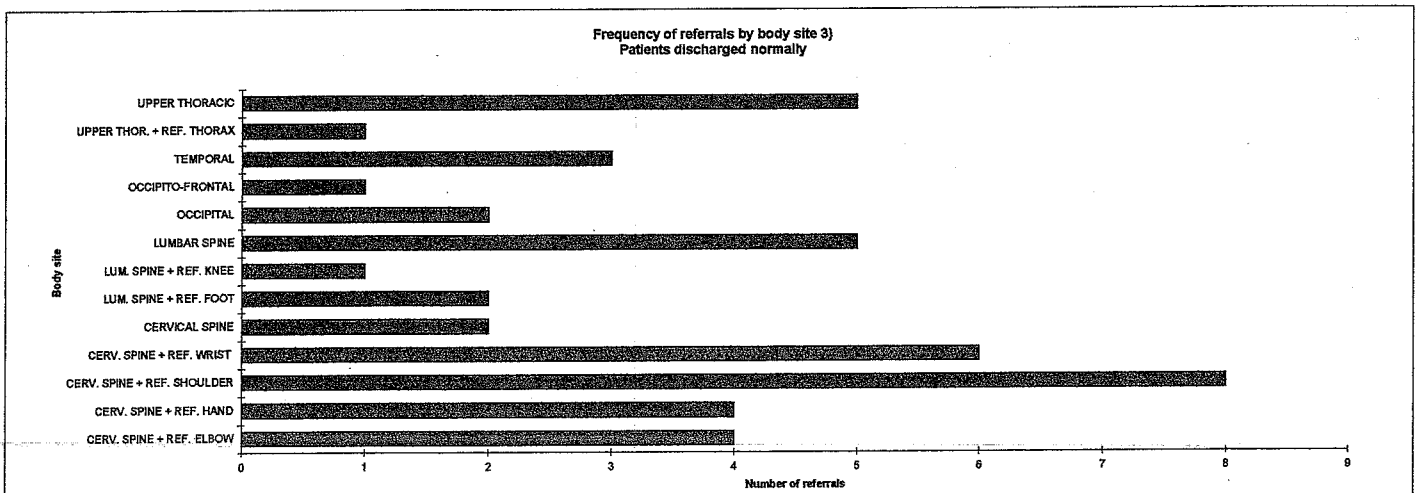


Table 11a(4) Frequency of referrals by body site (4) - All referrals

Body site	Number	Percent
CERV. SPINE + REF. HAND	7	43.8%
CERV. SPINE + REF. SHOULDER	4	25.0%
CERVICAL SPINE	2	12.5%
LUM. SPINE + REF. BUTTOCK	1	6.3%
LUMBAR SPINE	1	6.3%
UPPER THOR. + REF. THORAX	1	6.3%
Total	16	100.0%

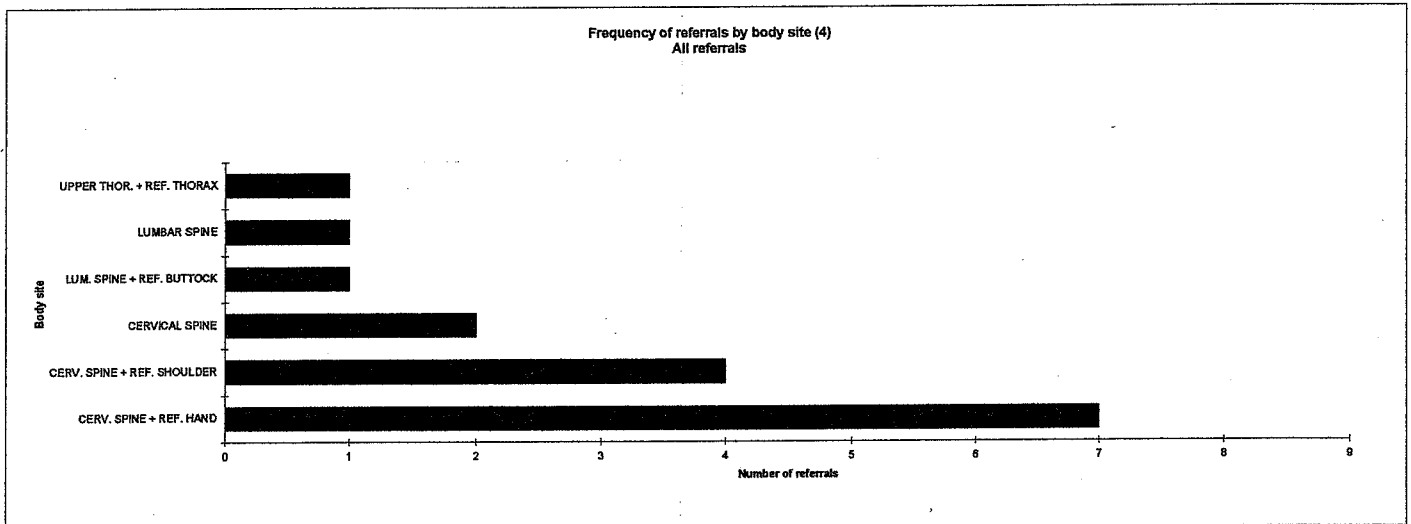


Table 11b(4) Frequency of referrals by body site (4) - Patients discharged normally

Body site	Number	Percent
CERV. SPINE + REF. HAND	4	40.0%
CERV. SPINE + REF. SHOULDER	3	30.0%
CERVICAL SPINE	1	10.0%
LUM. SPINE + REF. BUTTOCK	1	10.0%
UPPER THOR. + REF. THORAX	1	10.0%
Total	10	100.0%

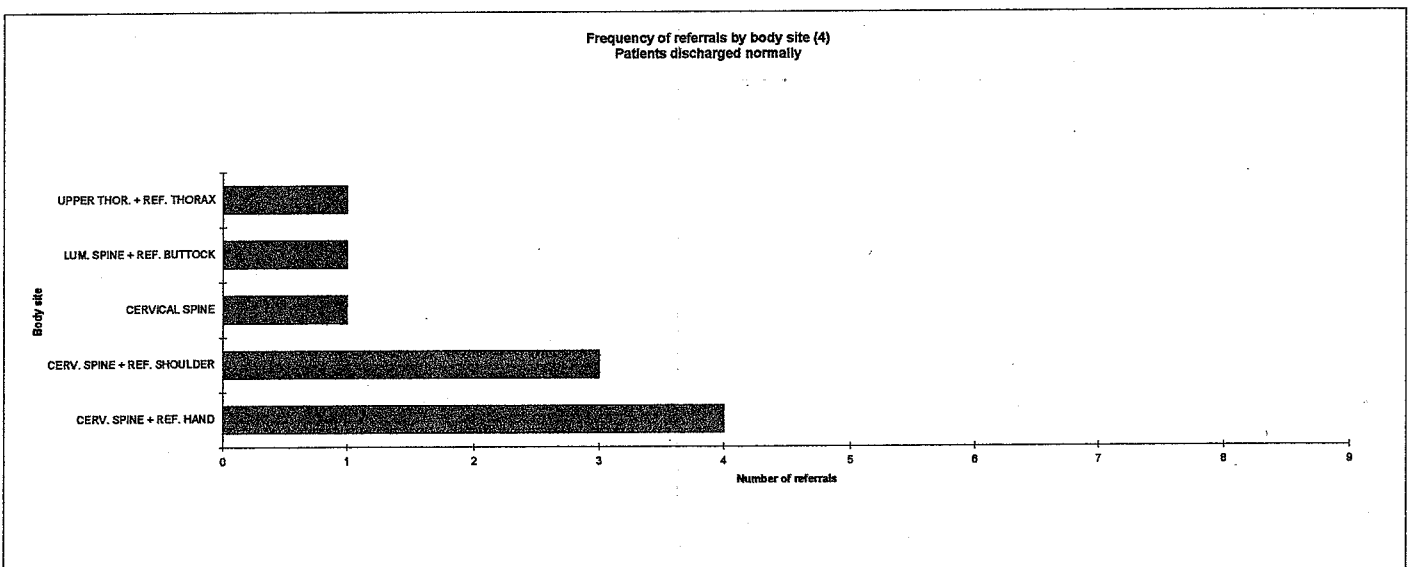


Table 12a Frequency of referrals by origin - All referrals

Origin	Number	Percent
NERVE ROOT	345	60.1%
SPINAL CORD	12	2.1%
OTHER	217	37.8%
Total	357	62.2%

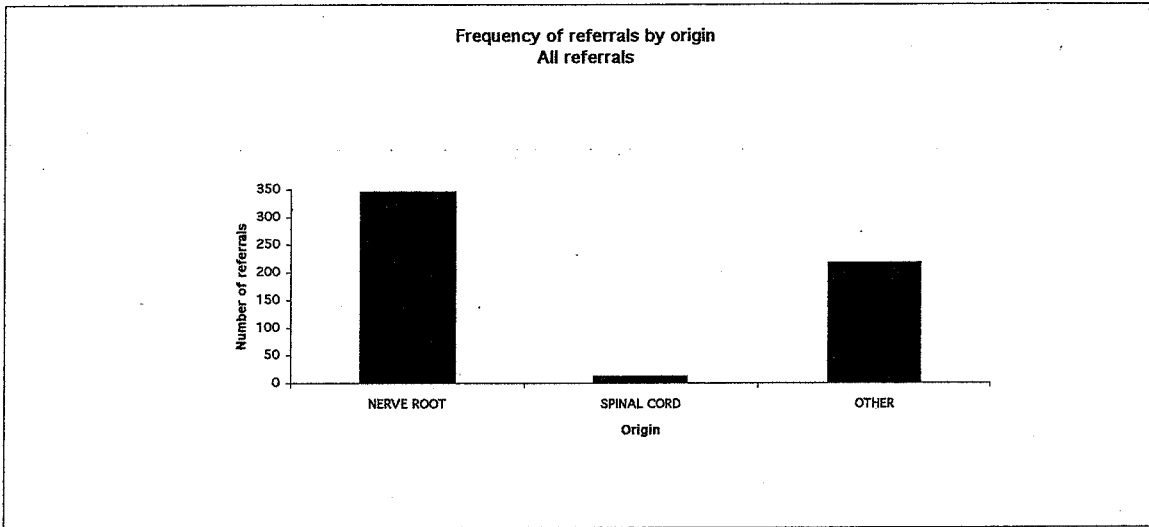


Table 12b Frequency of referrals by origin - Patients discharged normally

Origin	Number	percent
NERVE ROOT	232	57%
SPINAL CORD	8	2.0%
OTHER ORIGIN	166	40.9%
Total	240	59.1%

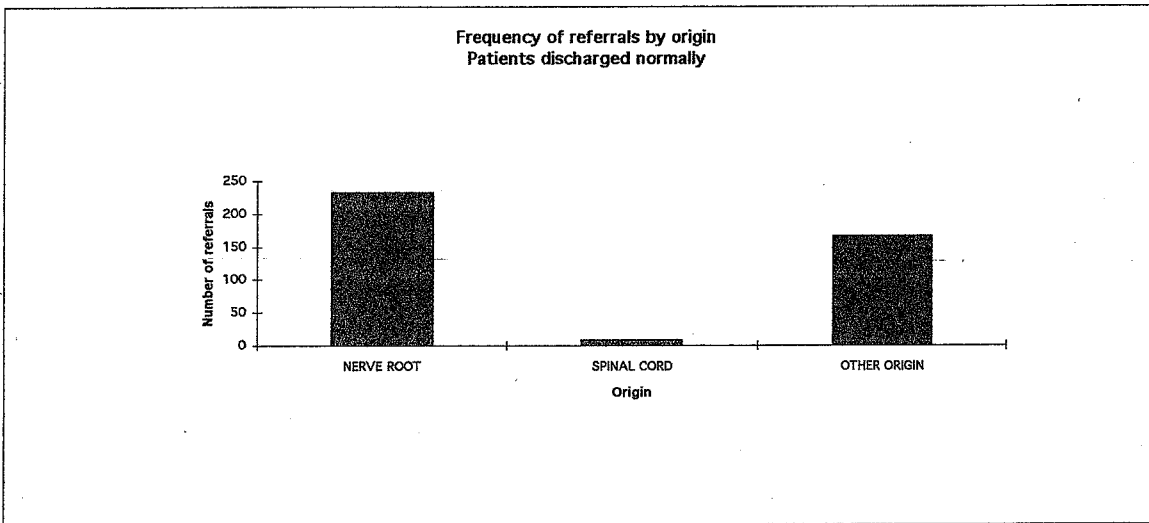


Table 13a Frequency of referrals by laterality - All referrals

Laterality	Number	Percent
BILATERAL	275	43.9%
UNILATERAL	351	56.1%
Total	626	100.0%

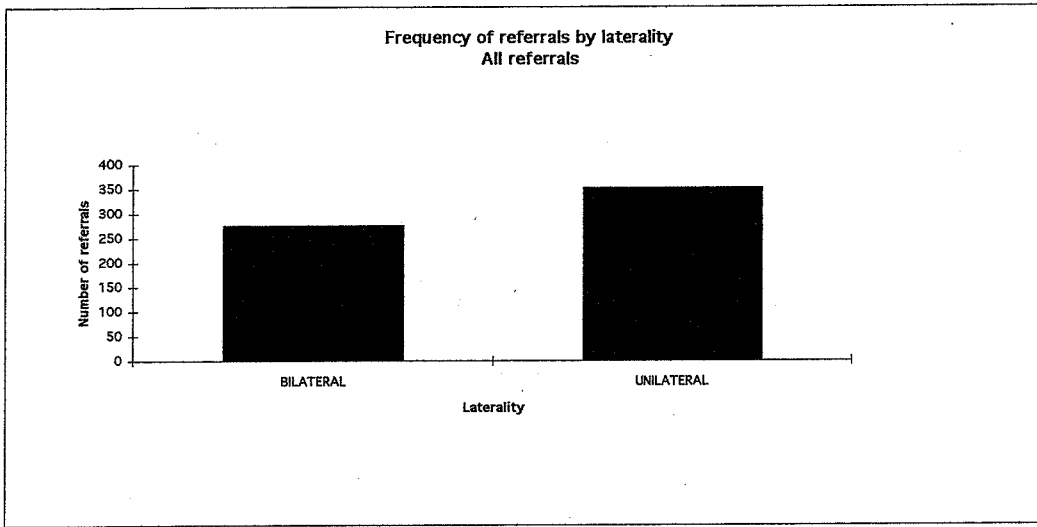


Table 13b Frequency of referrals by laterality - Patients discharged normally

Laterality	Number	Percent
BILATERAL	181	40.5%
UNILATERAL	266	59.5%
Total	447	100.0%

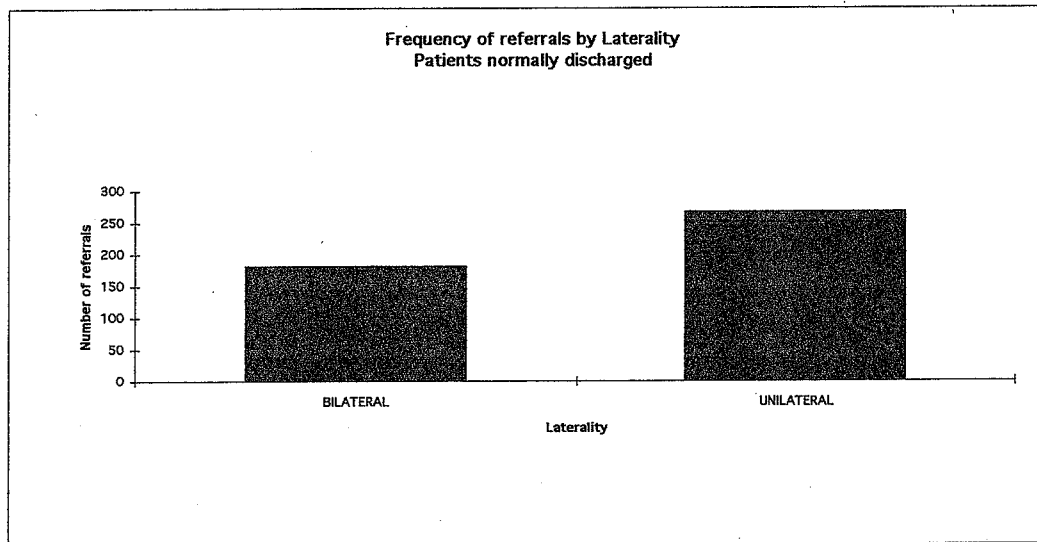


Table 14a(1) Frequency of referrals by level (1) - All referrals

Level	Number	Percent
C0-C1	30	4.7%
C1-C2	29	4.6%
C2-C3	42	6.6%
C3-C4	48	7.6%
C4-C5	69	10.9%
C5-C6	97	15.3%
C6-C7	93	14.6%
C7-T1	59	9.3%
T1-T2	7	1.1%
T2-T3	4	0.6%
T3-T4	4	0.6%
T4-T5	3	0.5%
T5-T6	2	0.3%
T6-T7	3	0.5%
T7-T8	1	0.2%
L2-L3	1	0.2%
MULTIPLE	143	22.5%
Total	491	100.0%

Frequency of referrals by level 1
All referrals

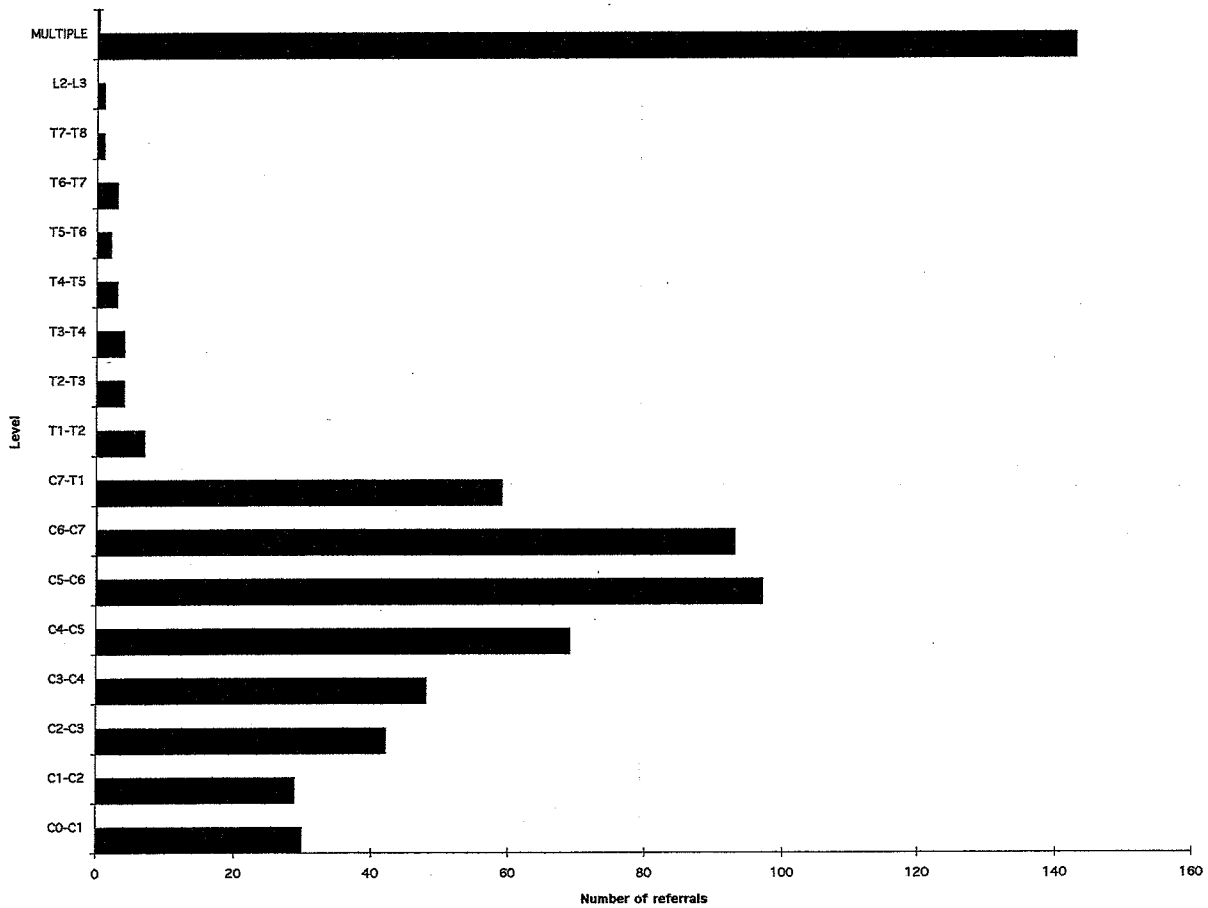


Table 14b(1) Frequency of referrals by level (1) - Patients discharged normally

Level	Number	percent
C0-C1	23	5.1%
C1-C2	25	5.5%
C2-C3	33	7.3%
C3-C4	36	7.9%
C4-C5	51	11.2%
C5-C6	68	14.9%
C6-C7	71	15.6%
C7-T1	45	9.9%
T1-T2	5	1.1%
T2-T3	3	0.7%
T4-T5	1	0.2%
T5-T6	2	0.4%
T6-T7	3	0.7%
L2-L3	1	0.2%
MULTIPLE	88	19.3%
Total	366	80.5%

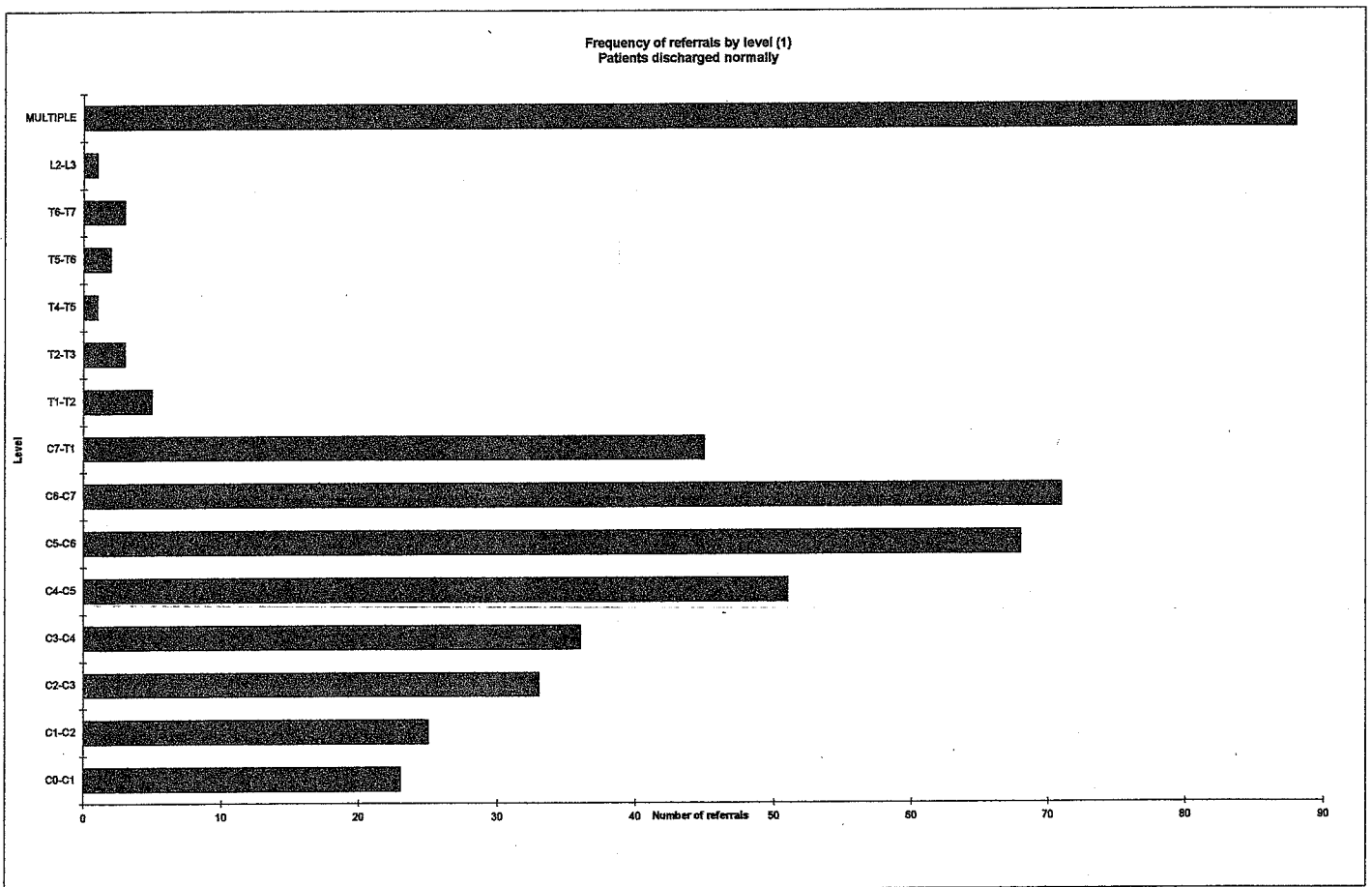


Table 14a(2) Frequency of referrals by level (2) - All referrals

Level	Number	Percent
C0-C1	2	0.6%
C1-C2	24	7.5%
C2-C3	15	4.7%
C3-C4	28	8.7%
C4-C5	30	9.3%
C5-C6	46	14.3%
C6-C7	63	19.6%
C7-T1	59	18.3%
T1-T2	20	6.2%
T2-T3	9	2.8%
T3-T4	6	1.9%
T4-T5	5	1.6%
T5-T6	3	0.9%
T6-T7	3	0.9%
T7-T8	1	0.3%
T8-T9	1	0.3%
L2-L3	1	0.3%
MULTIPLE	6	1.9%
Total	315	100.0%

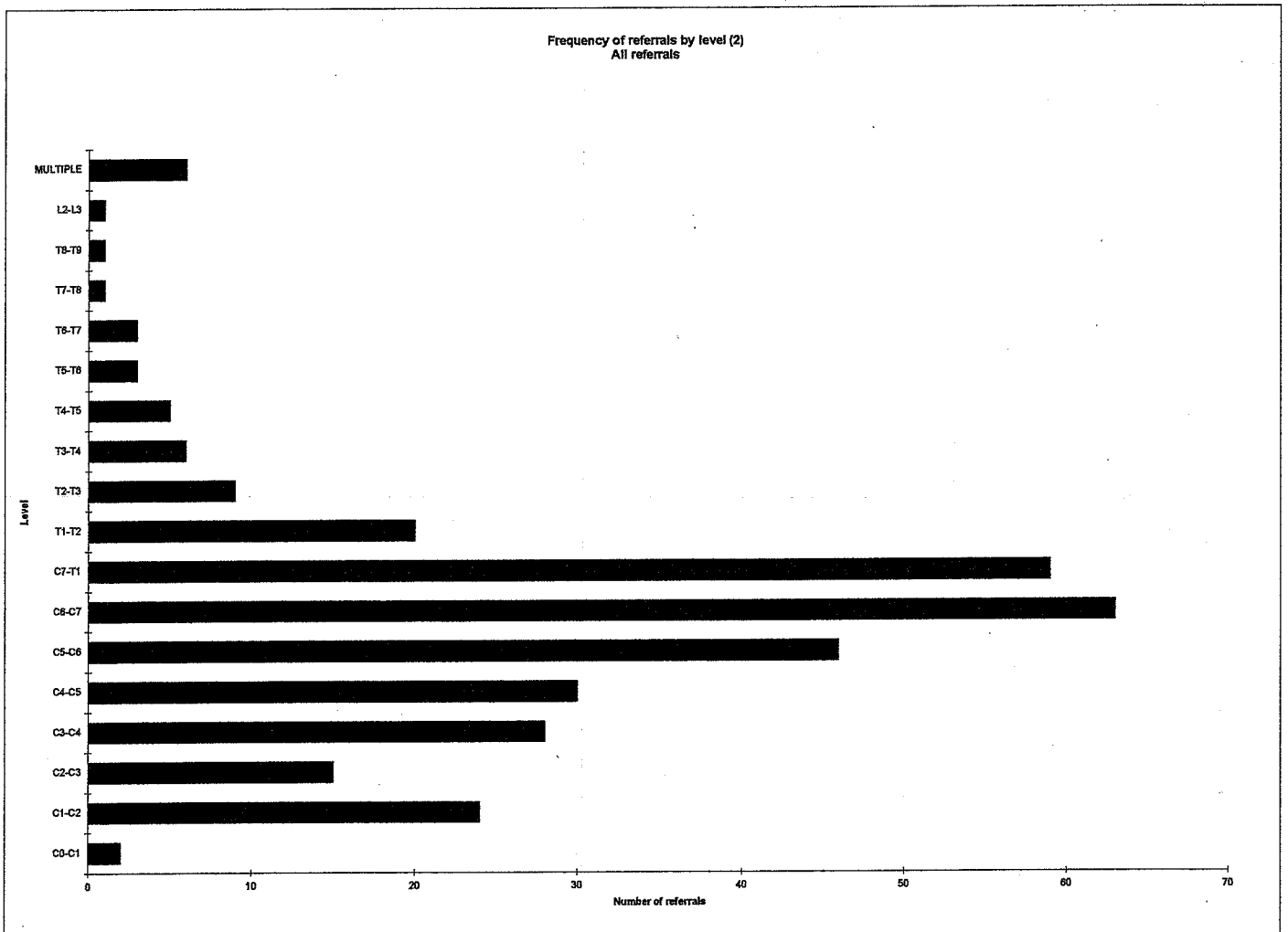


Table 14b(2) Frequency of referrals by level (2) - Patients discharged normally

Level	Number	Percent
C0-C1	1	0.4%
C1-C2	16	6.8%
C2-C3	13	5.5%
C3-C4	18	7.6%
C4-C5	21	8.9%
C5-C6	33	13.9%
C6-C7	49	20.7%
C7-T1	44	18.6%
T1-T2	16	6.8%
T2-T3	6	2.5%
T3-T4	6	2.5%
T4-T5	4	1.7%
T5-T6	2	0.8%
T6-T7	2	0.8%
T7-T8	1	0.4%
MULTIPLE	5	2.1%
Total	237	100.0%

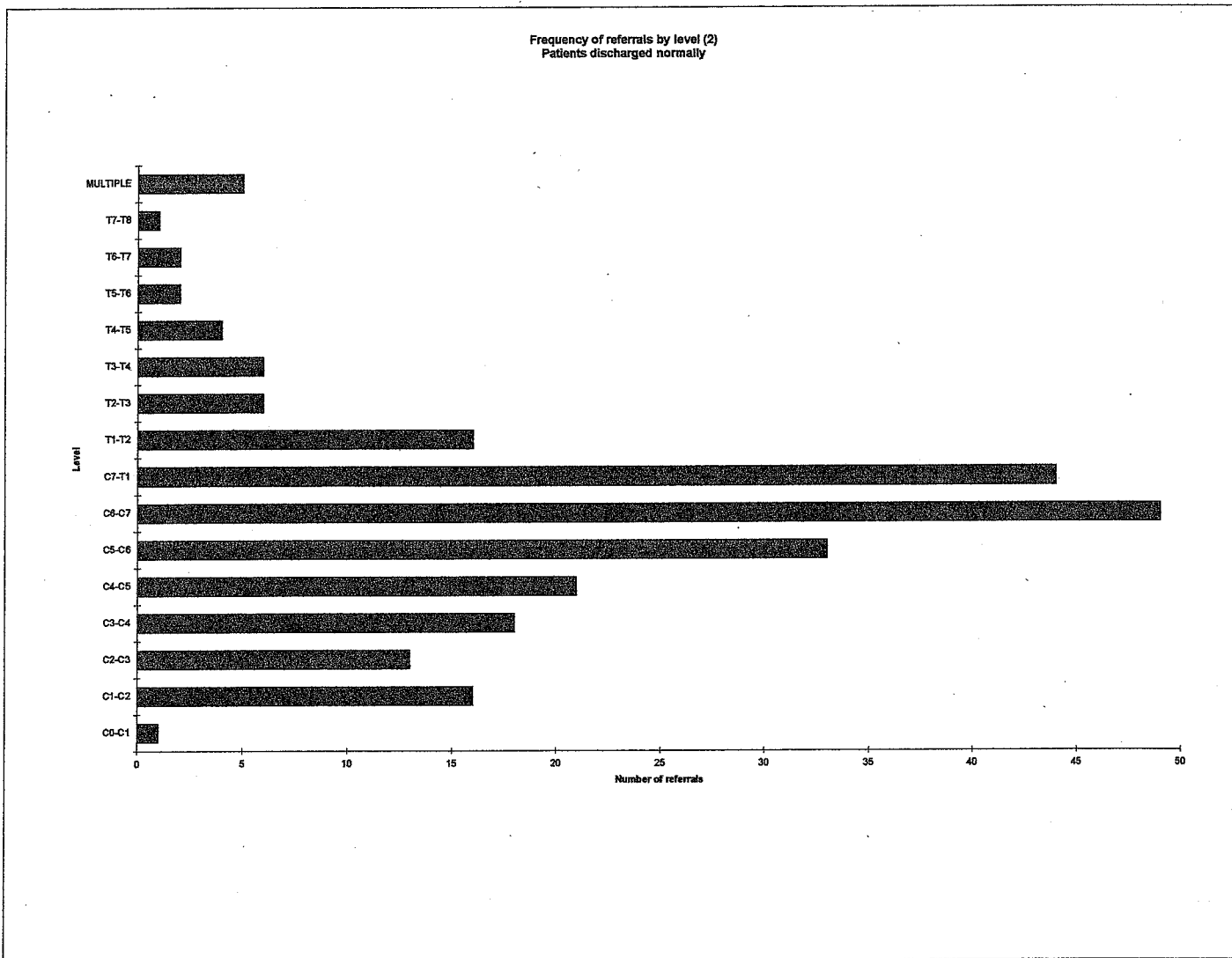


Table 14a(3) Frequency of referrals by level (3) - All referrals

Level	Number	Percent
C0-C1	4	2.0%
C1-C2	11	5.5%
C2-C3	4	2.0%
C3-C4	17	8.5%
C4-C5	20	10.1%
C5-C6	35	17.6%
C6-C7	30	15.1%
C7-T1	1	0.5%
T1-T2	28	14.1%
T2-T3	14	7.0%
T3-T4	13	6.5%
T4-T5	8	4.0%
T5-T6	3	1.5%
T6-T7	2	1.0%
T7-T8	3	1.5%
T8-T9	1	0.5%
T9-T10	2	1.0%
L4-L5	1	0.5%
MULTIPLE	2	1.0%
Total	196	100.0%

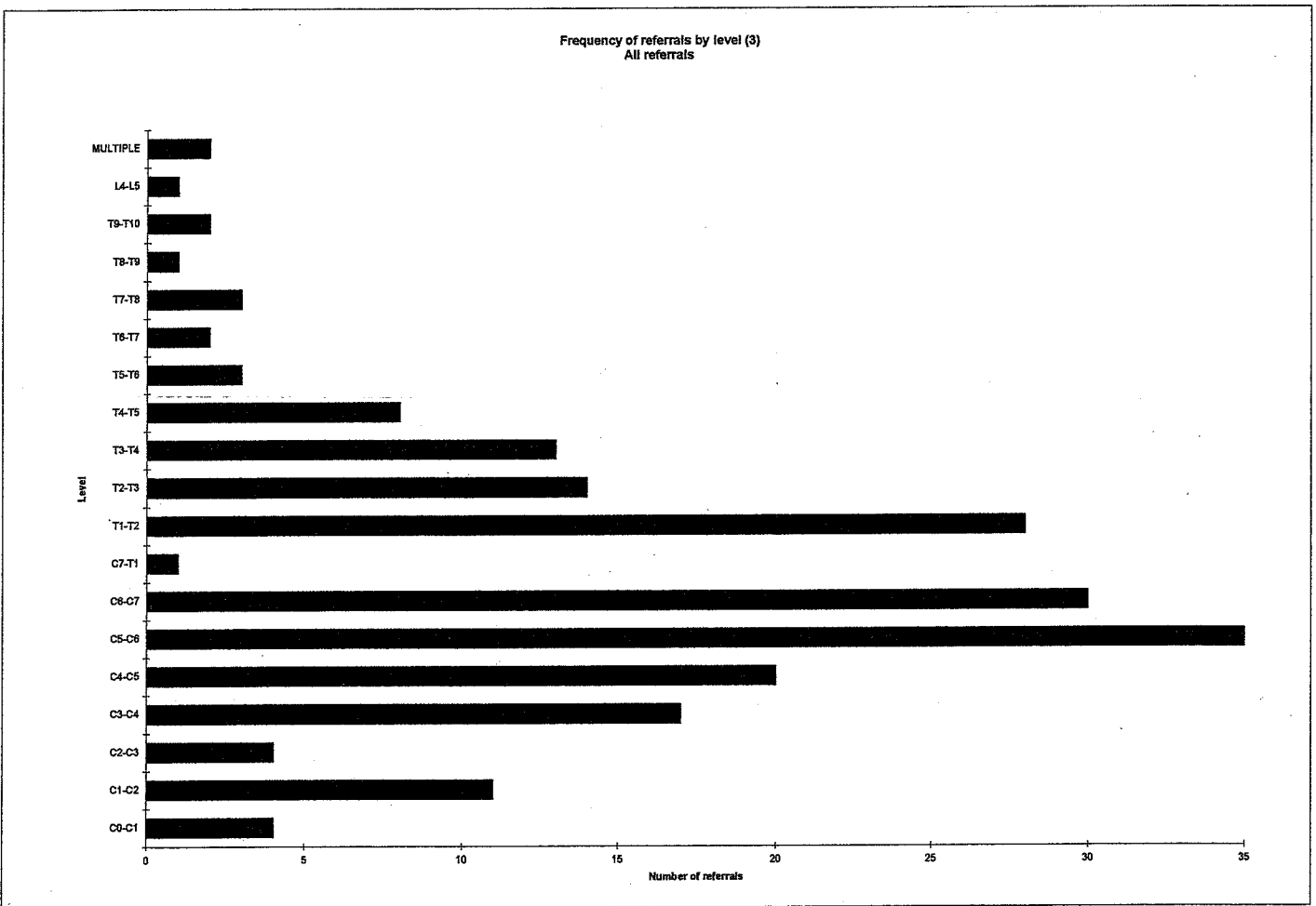


Table 14b(3) Frequency of referrals by level (3) - Patients discharged normally

Level	Number	Percent
C1-C2	2	1.4%
C2-C3	10	6.8%
C3-C4	4	2.7%
C4-C5	10	6.8%
C5-C6	14	9.6%
C6-C7	28	19.2%
C7-T1	24	16.4%
T1-T2	18	12.3%
T2-T3	11	7.5%
T3-T4	9	6.2%
T4-T5	6	4.1%
T5-T6	2	1.4%
T6-T7	1	0.7%
T7-T8	3	2.1%
T9-T10	1	0.7%
L4-L5	1	0.7%
MULTIPLE	2	1.4%
Total	146	100.0%

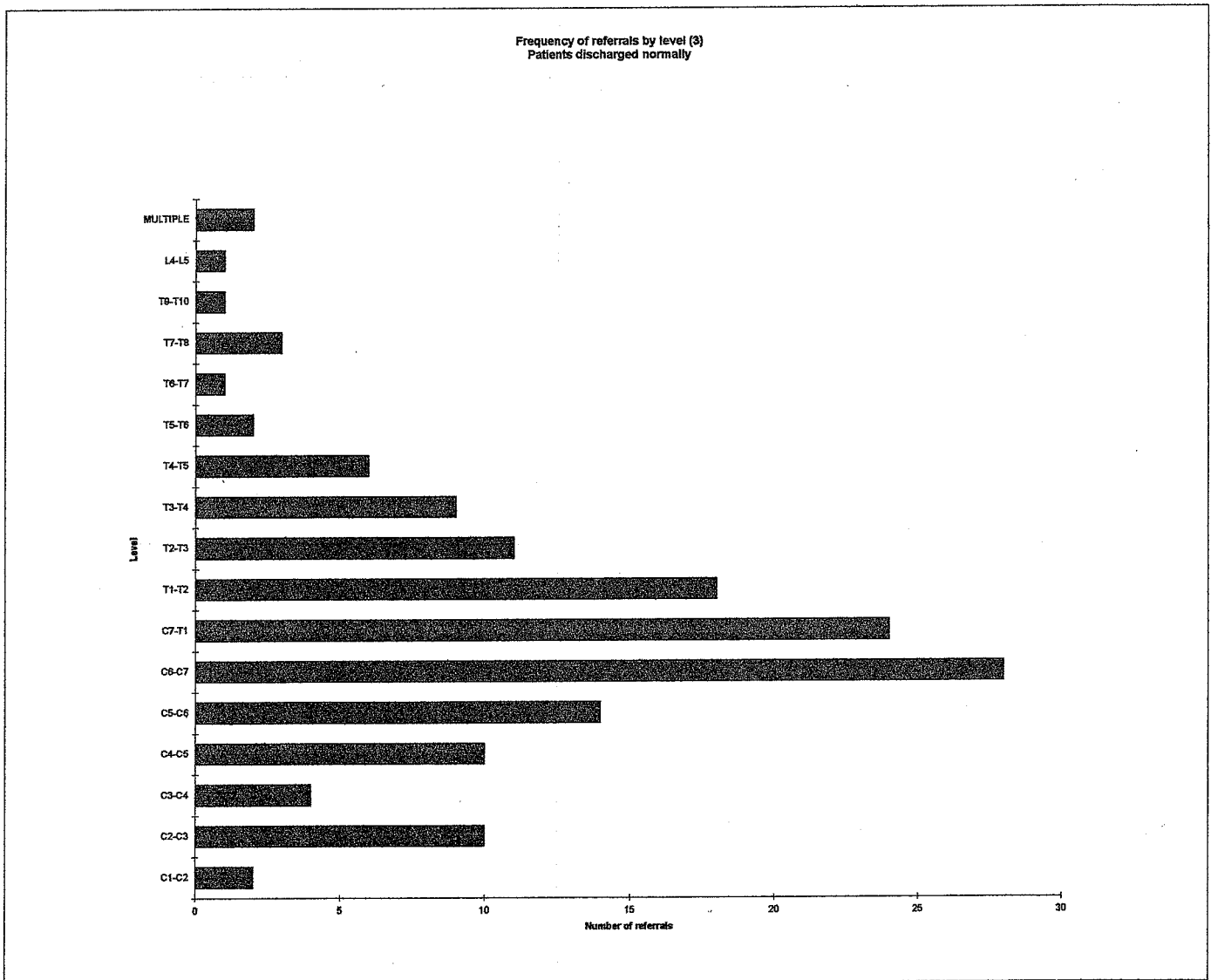


Table 15a Frequency of wait in weeks from consultation with GP to referral to physiotherapy - All referrals

Length of wait	Number	Percent
0	163	27.8%
1	88	15.0%
2	45	7.7%
3	29	4.9%
4	40	6.8%
5	17	2.9%
6	19	3.2%
7	11	1.9%
8	31	5.3%
9	5	0.9%
10	16	2.7%
11	5	0.9%
12	17	2.9%
13	3	0.5%
14	6	1.0%
15	3	0.5%
16	4	0.7%
17	2	0.3%
18	2	0.3%
20	7	1.2%
21	1	0.2%
22	2	0.3%
23	2	0.3%
24	8	1.4%
25	6	1.0%
26	4	0.7%
28	2	0.3%
30	5	0.9%
31	1	0.2%
32	2	0.3%
35	2	0.3%
36	1	0.2%
44	1	0.2%
45	1	0.2%
50	4	0.7%
52	10	1.7%
60	2	0.3%
61	1	0.2%
70	1	0.2%
72	1	0.2%
75	1	0.2%
78	2	0.3%
83	1	0.2%
100	4	0.7%
104	3	0.5%
156	2	0.3%
365	1	0.2%
420	1	0.2%
520	1	0.2%
Total	586	100.0%

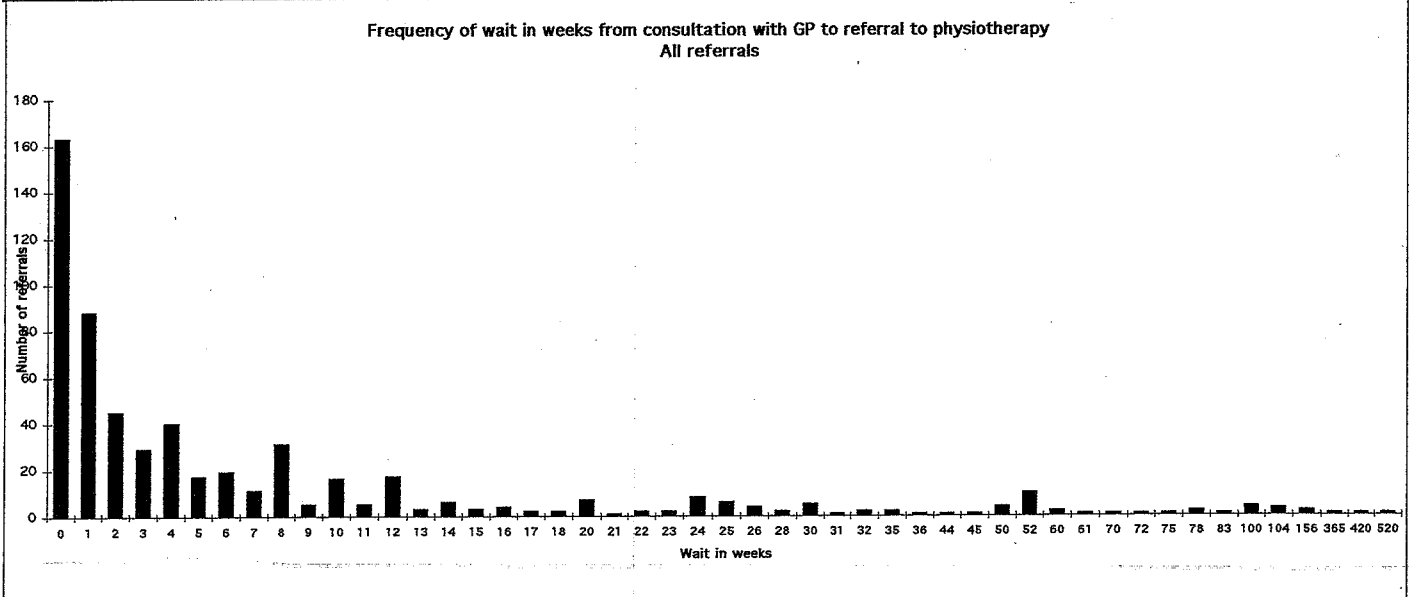


Table 15b Frequency of wait in weeks from consultation with GP to referral to physiotherapy - Patients discharged normally

Length of wait	Number	Percent
0	125	29.4%
1	62	14.6%
2	32	7.5%
3	23	5.4%
4	31	7.3%
5	15	3.5%
6	12	2.8%
7	7	1.6%
8	21	4.9%
9	4	0.9%
10	13	3.1%
11	3	0.7%
12	11	2.6%
13	2	0.5%
14	6	1.4%
15	2	0.5%
16	1	0.2%
17	2	0.5%
20	4	0.9%
22	2	0.5%
23	1	0.2%
24	4	0.9%
25	4	0.9%
28	2	0.5%
30	3	0.7%
31	1	0.2%
32	1	0.2%
35	2	0.5%
36	1	0.2%
44	1	0.2%
45	1	0.2%
50	3	0.7%
52	10	2.4%
60	1	0.2%
61	1	0.2%
72	1	0.2%
78	1	0.2%
100	3	0.7%
104	3	0.7%
156	1	0.2%
420	1	0.2%
520	1	0.2%
Total	425	100.0%

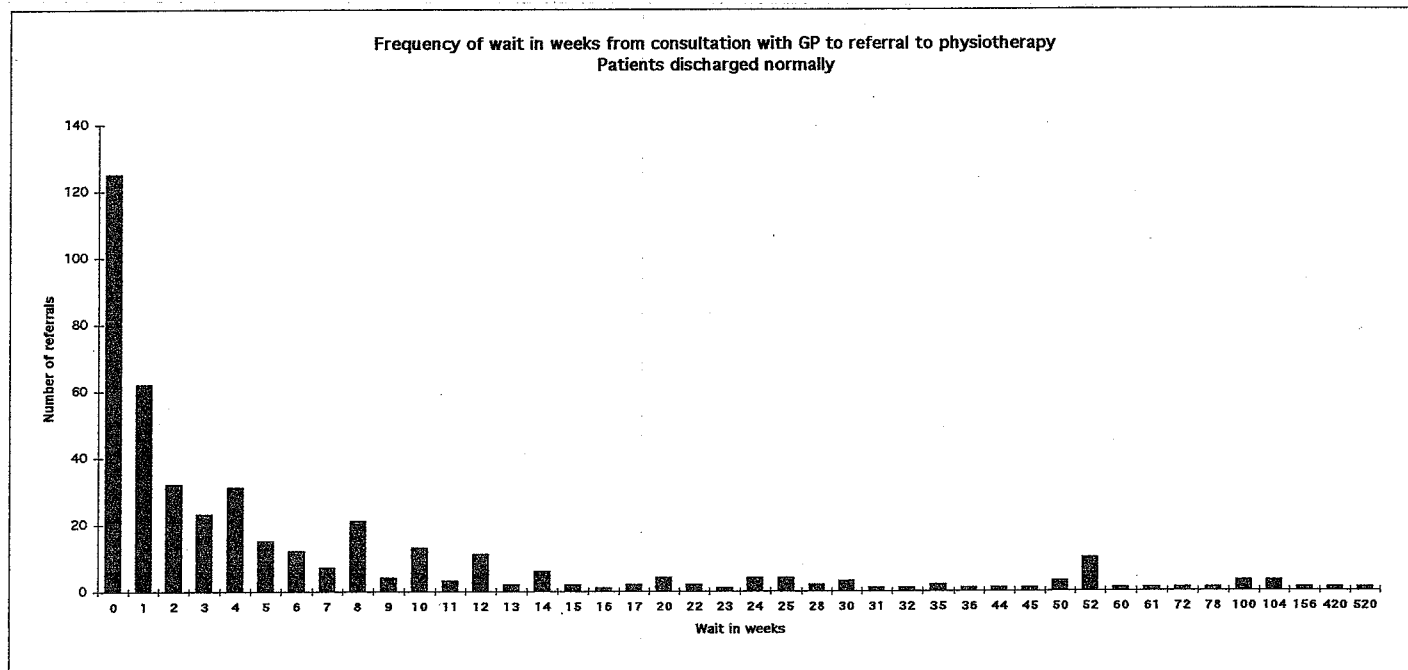


Table 16a Length of wait in weeks from referral to commencement of physiotherapy - All referrals

Length of wait	Number	Percent
0	55	8.6%
1	112	17.4%
2	103	16.0%
3	55	8.6%
4	64	10.0%
5	47	7.3%
6	40	6.2%
7	28	4.4%
8	27	4.2%
9	13	2.0%
10	19	3.0%
11	19	3.0%
12	12	1.9%
13	13	2.0%
14	3	0.5%
15	3	0.5%
16	5	0.8%
18	1	0.2%
20	5	0.8%
21	1	0.2%
22	2	0.3%
23	2	0.3%
24	3	0.5%
25	2	0.3%
27	1	0.2%
29	1	0.2%
30	2	0.3%
32	2	0.3%
34	1	0.2%
40	1	0.2%
	642	100.0%

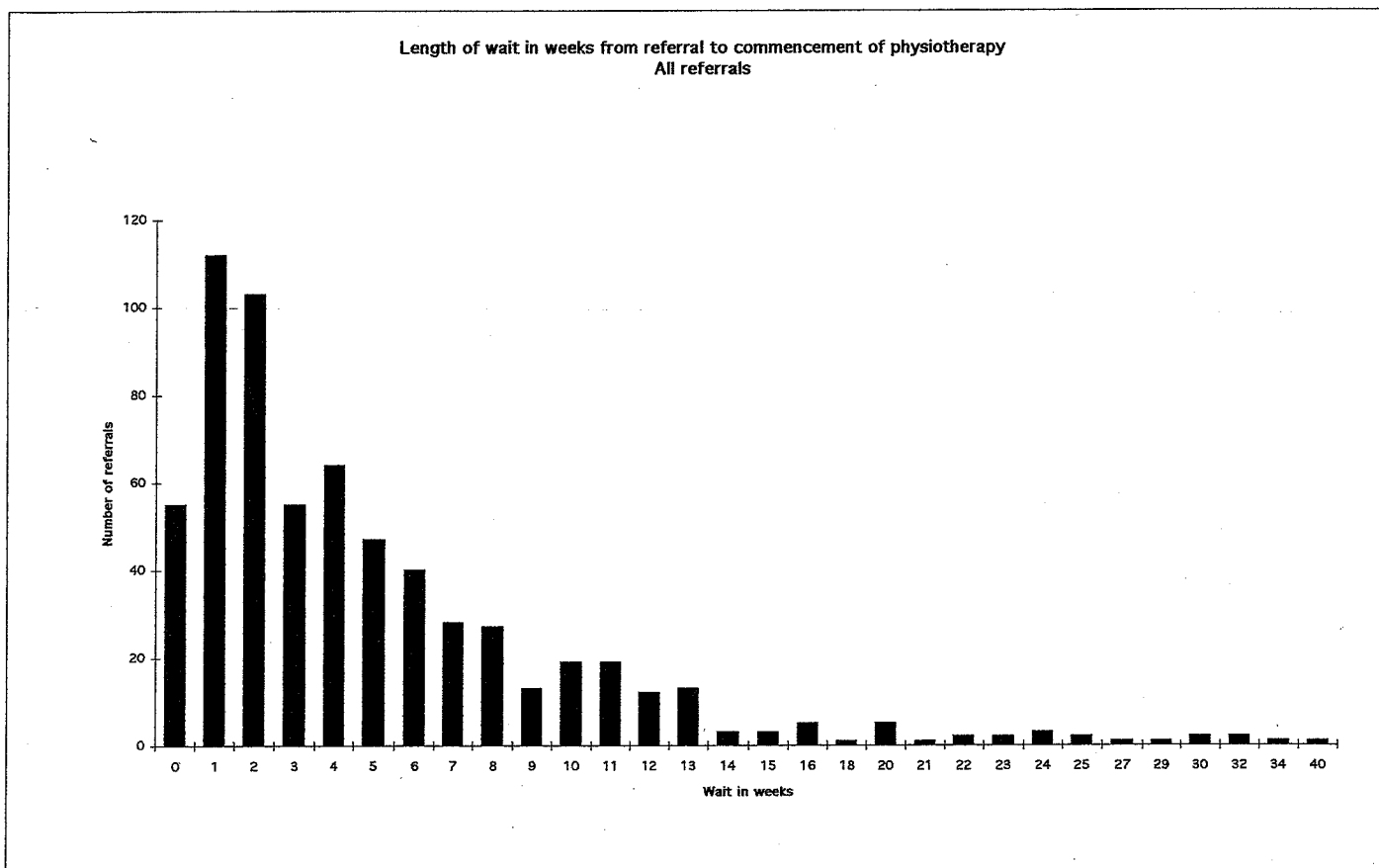


Table 16b Length of wait in weeks from referral to commencement of physiotherapy - Patients discharged normally

Length of wait	Number	Percent
0	37	8.2%
1	85	18.8%
2	74	16.4%
3	36	8.0%
4	38	8.4%
5	35	7.8%
6	33	7.3%
7	17	3.8%
8	19	4.2%
9	7	1.6%
10	14	3.1%
11	15	3.3%
12	8	1.8%
13	9	2.0%
14	3	0.7%
15	3	0.7%
16	4	0.9%
18	1	0.2%
20	5	1.1%
22	1	0.2%
23	2	0.4%
24	2	0.4%
25	2	0.4%
40	1	0.2%
Total	451	100.0%

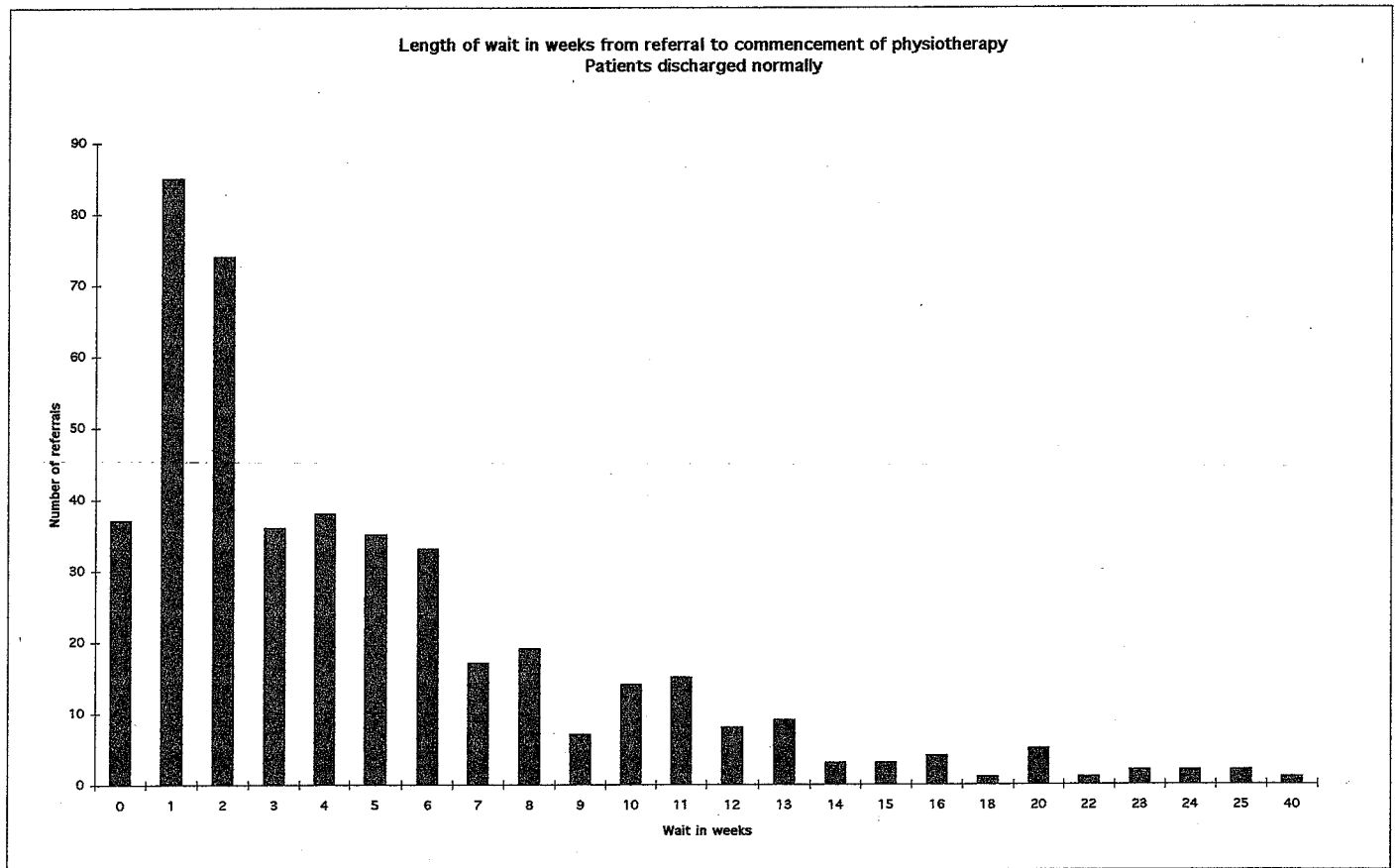


Table 17a Length of wait from referral to commencement of physiotherapy - All referrals

Wait in weeks	Number	Percent
0 to 2	270	42.1%
3 to 5	166	25.9%
6 to 8	95	14.8%
9 to 11	51	7.9%
12 to 14	28	4.4%
15 to 17	8	1.2%
18 to 20	6	0.9%
21 to 23	5	0.8%
24 to 26	5	0.8%
27 to 29	2	0.3%
30 to 32	4	0.6%
33 to 35	1	0.2%
39 to 41	1	0.2%
Total	642	100.0%

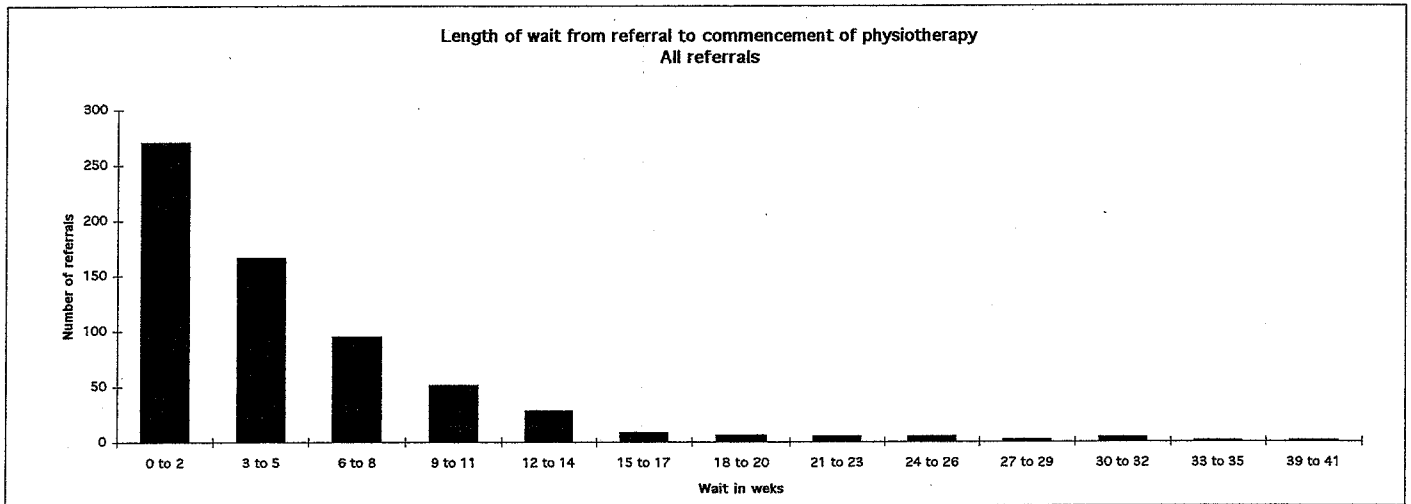


Table 17b Length of wait from referral to commencement of physiotherapy - Patients discharged normally

Wait in weeks	Number	Percent
0 to 2	196	43.5%
3 to 5	109	24.2%
6 to 8	69	15.3%
9 to 11	36	8.0%
12 to 14	20	4.4%
15 to 17	7	1.6%
18 to 20	6	1.3%
21 to 23	3	0.7%
24 to 26	4	0.9%
39 to 41	1	0.2%
Total	451	100.0%

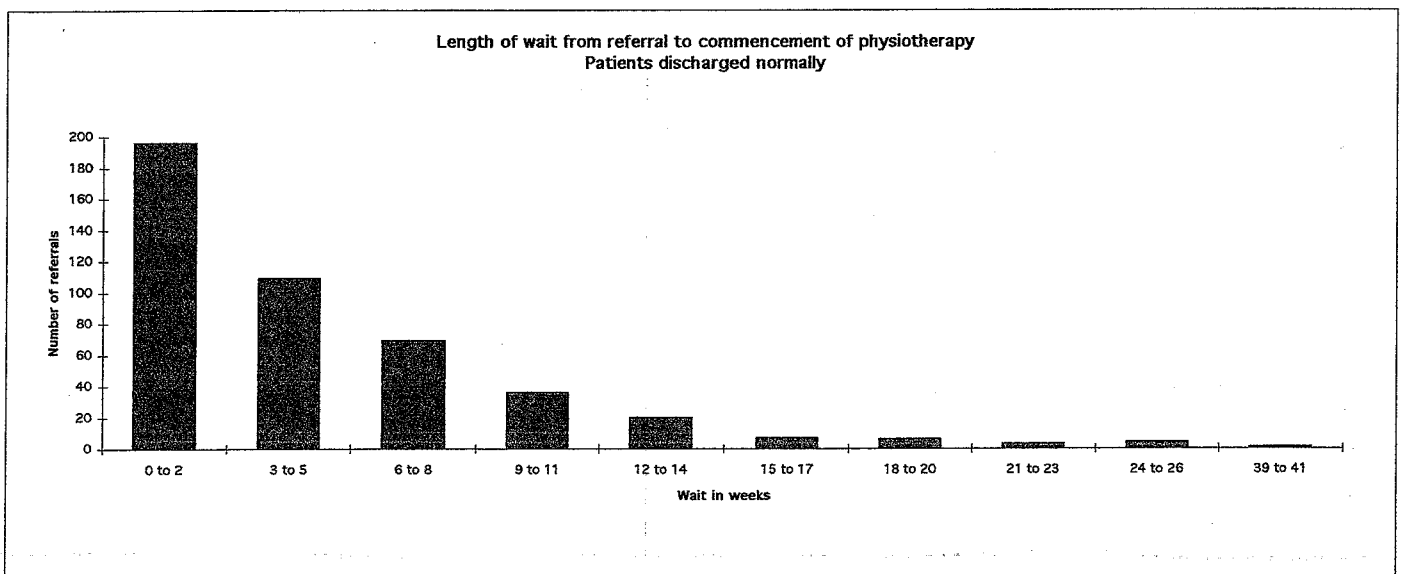
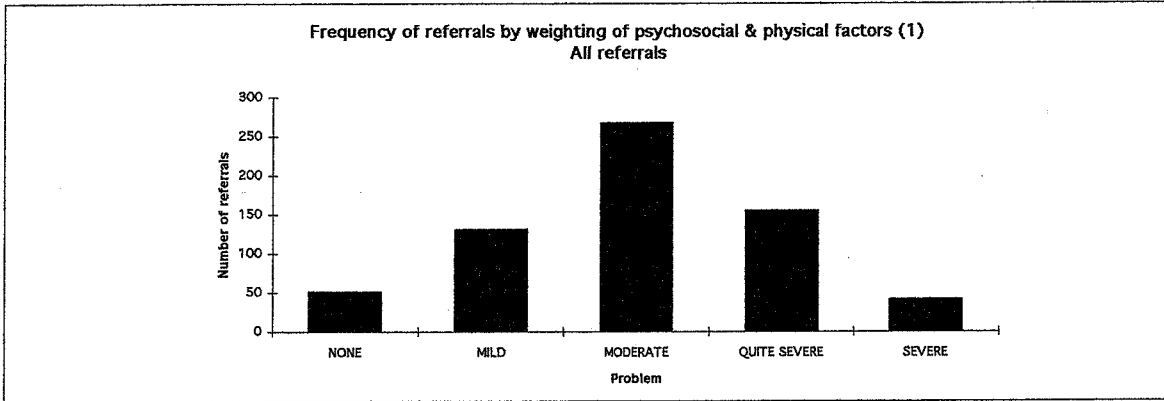


Table 18a 1-3 Weighting of Psychosocial & Physical Factors - All referrals

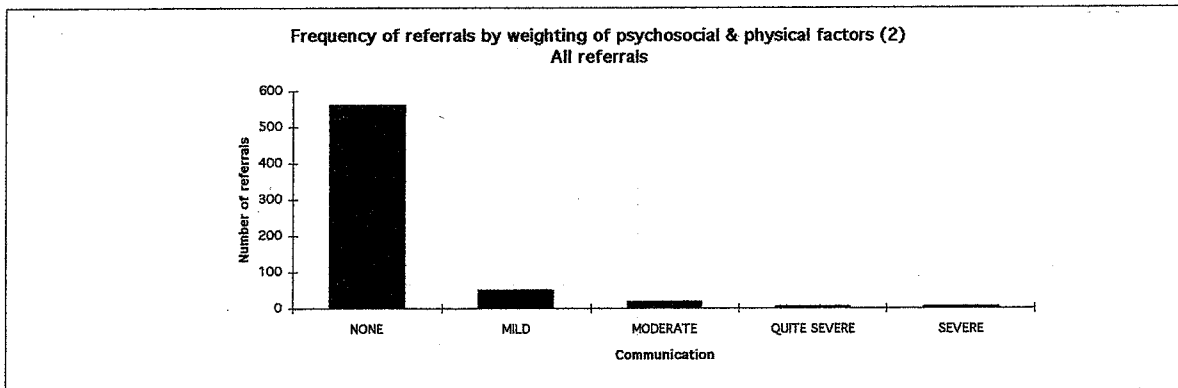
1

Problem	Number	Percent
NONE	51	7.9%
MILD	131	20.3%
MODERATE	267	41.4%
QUITE SEVERE	155	24.0%
SEVERE	41	6.4%
Total	645	100.0%



2

Communication	Number	Percent
NONE	560	88.1%
MILD	50	7.9%
MODERATE	17	2.7%
QUITE SEVERE	4	0.6%
SEVERE	5	0.8%
Total	636	100.0%



3

Mobility	Number	Percent
NONE	483	75.9%
MILD	91	14.3%
MODERATE	46	7.2%
QUITE SEVERE	13	2.0%
SEVERE	3	0.5%
Total	636	100.0%

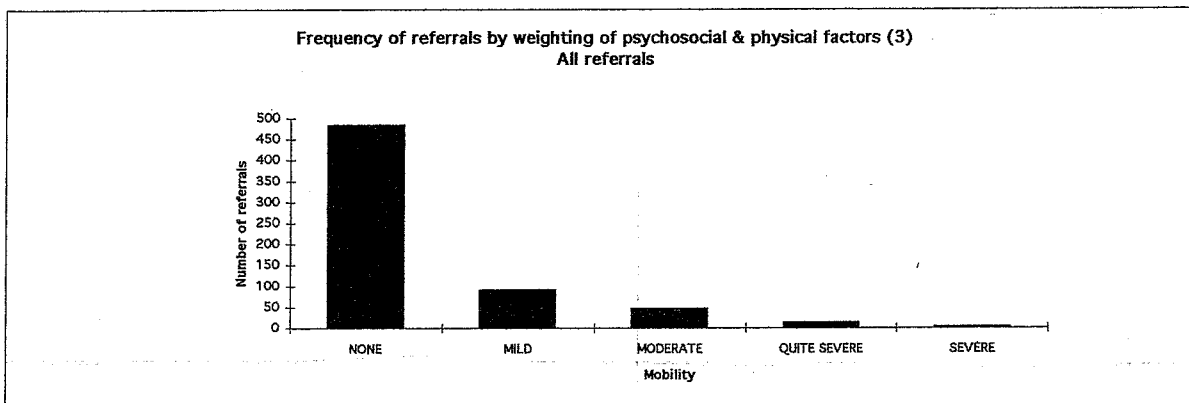
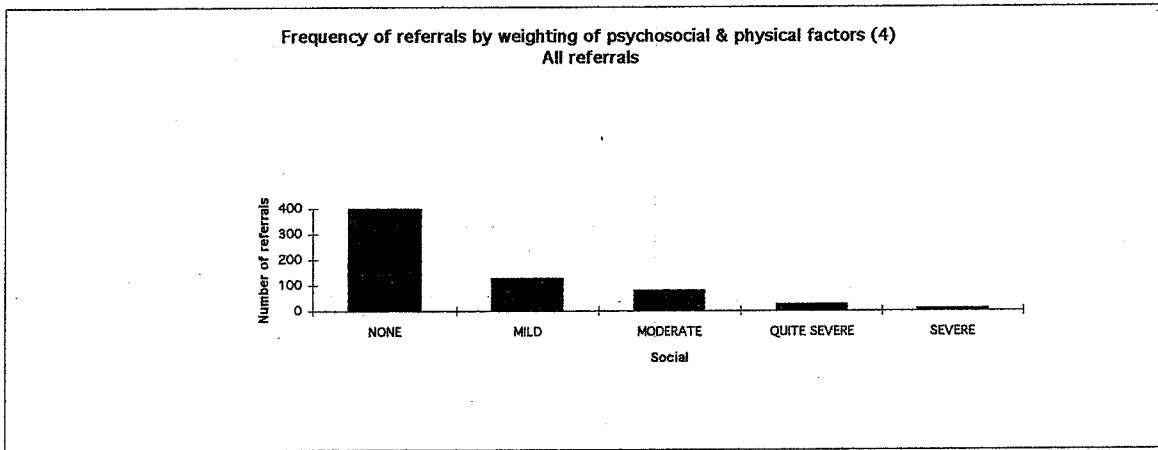


Table 18a 4-5 Weighting of Psychosocial & Physical Factors - All referrals

4

Social	Number	Percent
NONE	397	62.3%
MILD	127	19.9%
MODERATE	79	12.4%
QUITE SEVERE	25	3.9%
SEVERE	9	1.4%
Total	637	100.0%



5

Other	Number	Percent
NONE	414	65.7%
MILD	99	15.7%
MODERATE	62	9.8%
QUITE SEVERE	44	7.0%
SEVERE	11	1.7%
Total	630	100.0%

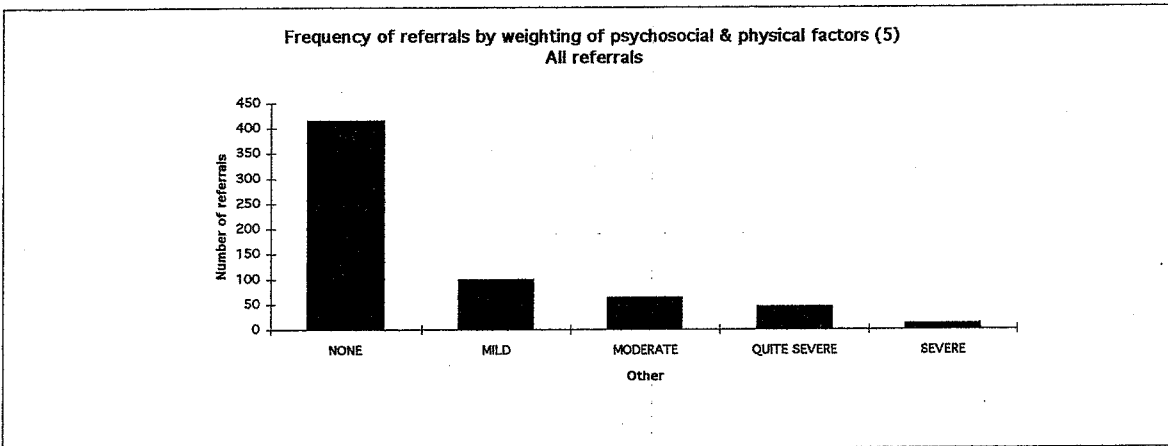
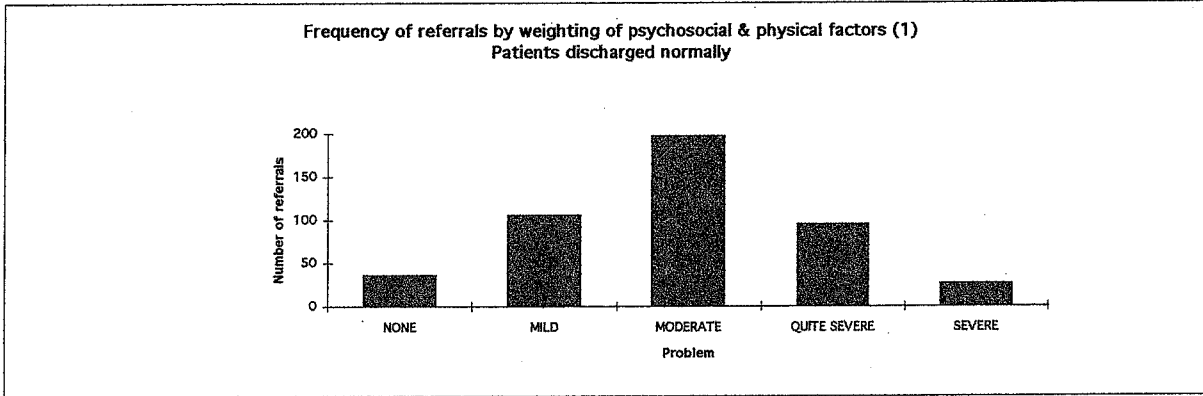


Table 18b 1-3 Weighting of Psychosocial & Physical Factors - Patients discharged normally

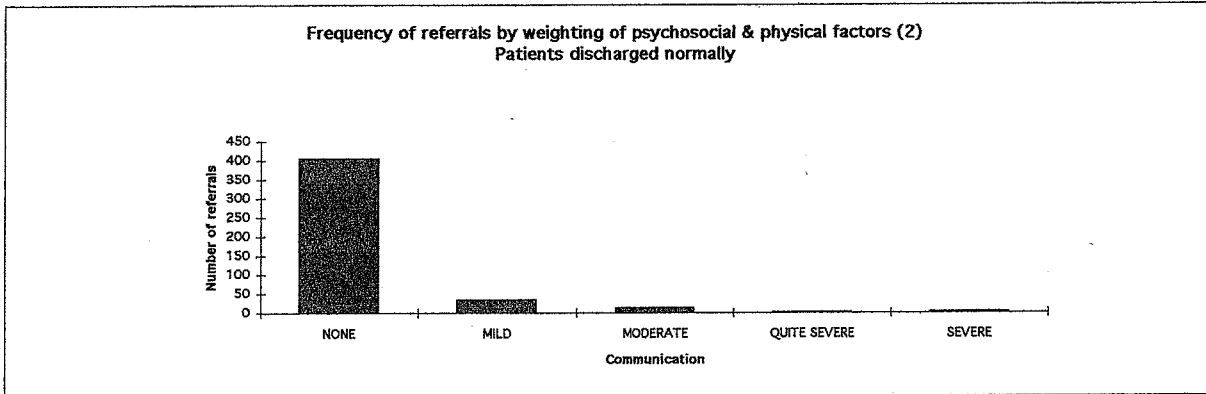
1

Problem	Number	Percent
NONE	36	7.8%
MILD	105	22.9%
MODERATE	197	42.9%
QUITE SEVERE	95	20.7%
SEVERE	26	5.7%
Total	459	100.0%



2

Communication	Number	Percent
NONE	404	89.0%
MILD	33	7.3%
MODERATE	12	2.6%
QUITE SEVERE	2	0.4%
SEVERE	3	0.7%
Total	454	100.0%



3

Mobility	Number	Percent
NONE	354	77.8%
MILD	67	14.7%
MODERATE	25	5.5%
QUITE SEVERE	9	2.0%
Total	455	100.0%

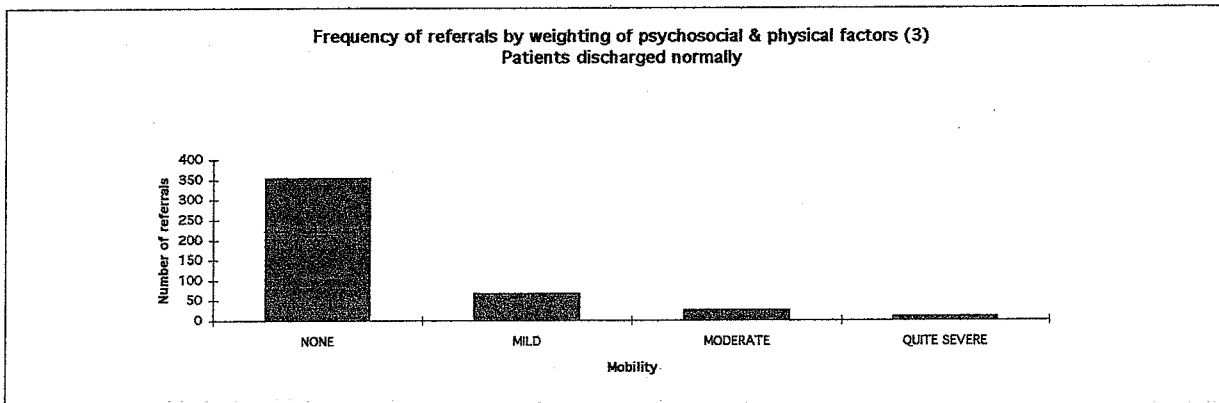
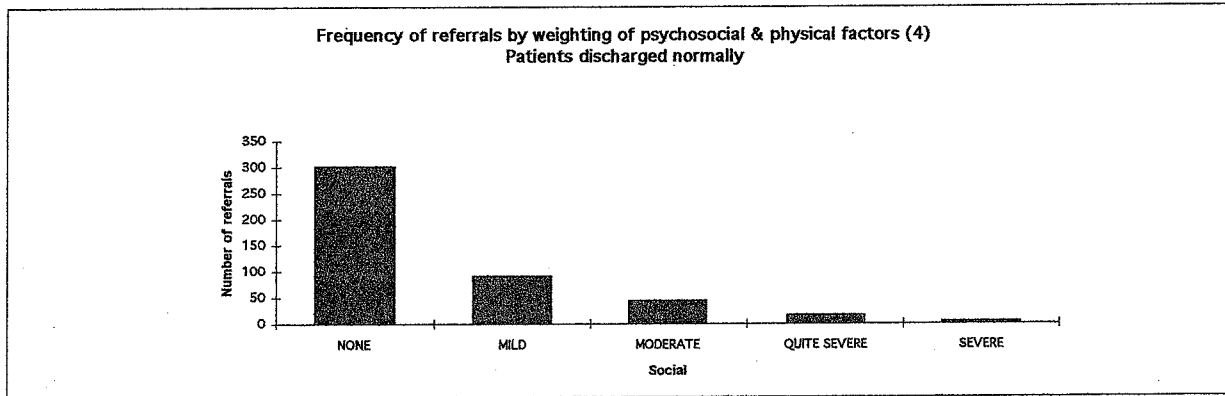


Table 18b 4-5 Weighting of Psychosocial & Physical Factors - Patients discharged normally

4

Social	Number	Percent
NONE	301	66.0%
MILD	91	20.0%
MODERATE	44	9.6%
QUITE SEVERE	16	3.5%
SEVERE	4	0.9%
Total	456	100.0%



5

Other	Number	Percent
NONE	299	66.6%
MILD	79	17.6%
MODERATE	40	8.9%
QUITE SEVERE	26	5.8%
SEVERE	5	1.1%
Total	449	100.0%

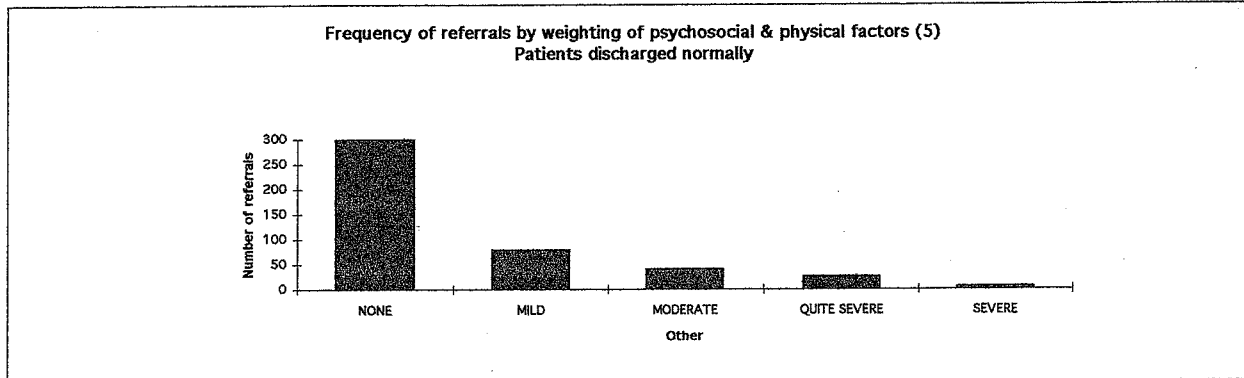


Table 19 Frequency of outcome of referral - All referrals

Referral outcome	Number	Percent
ASSESSMENT COMPLETED R/V ARR.	12	1.8%
ASSESSMENT COMPLETED NO PT	4	0.6%
DNA	36	5.5%
DISCHARGED NORMALLY	464	70.9%
INAPPROPRIATE REFERRAL	7	1.1%
INTERRUPTED (FTA)	44	6.7%
INTERRUPTED (UTA)	8	2.8%
OTHER	2	0.3%
PATIENT NON COMPLIANT	1	0.2%
PT NOT EFFECTIVE	17	2.6%
REFERRED BACK TO GP/CONS	43	6.6%
TREATMENT NOT COMMENCED	3	0.5%
TRANSFER OUTSIDE	3	0.5%
Total	644	100.0%

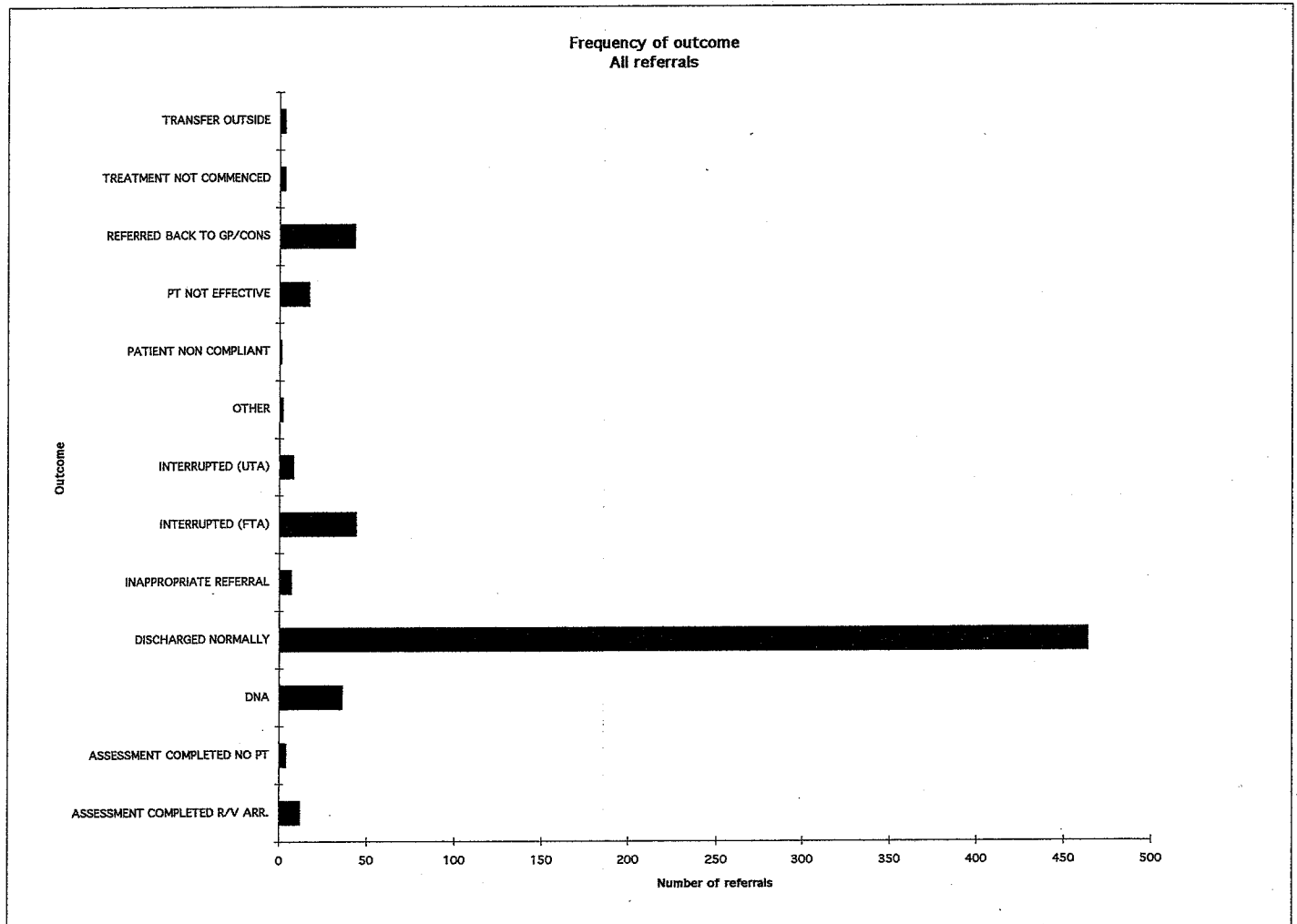


Table 20 Frequency of other factors influencing outcome - All referrals

Other factors	Number	Percent
CEASED TO ATTEND	45	7.8%
CHANGED GRADE THERAPIST	5	0.9%
EDUCATION / ADVICE ONLY	4	0.7%
EXACERBATION OF CONDITION	12	2.1%
GENERAL STATE	57	9.9%
INAPPROPRIATE REFERRAL	2	0.3%
LIFESTYLE INFLUENCES	67	11.6%
NO OTHER FACTORS	281	48.7%
OTHER MEDICAL CONDITIONS	48	8.3%
OTHER MEDICAL INTERVENTIONS	13	2.3%
PAIN FREE FIRST VISIT	3	0.5%
REFERRAL TO CONS OR GP	20	3.5%
TEAMWORK	1	0.2%
TIME,PROG,NO T'MENT	16	2.8%
TRANSFER TO OTHER HOSPITAL	1	0.2%
TRANSPORT DIFFICULTIES	2	0.3%
Total	577	100%

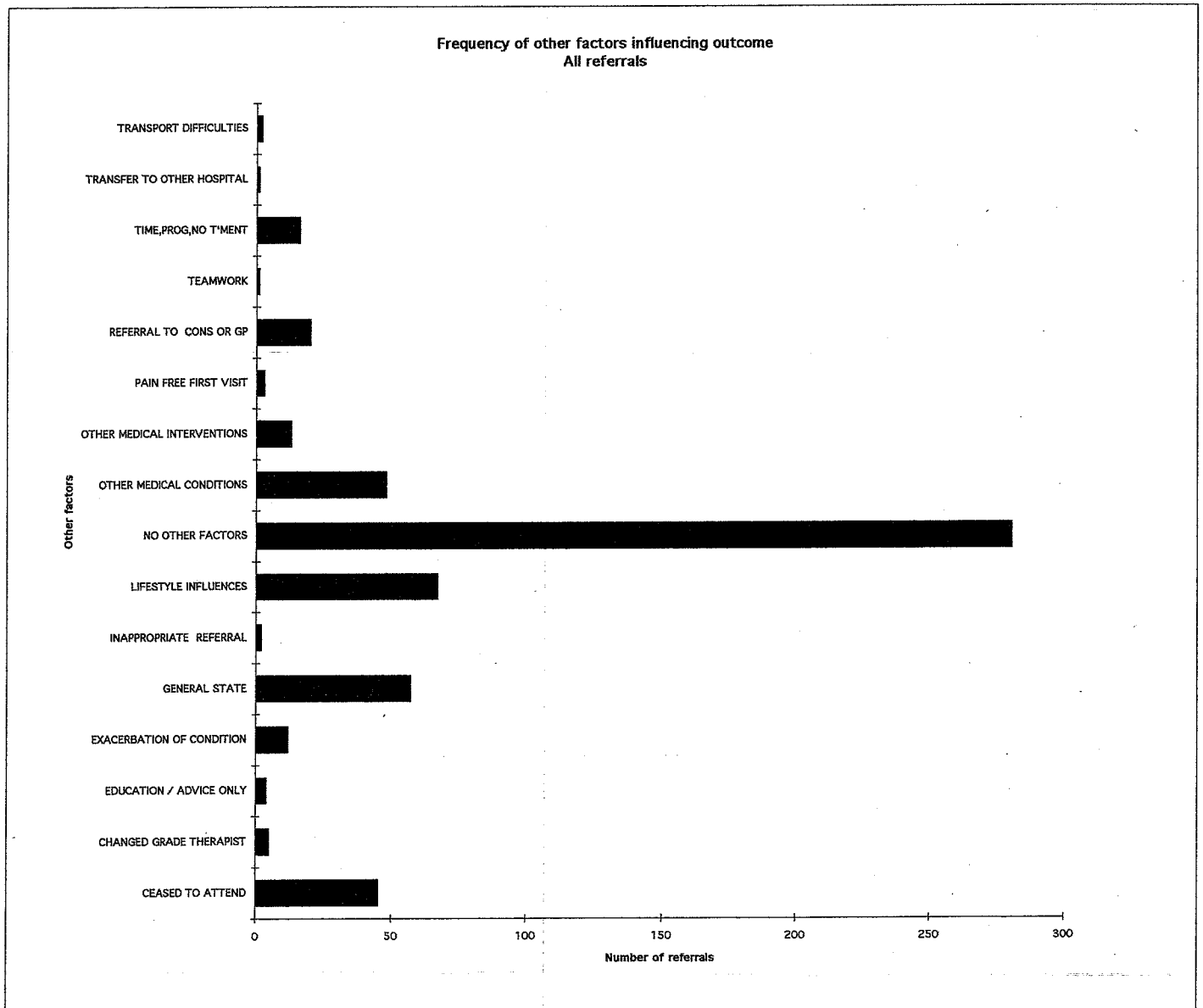


Table 21 Frequency of use of treatment modalities 1st choice - All referrals

TREATMENT 1ST	Number	Percent
ACTIVE EXERCISES	82	12.9%
ACUPUNCTURE	5	0.8%
ADVICE ON SELF- MANAGEMENT	139	21.9%
AROMATHERAPY	2	0.3%
COMBINED MOVEMENTS	1	0.2%
CYRIAX MANIPULATIONS	8	1.3%
EDUCATION & ADVICE	30	4.7%
ICE	2	0.3%
INTERFERENTIAL	16	2.5%
LASER	1	0.2%
LOCAL HEAT (IR PP)	10	1.6%
MANIPULATION GRADE 5	3	0.5%
MASSAGE	5	0.8%
MCKENZIE APPROACH	28	4.4%
MAITLAND MOBILISATION	167	26.3%
NEURODYNAMIC FACILITATION	10	1.6%
PNF	2	0.3%
PASSIVE EXERCISES	3	0.5%
RE-EDUCATION OF MUSCLE IMBALANCE	4	0.6%
SWD	22	3.5%
SNAGS	13	2.1%
SOFT TISSUE STRETCHES	4	0.6%
TENS	9	1.4%
TRACTION	27	4.3%
TRIGGER POINT RELEASE	7	1.1%
ULTRASOUND	34	5.4%
Total	634	100.0%

Table 22 Frequency of use of additional treatment modalities 2nd choice - All referrals

TREATMENT 2ND	Number	Percent
ACTIVE EXERCISES	140	23.7%
ACUPUNCTURE	4	0.7%
ADVICE ON SELF-MANAGEMENT	28	4.7%
COMBINED MOVEMENTS	1	0.2%
CYRIAX MANIPULATIONS	4	0.7%
EDUCATION & ADVICE	40	6.8%
FRICTIONS	3	0.5%
ICE	2	0.3%
INTERFERENTIAL	16	2.7%
LASER	2	0.3%
LOCAL HEAT (IR PP)	11	1.9%
MANIPULATION GRADE 5	2	0.3%
MASSAGE	9	1.5%
MCKENZIE APPROACH	18	3.1%
MAITLAND MOBILISATION	109	18.5%
NEURODYNAMIC FACILITATION	15	2.5%
PASSIVE EXERCISES	10	1.7%
RE-EDUCATION OF MUSCLE IMBALANCE	14	2.4%
SWD	17	2.9%
SNAGS	31	5.3%
SOFT TISSUE STRETCHES	16	2.7%
STRAPPING	2	0.3%
TENS	11	1.9%
TRACTION	34	5.8%
TRIGGER POINT RELEASE	20	3.4%
ULTRASOUND	31	5.3%
Total	590	100.0%

Table 23a Frequency of use of additional treatment modalities 3rd choice - All referrals

TREATMENT 3RD	Number	Percent
ACTIVE EXERCISES	79	16.4%
ACUPUNCTURE	6	1.2%
ADVICE ON SELF-MANAGEMENT	16	3.3%
APPLIANCE FITTING	1	0.2%
COMBINED MOVEMENTS	3	0.6%
CYRIAX MANIPULATIONS	4	0.8%
EDUCATION & ADVICE	76	15.8%
FRICTIONS	1	0.2%
HYDROTHERAPY	1	0.2%
HYPERVENTILATION	1	0.2%
INTERFERENTIAL	7	1.5%
LOCAL HEAT (IR PP)	5	1.0%
MANIPULATION GRADE 5	5	1.0%
MASSAGE	8	1.7%
MCKENZIE APPROACH	11	2.3%
MAITLAND MOBILISATION	71	14.8%
NEURODYNAMIC FACILITATION	11	2.3%
PNF	1	0.2%
PASSIVE EXERCISE	9	1.9%
RE-EDUCATION OF MUSCLE IMBALANCE	16	3.3%
REIKI	1	0.2%
SWD	6	1.2%
SNAGS	40	8.3%
SOFT TISSUE STRETCHES	18	3.7%
STRAPPING	4	0.8%
TENS	4	0.8%
TRACTION	31	6.4%
TRIGGER POINT RELEASE	15	3.1%
ULTRASOUND	30	6.2%
Total	481	100.0%

Table 23b Frequency of use of additional treatment modalities 4th choice - All referrals

TREATMENT 3RD	Number	Percent
ACTIVE EXERCISES	40	15.1%
ACUPUNCTURE	3	1.1%
ADVICE ON SELF-MANAGEMENT	16	6.0%
APPLIANCE FITTING	2	0.8%
COMBINED MOVEMENTS	1	0.4%
CYRIAX MANIPULATIONS	1	0.4%
EDUCATION & ADVICE	61	23.0%
INTERFERENTIAL	6	2.3%
LOCAL HEAT (IR PP)	3	1.1%
MANIPULATION GRADE 5	3	1.1%
MASSAGE	5	1.9%
MCKENZIE APPROACH	3	1.1%
MAITLAND MOBILISATION	34	12.8%
NEURODYNAMIC FACILITATION	4	1.5%
PASSIVE EXERCISE	6	2.3%
RE-EDUCATION OF MUSCLE IMBALANCE	3	1.1%
SWD	4	1.5%
SNAGS	23	8.7%
SOFT TISSUE STRETCHES	10	3.8%
STRAPPING	4	1.5%
TENS	1	0.4%
TRACTION	11	4.2%
TRIGGER POINT RELEASE	10	3.8%
ULTRASOUND	11	4.2%
Total	265	100.0%

Table 24 Frequency of total effort scores in bands - All referrals

Effort band	Number	Percent
0 TO 9	47	7.4%
10 TO 19	201	31.9%
20 TO 29	189	30.0%
30 TO 39	106	16.8%
40 TO 49	44	7.0%
50 TO 59	20	3.2%
60 TO 69	10	1.6%
70 TO 79	6	0.3%
80 TO 89	2	0.3%
90 TO 99	2	0.3%
100 TO 109	2	0.3%
120 TO 129	2	0.3%
Total	631	100.0%

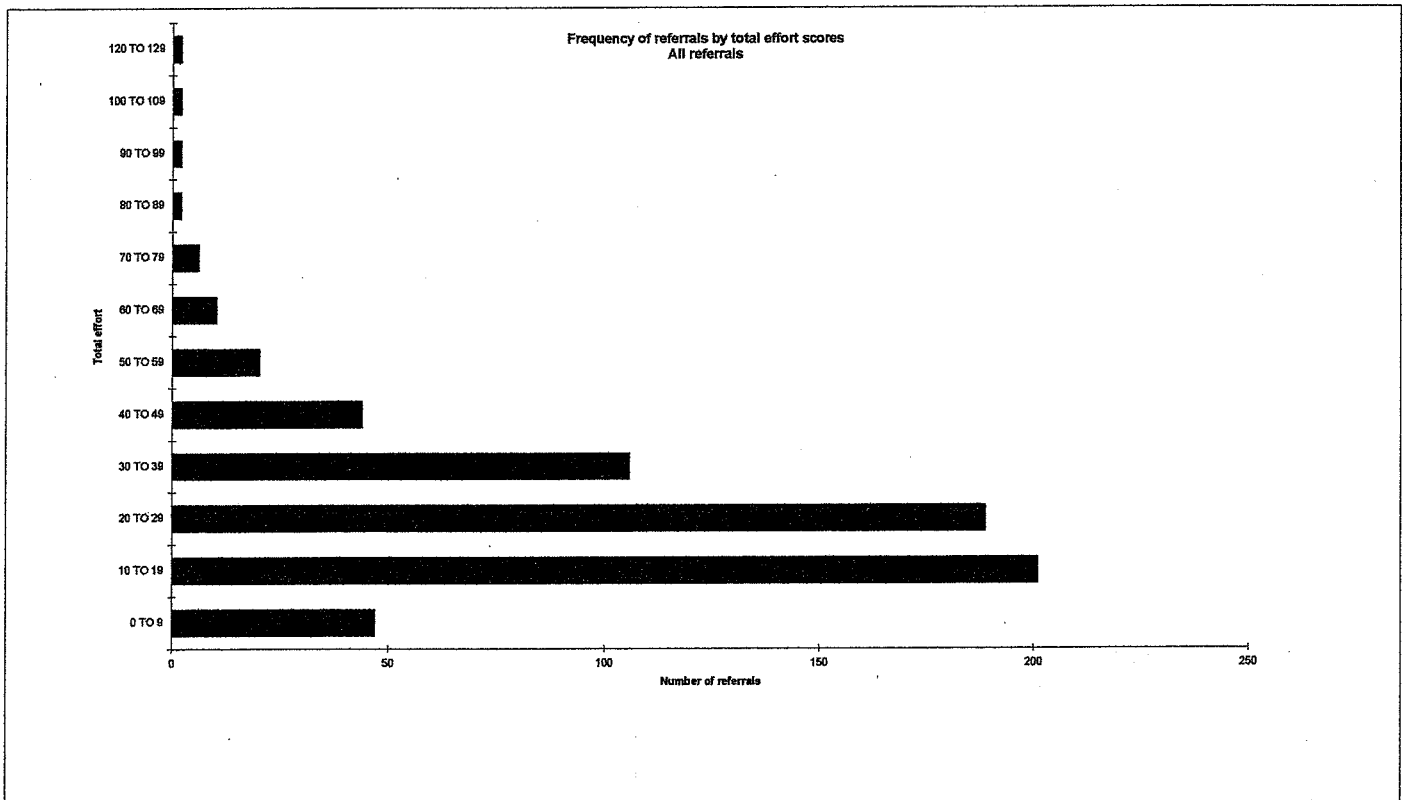


Table 25a Frequency of number of treatments received - All referrals

Number of treatm.	Number	Percent
0	5	0.8%
1	34	5.3%
2	62	9.7%
3	80	12.6%
4	109	17.1%
5	99	15.5%
6	80	12.6%
7	57	8.9%
8	24	3.8%
9	27	4.2%
10	10	1.6%
11	17	2.7%
12	12	1.9%
13	6	0.9%
14	2	0.3%
15	6	0.9%
16	3	0.5%
17	1	0.2%
18	1	0.2%
19	1	0.2%
22	1	0.2%
Total	637	100.0%

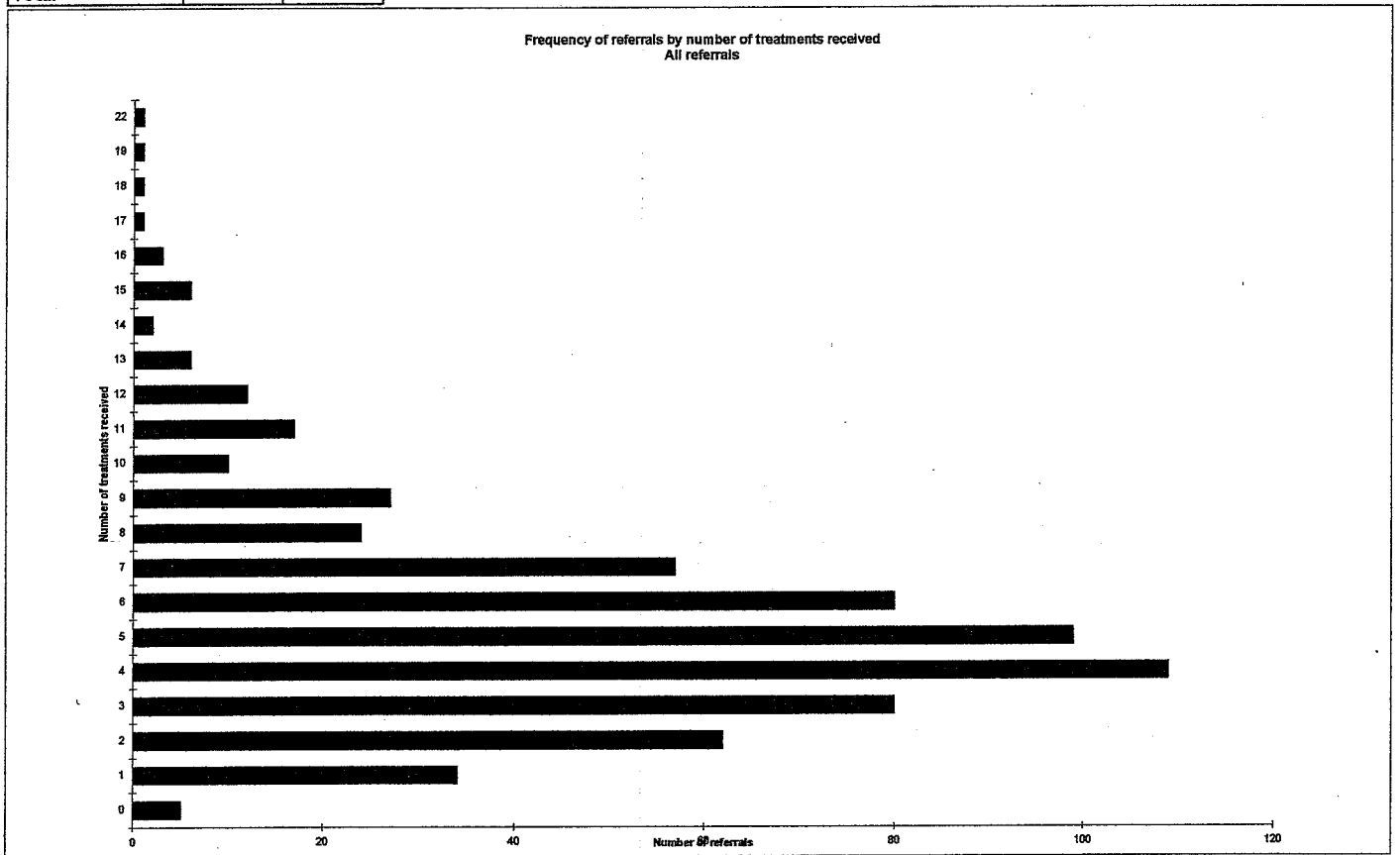


Table 25b Frequency of number of treatments received - Patients discharged normally

Number of treatm.	Number	Percent
1	7	1.5%
2	34	7.4%
3	59	12.8%
4	90	19.5%
5	84	18.2%
6	65	14.1%
7	42	9.1%
8	17	3.7%
9	23	5.0%
10	6	1.3%
11	14	3.0%
12	9	2.0%
13	4	0.9%
14	2	0.4%
15	1	0.2%
16	1	0.2%
17	1	0.2%
18	1	0.2%
22	1	0.2%
Total	461	100.0%

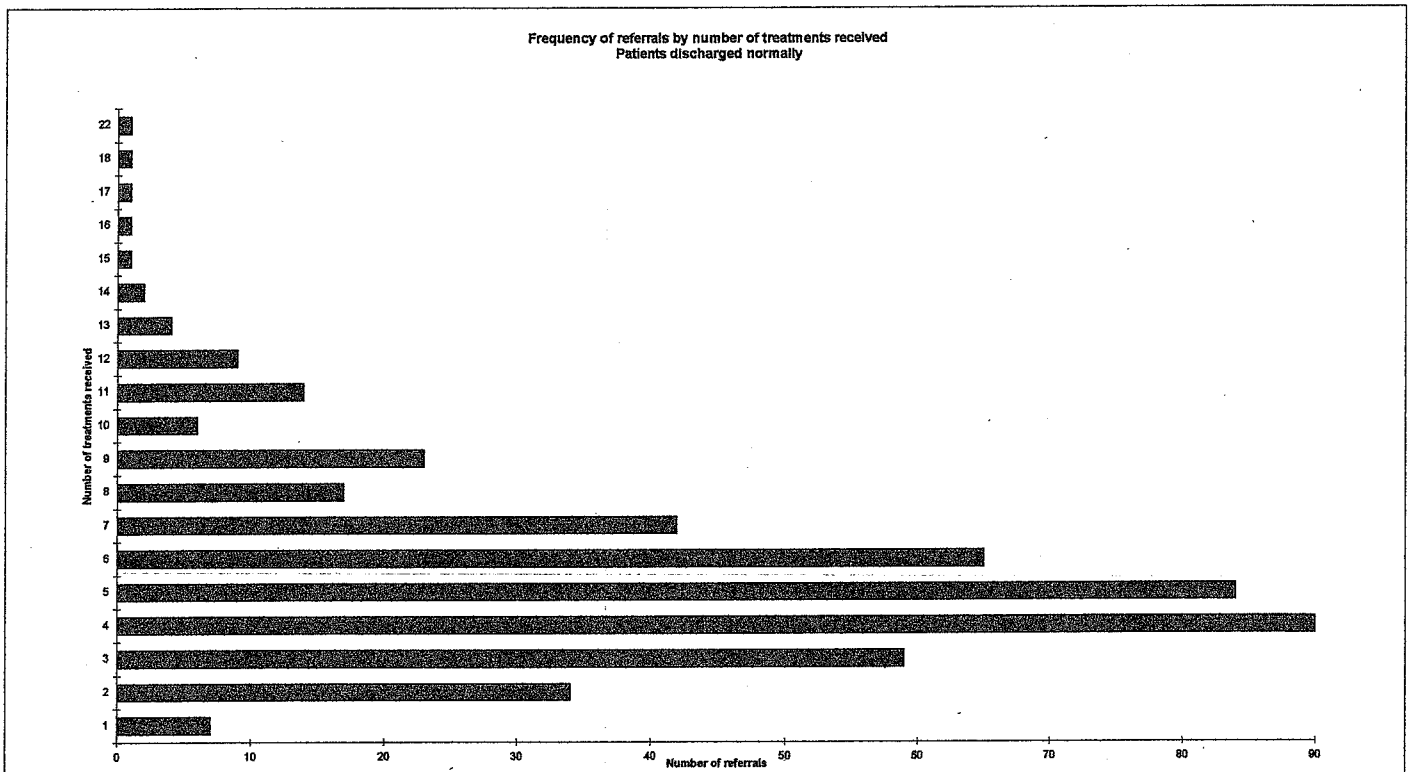


Table 25c Frequency of number of treatments - All referrals

Number of treatm.	Number	Percent
1 to 6	464	73.4%
7 to 12	147	23.3%
13 to 18	19	3.0%
19+	2	0.3%
Total	632	100.0%

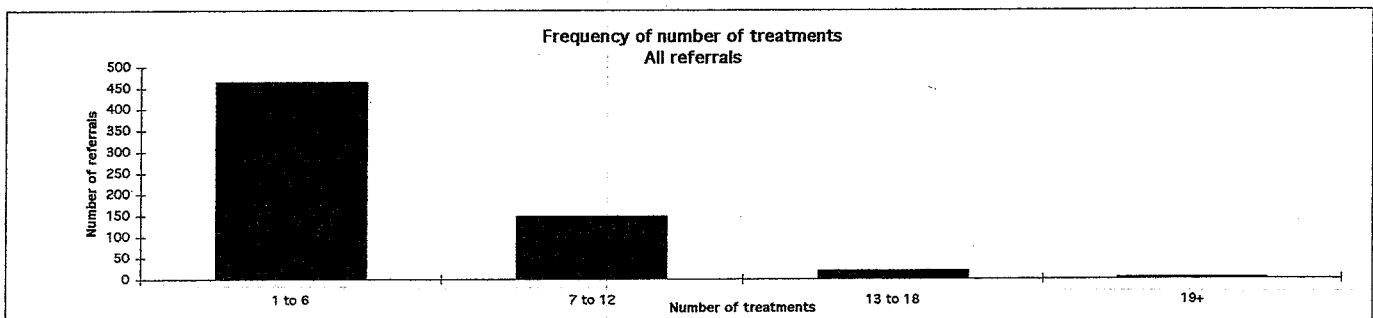


Table 26 Frequency of referral by grade of physiotherapist (1st PT) - All referrals

Physiograde (1)	Number	Percent
JUNIOR	67	10.2%
SENIOR I	230	35.2%
SENIOR II	289	44.2%
STUDENT	1	0.2%
SUPERINTENDENT I	2	0.3%
SUPERINTENDENT II	8	1.2%
SUPERINTENDENT III	48	7.3%
SUPERINTENDENT IV	9	1.4%
Total	654	100.0%

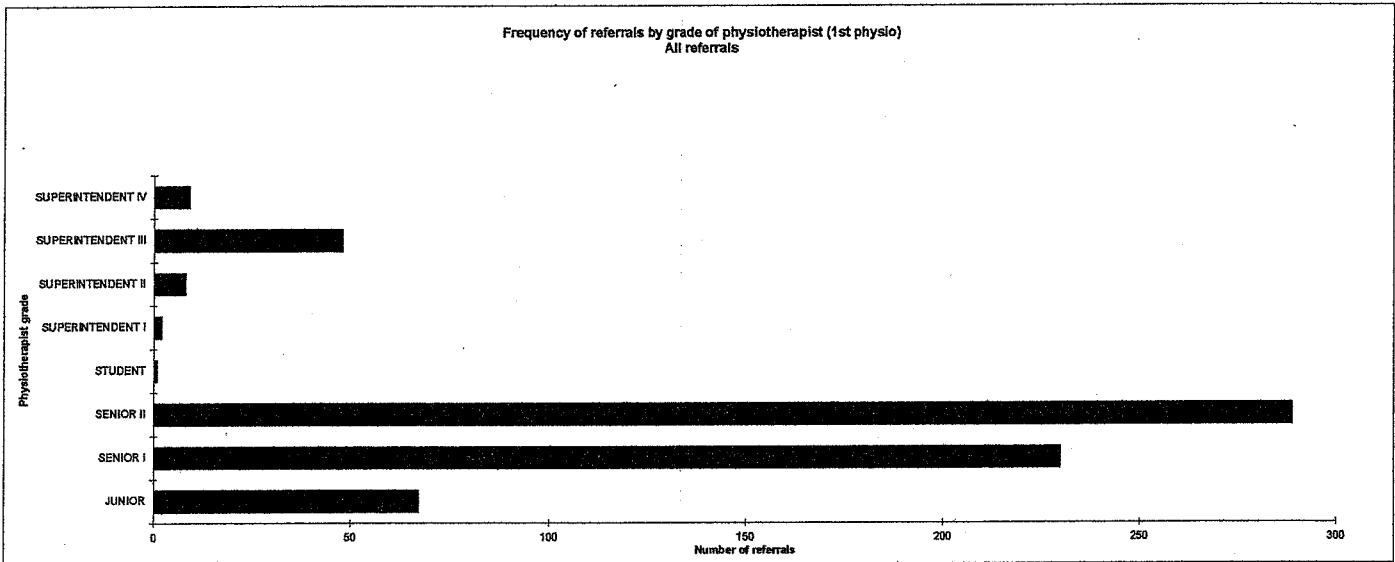


Table 27 Frequency of referral by grade of physiotherapist (2nd PT) - All referrals

Physiograde (2)	Number	Percent
JUNIOR	2	9.5%
SENIOR I	8	38.1%
SENIOR II	4	19.0%
STUDENT	1	4.8%
SUPERINTENDENT II	2	9.5%
SUPERINTENDENT III	4	19.0%
Total	21	100.0%

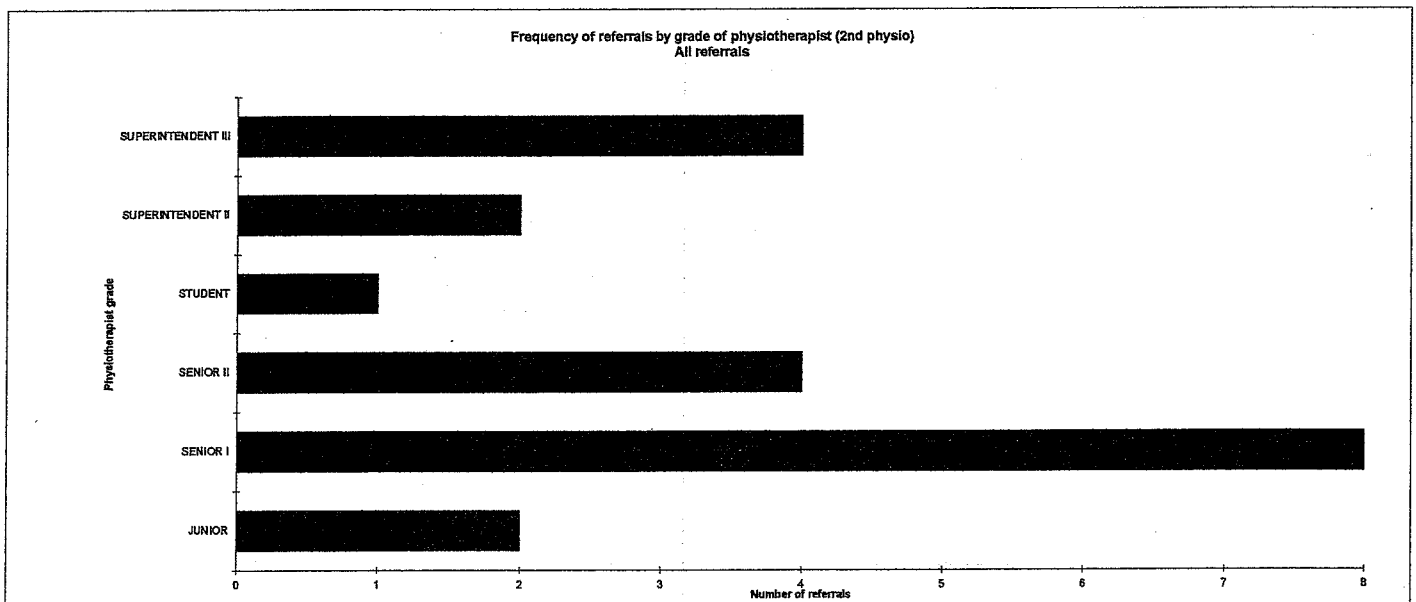


Table 28 Frequency of number of physiotherapists involved in treatment - All referrals

Number of therapists	Number	Percent
0	1	0.2%
1	577	90.2%
2	52	8.1%
3	8	1.3%
4	1	0.2%
5	1	0.2%
Total	640	100.0%

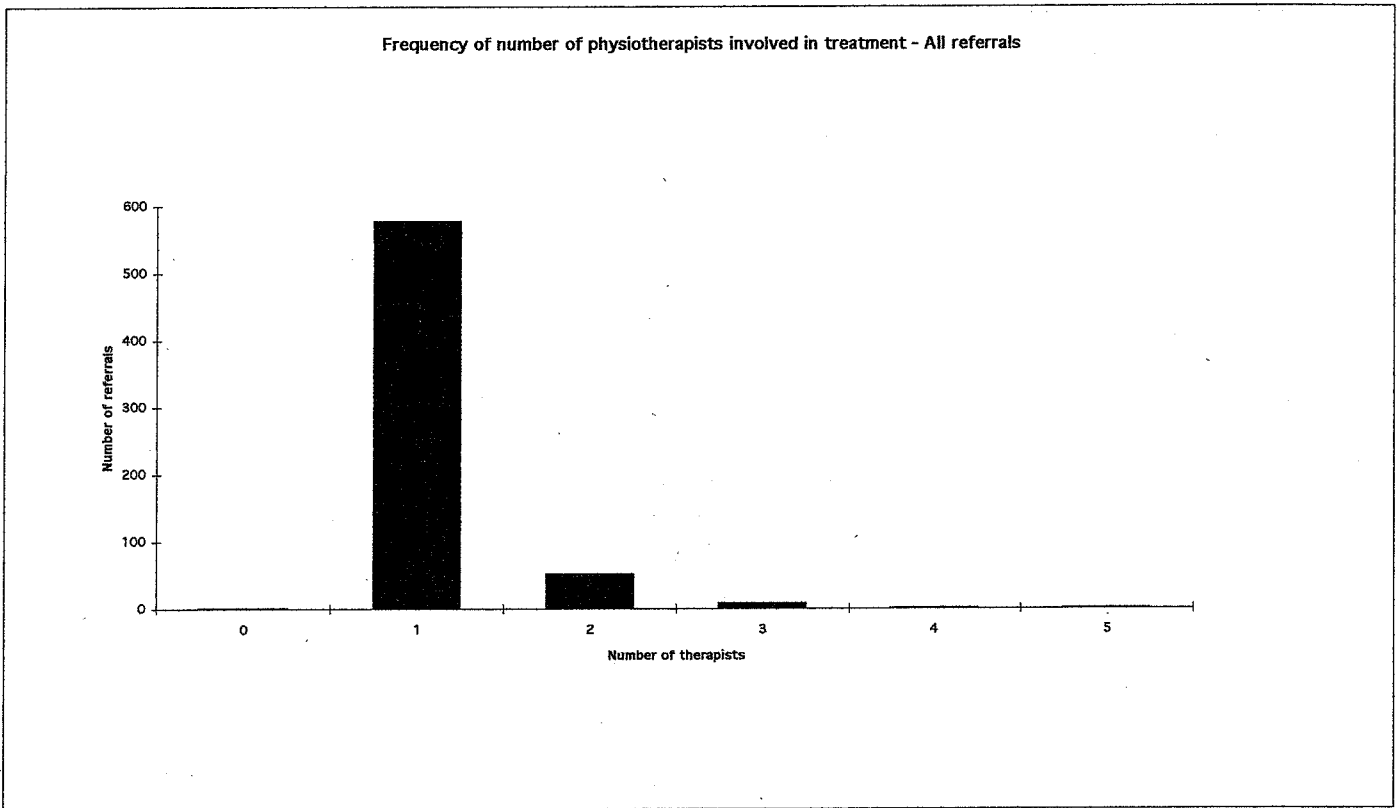


Table 29 Frequency of referral source - All referrals

Source	Number	Percent
CONSULTANT	85	13.1%
GENERAL PRACTITIONER	534	82.5%
ORTHOPAEDIC PRACTITIONER	12	1.9%
OTHER	16	2.5%
Total	647	100.0%

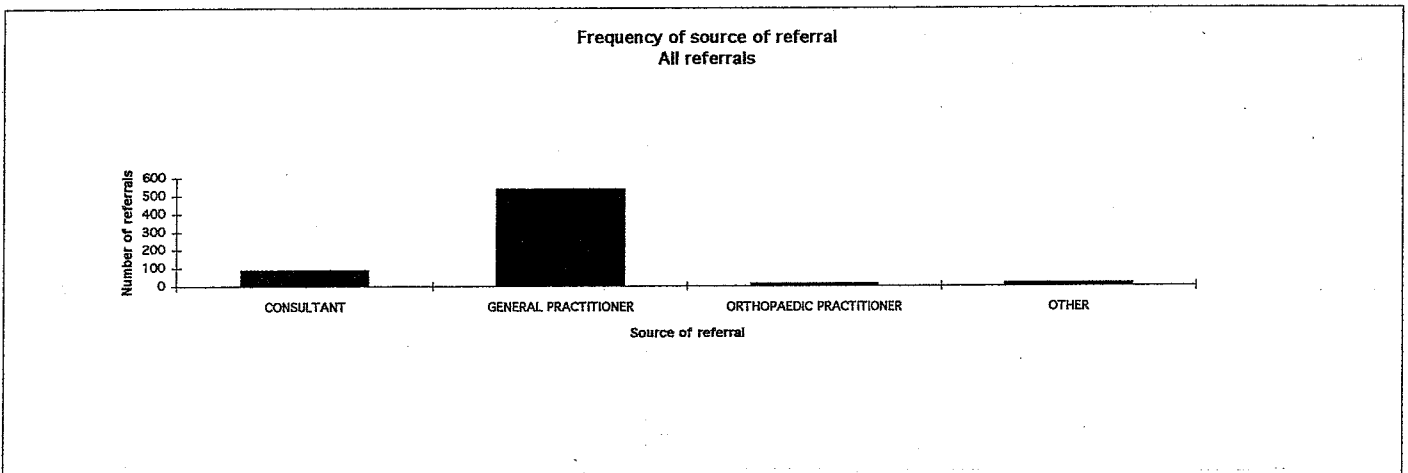


Table 30 Frequency of initial assessment of functional ability - All referrals

Functional Ab.	Number	Percent
1	5	0.8%
2	36	5.6%
3	118	18.2%
4	75	11.6%
5	95	14.7%
6	111	17.1%
7	84	13.0%
8	91	14.0%
9	28	4.3%
10	5	0.8%
Total	648	100.0%

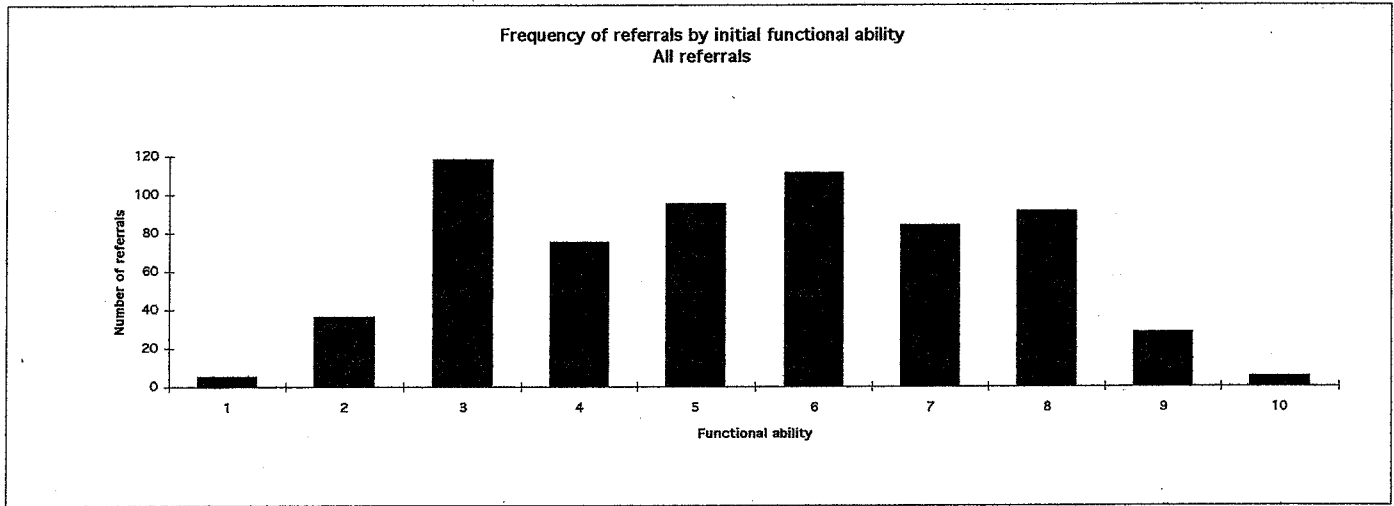


Table 31 Frequency of assessment of expected functional outcome - All referrals

outcome	Number	Percent
0	1	0.2%
1	1	0.2%
2	2	0.3%
3	2	0.3%
4	10	1.6%
5	26	4.0%
6	35	5.4%
7	70	10.9%
8	141	21.9%
8.5	1	0.2%
9	221	34.3%
9.5	2	0.3%
10	132	20.5%
Total	644	100.0%

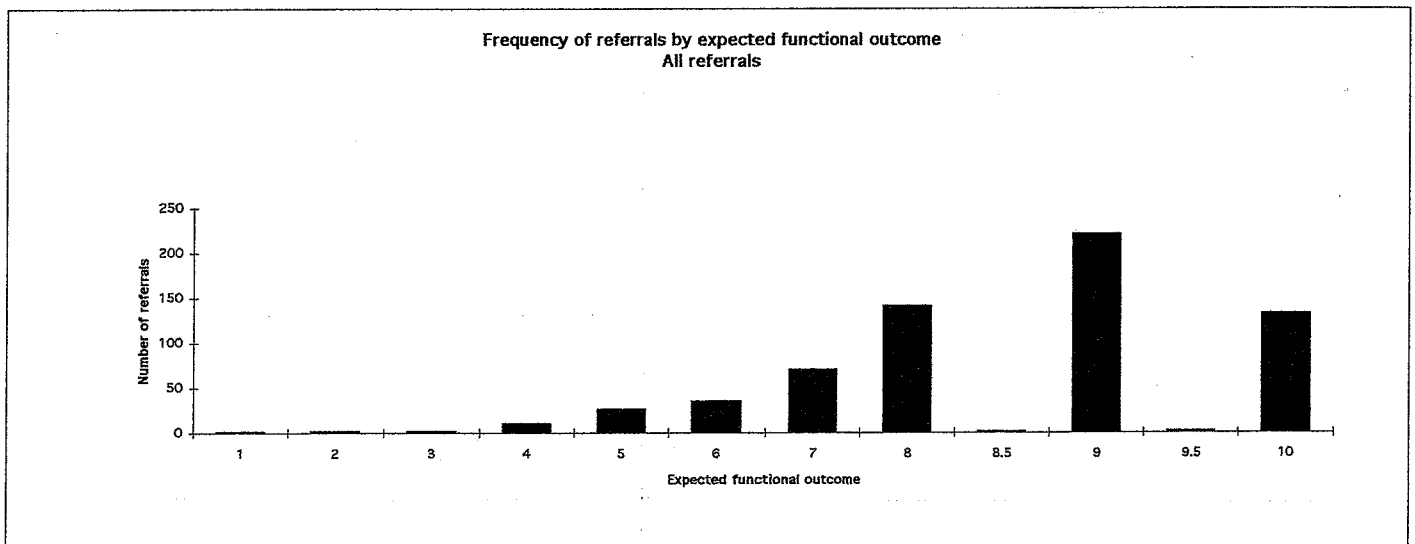


Table 32 Frequency of actual functional outcome - All referrals

Outcome	Number	Percent
0	1	0.2%
1	2	0.3%
2	4	0.7%
3	14	2.4%
4	15	2.6%
5	34	5.8%
6	24	4.1%
6.5	1	0.2%
7	54	9.2%
7.5	1	0.2%
8	102	17.3%
8.5	1	0.2%
9	194	33.0%
9.5	1	0.2%
10	140	23.8%
Total	588	100.0%

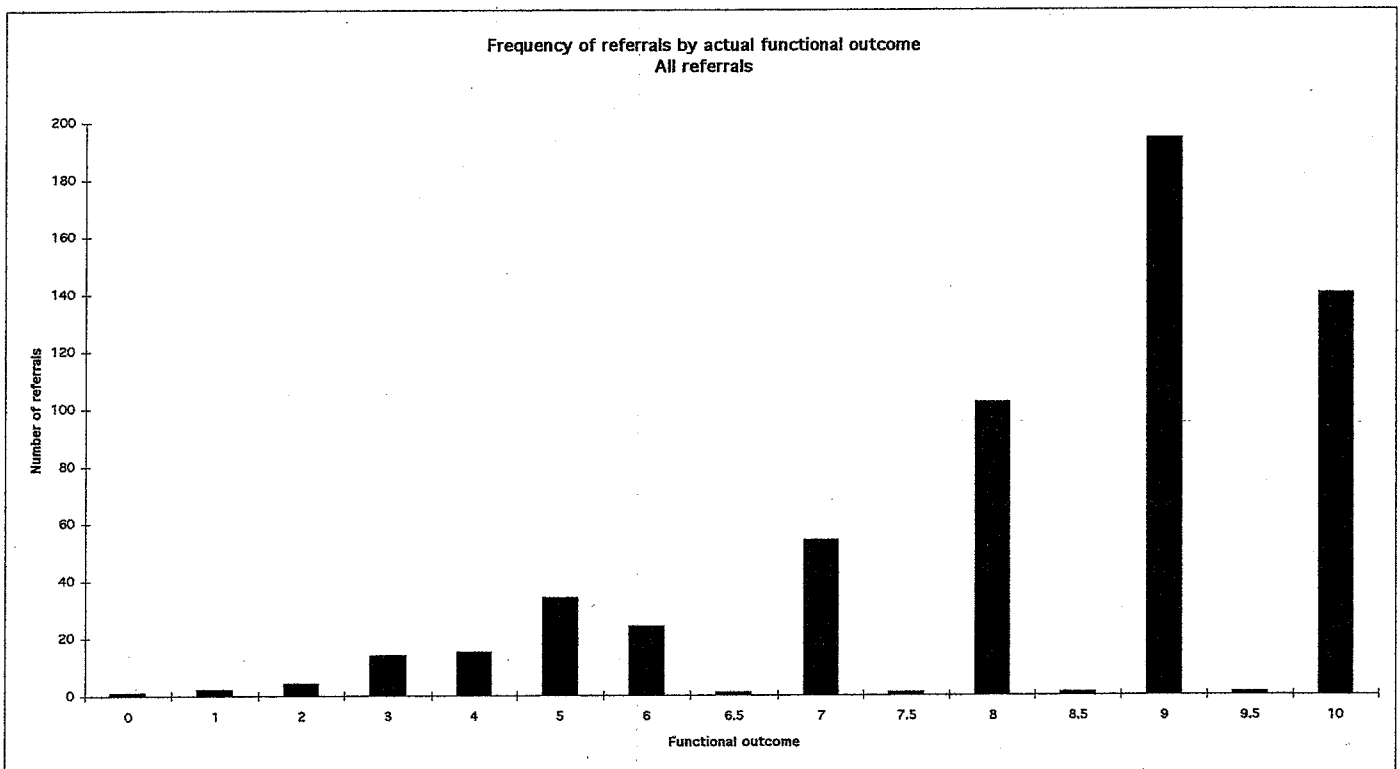


Table 33a Frequency of patient perceived pain prior to physiotherapy - All referrals

Pain score	Number	Percent
0	4	0.6%
1	13	2.0%
2	29	4.6%
3	32	5.0%
4	66	10.4%
5	115	18.1%
6	69	10.8%
7	89	14.0%
8	133	20.9%
9	43	6.8%
10	44	6.9%
Total	637	100.0%

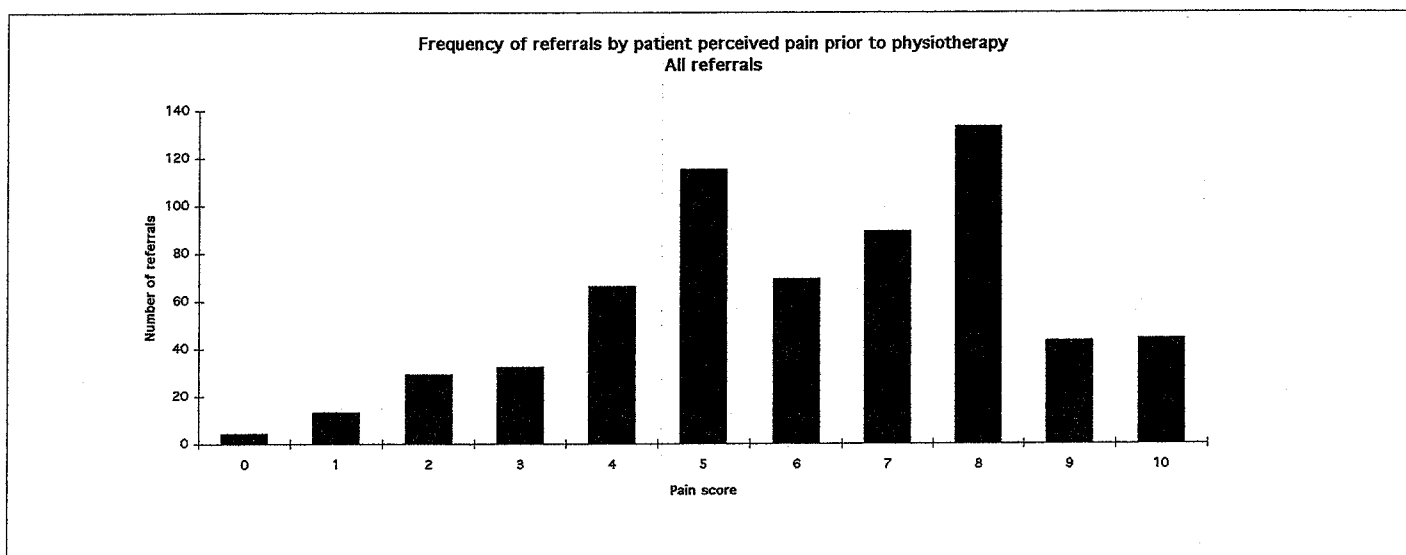


Table 33b Frequency of patient perceived pain prior to physiotherapy - Patients discharged normally

Pain score	Number	Percent
0	1	0.2%
1	11	2.4%
2	23	5.0%
3	28	6.1%
4	49	10.7%
5	82	17.9%
6	55	12.0%
7	61	13.3%
8	91	19.8%
9	27	5.9%
10	31	6.8%
Total	459	100.0%

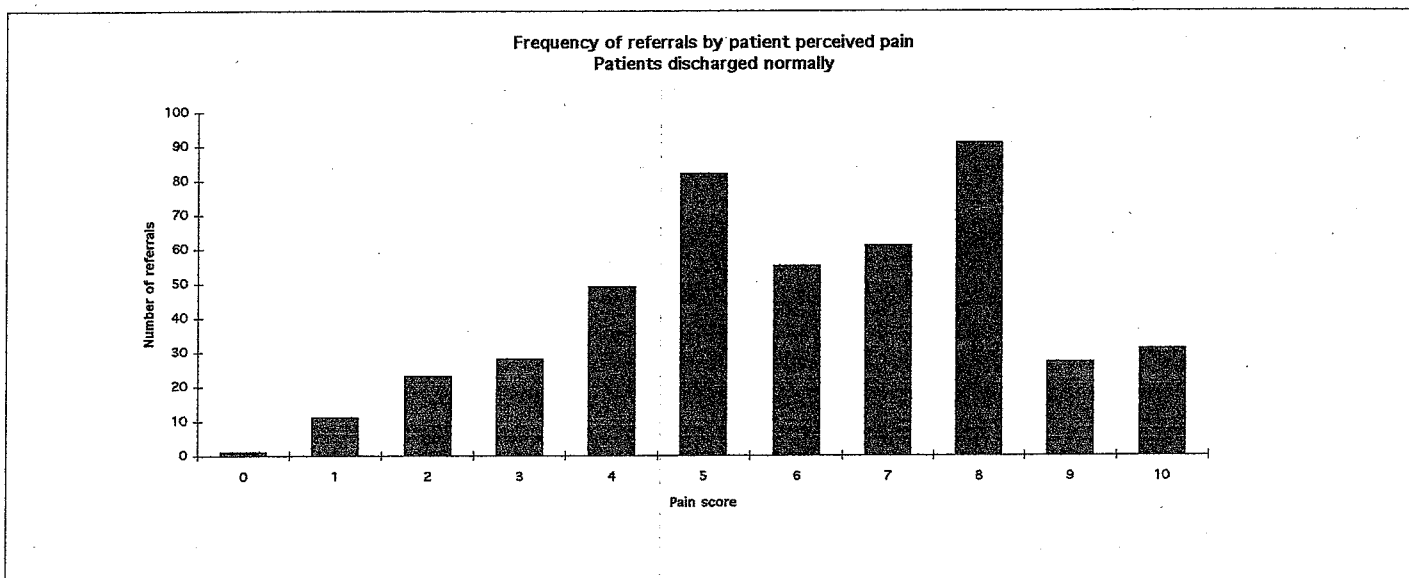


Table 34a Frequency of patient perceived pain after physiotherapy - All referrals

Pain score	Number	Percent
0	127	22.3%
1	130	22.8%
2	93	16.3%
3	56	9.8%
4	46	8.1%
5	38	6.7%
6	19	3.3%
7	18	3.2%
8	23	4.0%
9	10	1.8%
10	10	1.8%
Total	570	100.0%

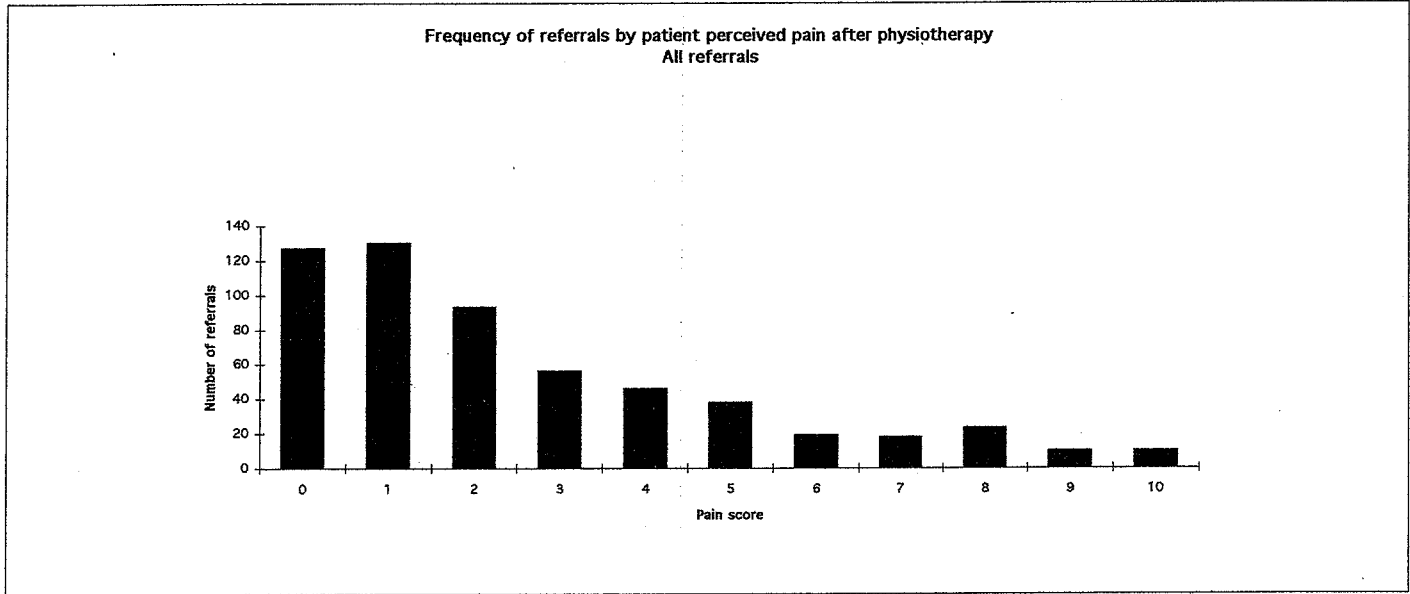


Table 34b Frequency of patient perceived pain after physiotherapy - Patients discharged normally

Pain score	Number	Percent
0	117	25.5%
1	118	25.8%
2	81	17.7%
3	48	10.5%
4	35	7.6%
5	23	5.0%
6	9	2.0%
7	7	1.5%
8	7	1.5%
9	7	1.5%
10	6	1.3%
Total	458	100.0%

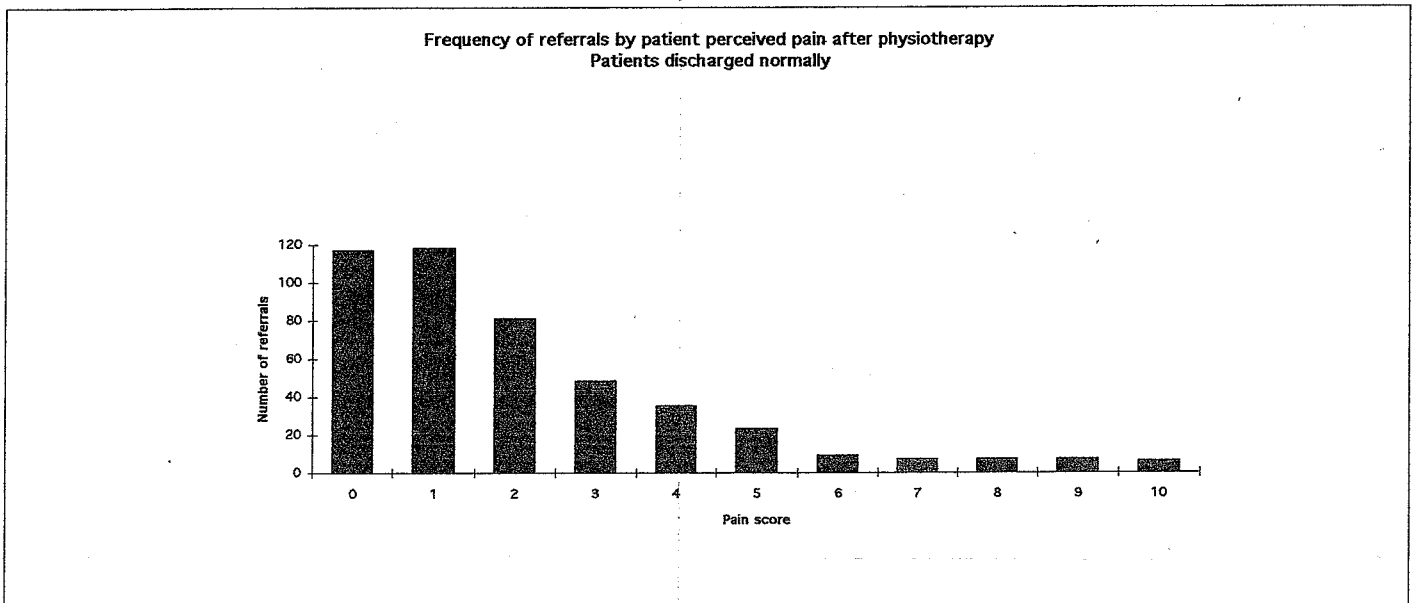


Table 35a Frequency of change in pain level after physiotherapy - All referrals

Pain score	Number	Percent
-6	1	0.2%
-5	4	0.7%
-4	1	0.2%
-3	1	0.2%
-2	1	0.2%
-1	8	1.4%
0	65	11.4%
1	60	10.6%
2	66	11.6%
3	82	14.4%
4	75	13.2%
5	66	11.6%
6	50	8.8%
7	39	6.9%
8	31	5.5%
9	11	1.9%
10	7	1.2%
Total	568	100.0%

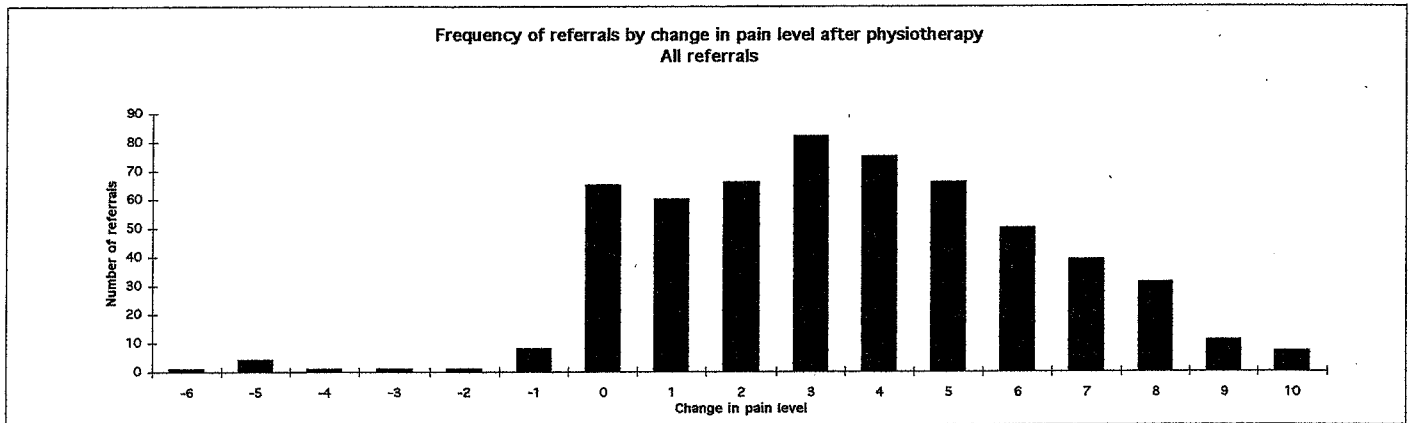


Table 35b Frequency of change in pain level after physiotherapy - Patients discharged normally

Pain score	Number	Percent
-6	1	0.2%
-5	4	0.9%
-4	1	0.2%
-3	1	0.2%
-2	1	0.2%
-1	7	1.5%
0	19	4.2%
1	45	9.9%
2	52	11.4%
3	70	15.4%
4	68	14.9%
5	59	12.9%
6	45	9.9%
7	37	8.1%
8	28	6.1%
9	11	2.4%
10	7	1.5%
Total	456	100.0%

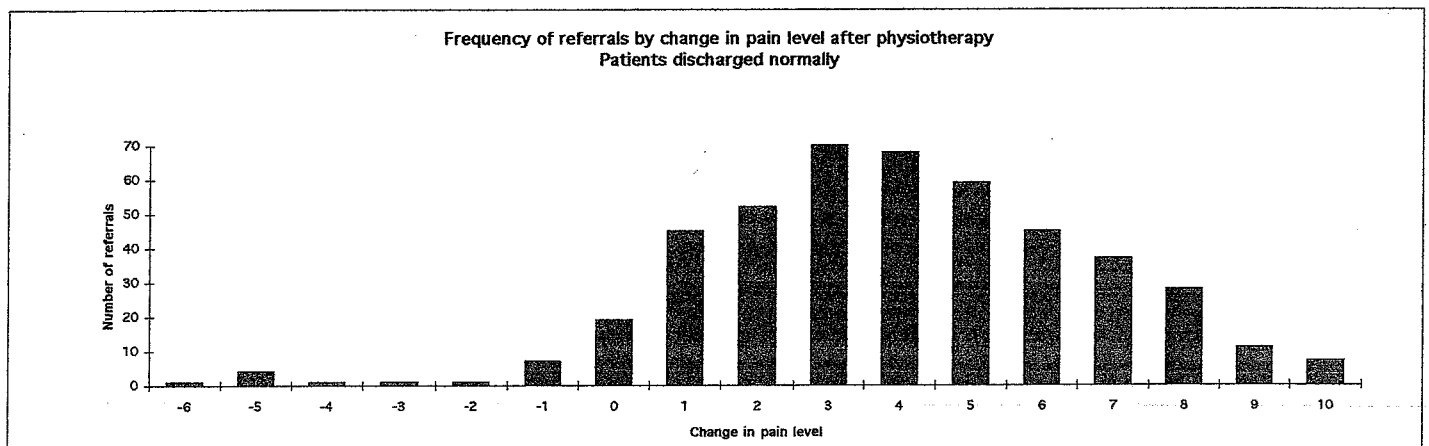


Table 36a Frequency of patient perceived functional ability prior to physiotherapy - All referrals

Function	Number	Percent
0	14	2.2%
1	5	0.8%
2	31	4.9%
3	33	5.2%
4	42	6.6%
5	100	15.8%
6	75	11.8%
7	82	12.9%
8	100	15.8%
9	70	11.0%
10	82	12.9%
Total	634	100.0%

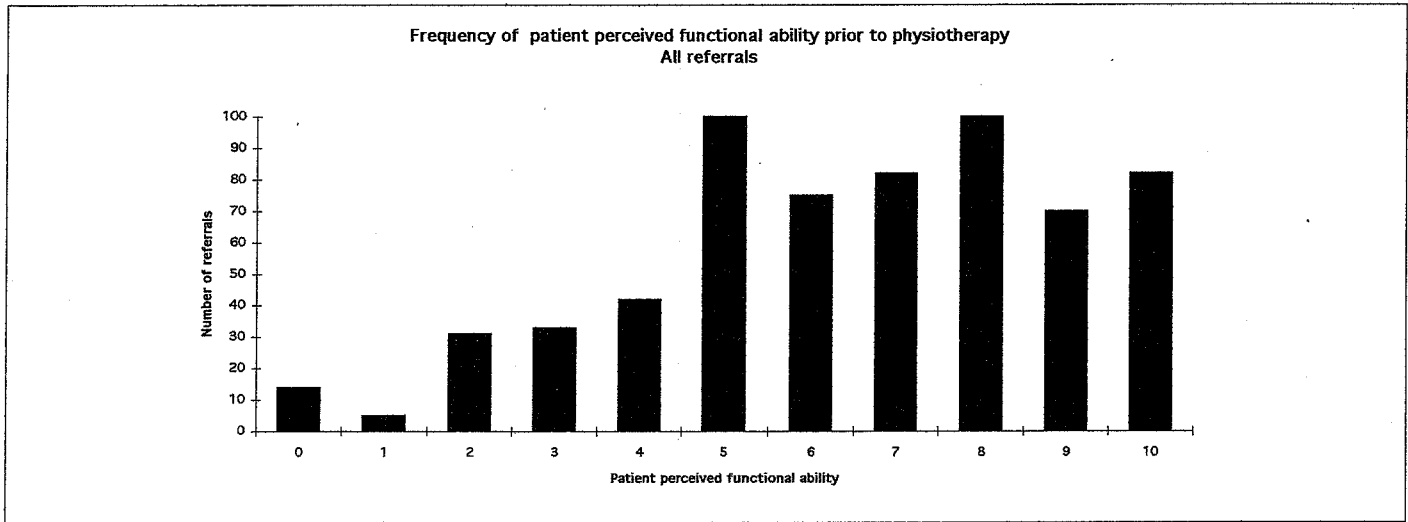


Table 36b Frequency of patient perceived functional ability prior to physiotherapy - Patients discharged normally

Function	Number	Percent
0	7	1.5%
1	5	1.1%
2	21	4.6%
3	23	5.0%
4	31	6.8%
5	71	15.6%
6	51	11.2%
7	64	14.0%
8	67	14.7%
9	52	11.4%
10	64	14.0%
Total	456	100.0%

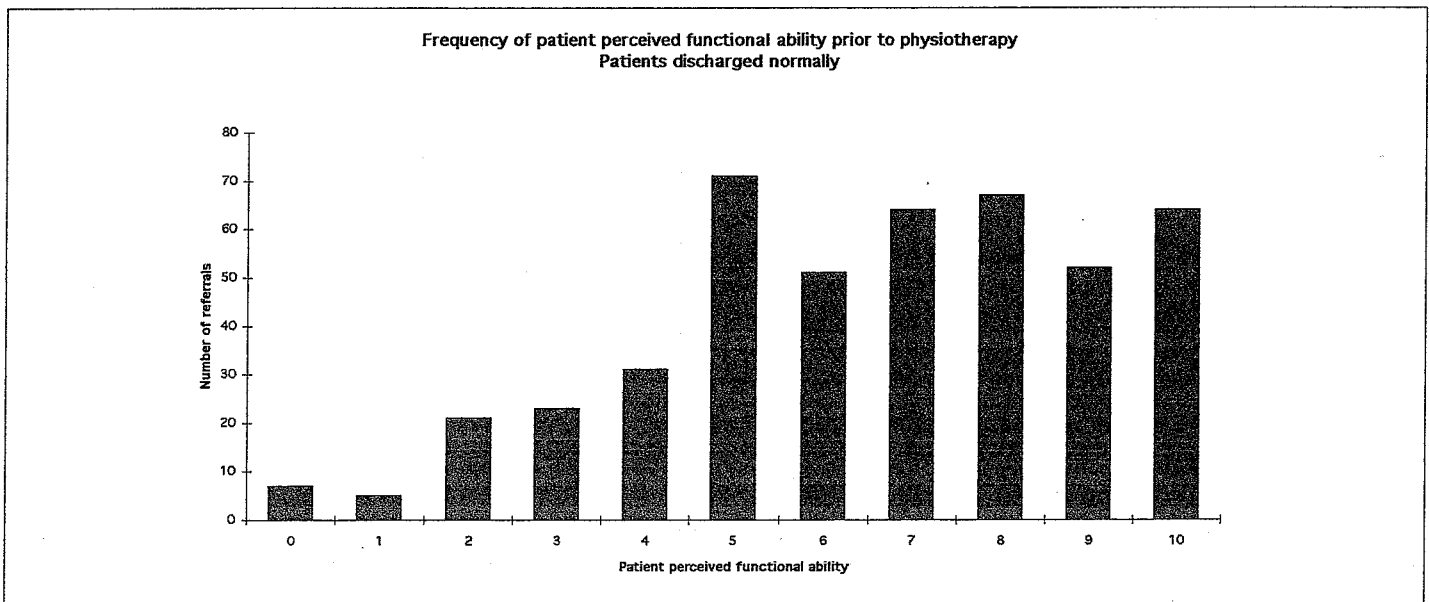


Table 37a Frequency of patient perceived functional ability after physiotherapy - All referrals

Function	Number	Percent
0	19	3.4%
1	12	2.1%
2	16	2.8%
3	10	1.8%
4	7	1.2%
5	22	3.9%
6	20	3.5%
7	31	5.5%
8	77	13.6%
9	105	18.6%
10	247	43.6%
Total	566	100.0%

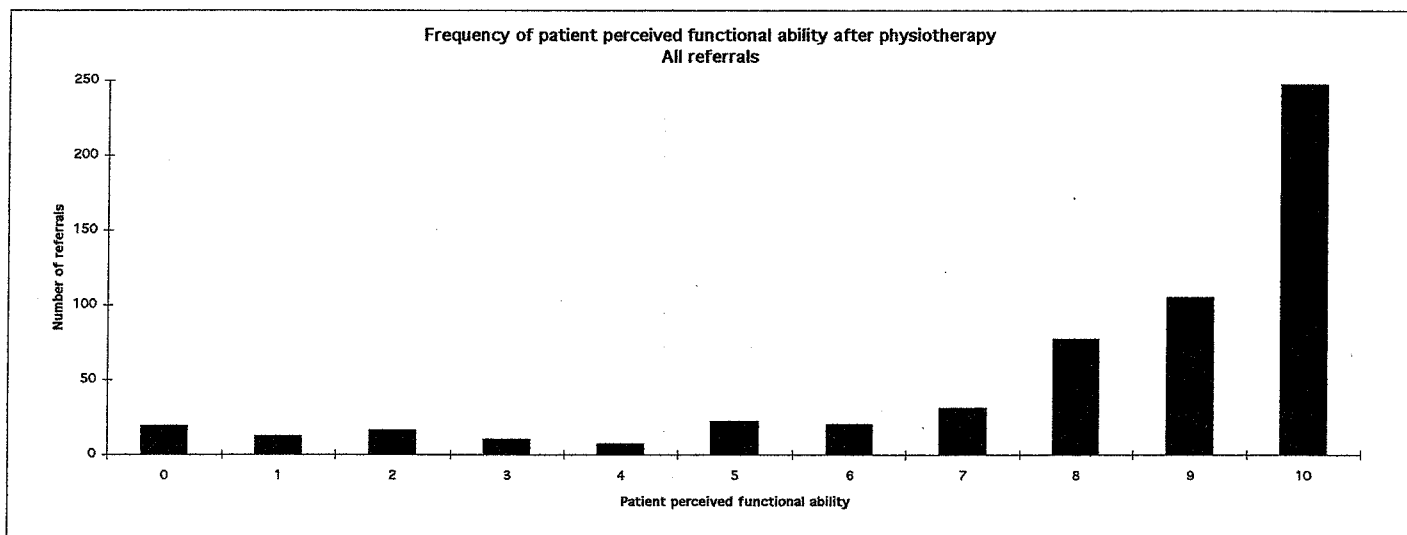


Table 37b Frequency of patient perceived functional ability after physiotherapy - Patients discharged normally

Function	Number	Percent
0	13	2.9%
1	12	2.6%
2	11	2.4%
3	7	1.5%
4	3	0.7%
5	10	2.2%
6	13	2.9%
7	18	3.9%
8	59	12.9%
9	85	18.6%
10	225	49.3%
Total	456	100.0%

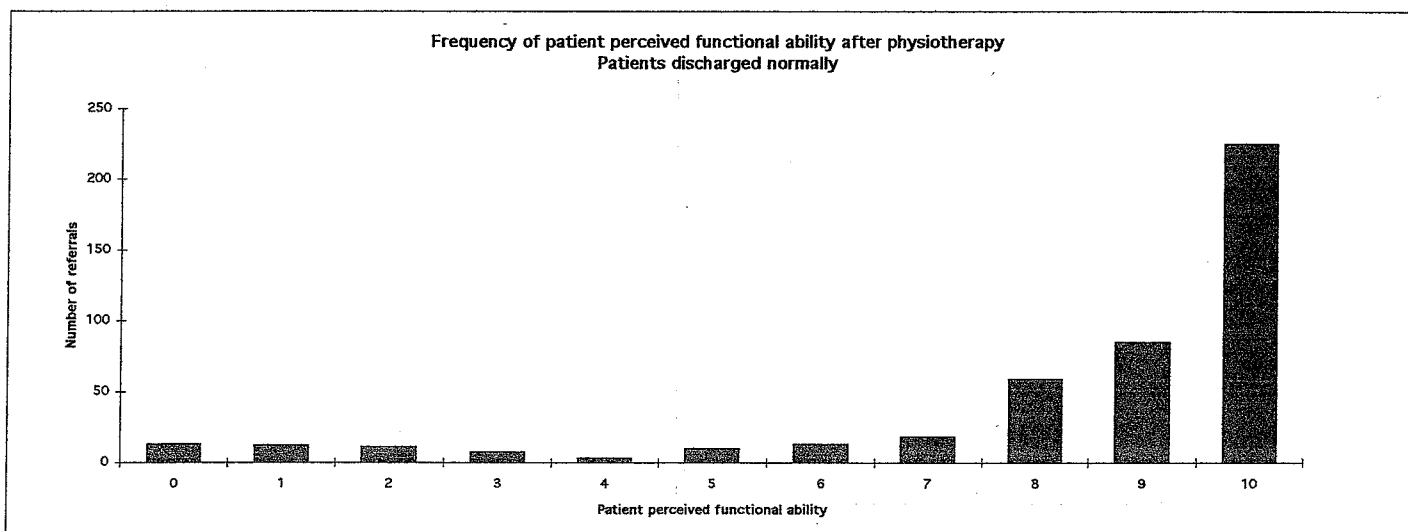


Table 38a Frequency of patient perceived change in functional ability- All referrals

Pain change	Number	Percent
-10	1	0.002
-8	5	0.009
-7	2	0.004
-6	1	0.2%
-5	6	1.1%
-4	9	1.6%
-3	6	1.1%
-2	11	2.0%
-1	8	1.4%
0	142	25.2%
1	100	17.7%
2	93	16.5%
3	69	12.2%
4	32	5.7%
5	41	7.3%
6	14	2.5%
7	13	2.3%
8	7	1.2%
9	1	0.2%
10	3	0.5%
Total	564	100.0%

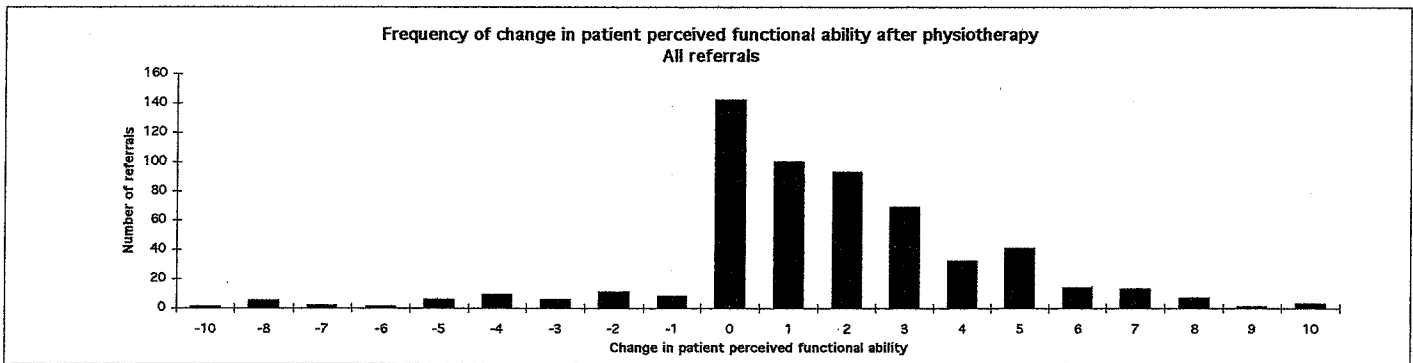


Table 38b Frequency of patient perceived change in functional ability - Patients discharged normally

Pain change	Number	Percent
-10	1	0.002
-8	3	0.007
-7	1	0.002
-6	1	0.2%
-5	5	1.1%
-4	9	2.0%
-3	6	1.3%
-2	10	2.2%
-1	7	1.5%
0	95	20.9%
1	77	17.0%
2	78	17.2%
3	59	13.0%
4	29	6.4%
5	37	8.1%
6	14	3.1%
7	12	2.6%
8	7	1.5%
9	1	0.2%
10	2	0.4%
Total	454	100.0%

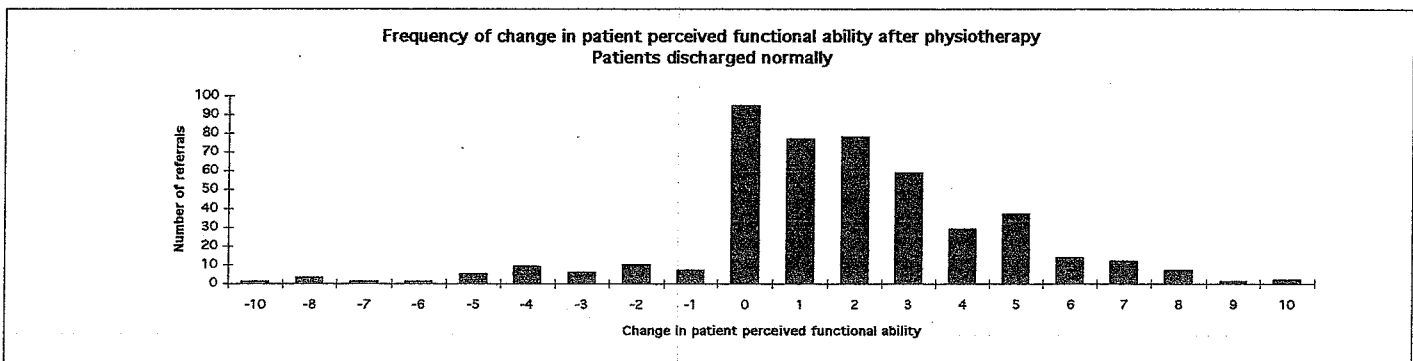


Table 39 Grade of physiotherapist by patient perceived change in functional ability

Physiotherapist Grade	Increase in functional score										Total
	1	1.5	2	3	4	5	6	7	8	9	
JUNIOR	4	0	13	9	4	4	4	2	1	0	41
SENIOR 1	25	1	37	37	23	14	7	4	1	1	150
SENIOR 2	30	0	45	33	31	26	15	15	2	0	197
STUDENT	0	0	0	0	1	0	0	0	0	0	1
SUPERINTENDENT I	0	0	2	0	0	0	0	0	0	0	2
SUPERINTENDENT II	1	0	0	1	0	1	0	1	0	0	4
SUPERINTENDENT III	7	0	5	7	3	5	3	2	1	0	33
SUPERINTENDENT IV	3	0	3	1	1	0	0	0	0	0	8
Total	70	1	105	88	63	50	29	24	5	1	436

Table 40 Increase in functional ability by location

OPD location	Increase in functional ability										Total
	1	1.5	2	3	4	5	6	7	8	9	
1	0	0	0	1	1	0	0	0	0	0	2
2	5	0	10	5	1	3	1	0	0	0	25
3	1	0	2	2	2	0	2	0	1	0	10
5	3	0	1	1	4	2	3	0	0	0	14
6	2	0	20	10	6	3	4	2	0	0	47
7	1	0	1	5	3	2	0	2	0	1	15
8	9	0	15	14	11	2	3	0	1	0	55
9	3	0	5	11	4	3	4	2	0	0	32
10	13	1	7	7	9	5	1	3	0	0	46
11	3	0	16	8	10	11	4	5	0	0	57
12	0	0	0	1	0	1	0	1	0	0	3
13	2	0	3	2	2	3	3	2	1	0	18
14	18	0	15	12	4	9	2	2	0	0	62
15	3	0	1	3	0	2	0	2	1	0	12
16	7	0	9	6	6	6	2	3	1	0	40
Total	70	1	105	88	63	52	29	24	5	1	438

Table 41 Change in patient perceived functional ability by location

OPD location	worse	same	Improved	Total
1	0	0	3	3
2	2	7	18	27
3	1	2	7	10
5	3	1	12	16
6	4	8	36	48
7	1	6	15	22
8	4	8	44	56
9	5	7	21	33
10	1	14	32	47
11	5	10	40	55
12	1	1	2	4
13	1	2	11	14
14	11	12	43	66
15	1	4	9	14
16	3	13	24	40
Total	43	95	317	455

Table 42a Frequency of patient perceived ability to work prior to physiotherapy - All referrals

Ability to work	Number	Percent
0	64	12.6%
1	7	1.4%
2	22	4.3%
3	16	3.1%
4	26	5.1%
5	63	12.4%
6	44	8.6%
7	47	9.2%
8	73	14.3%
9	52	10.2%
10	95	18.7%
Total	509	100.0%

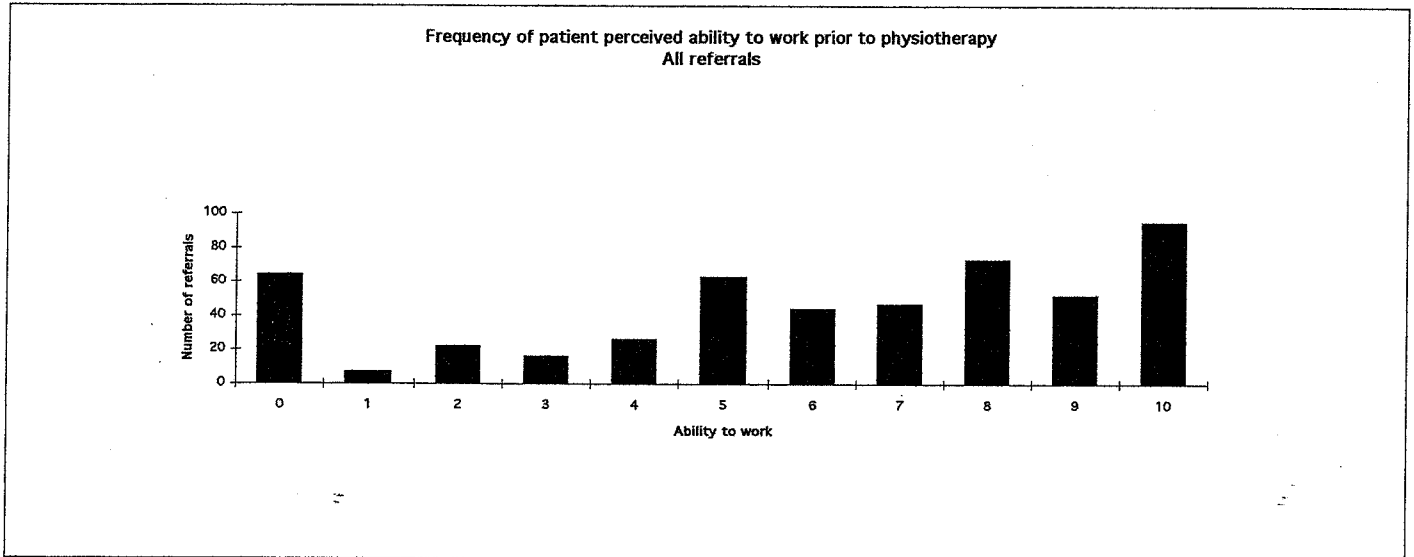


Table 42b Frequency of patient perceived ability to work prior to physiotherapy - Patients discharged normally

Ability to work	Number	Percent
0	39	10.9%
1	6	1.7%
2	11	3.1%
3	14	3.9%
4	16	4.5%
5	46	12.8%
6	31	8.7%
7	37	10.3%
8	54	15.1%
9	35	9.8%
10	69	19.3%
Total	358	100.0%

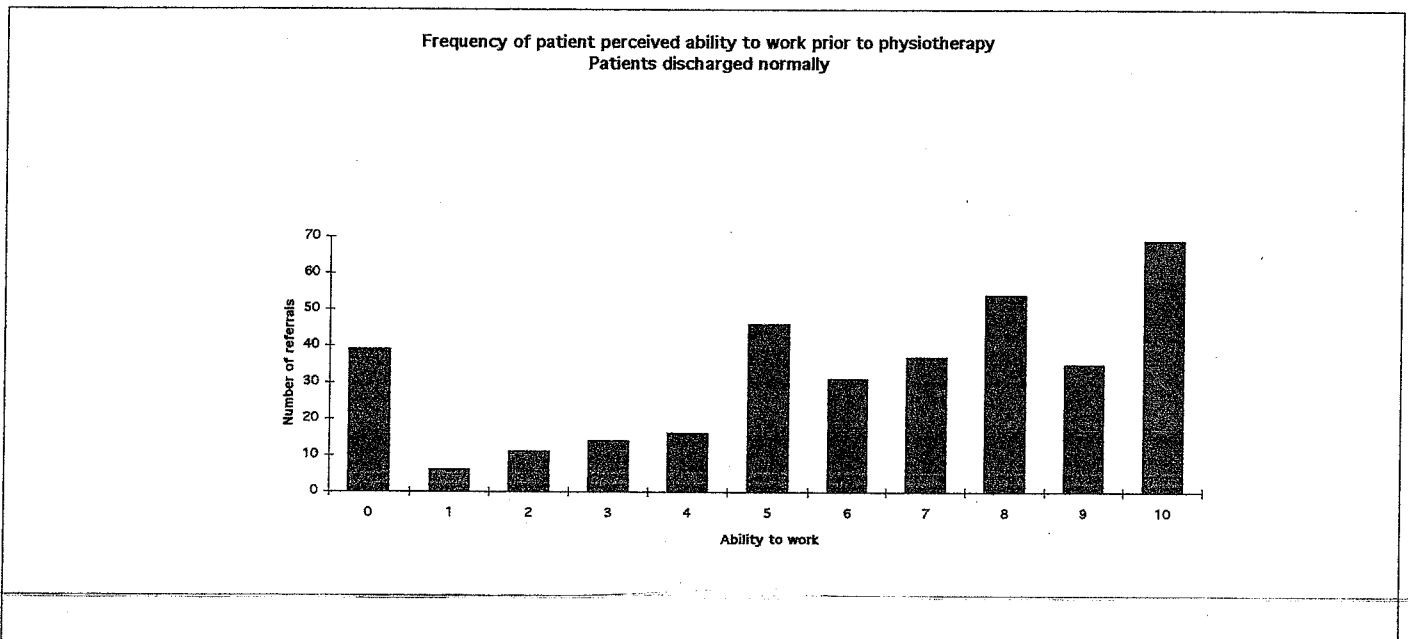


Table 43a Frequency of patient perceived ability to work after physiotherapy - All referrals

Ability to work	Number	Percent
0	23	5.0%
1	10	2.2%
2	16	3.5%
3	8	1.8%
4	7	1.5%
5	15	3.3%
6	9	2.0%
7	16	3.5%
8	43	9.4%
9	73	16.0%
10	236	51.8%
Total	456	100.0%

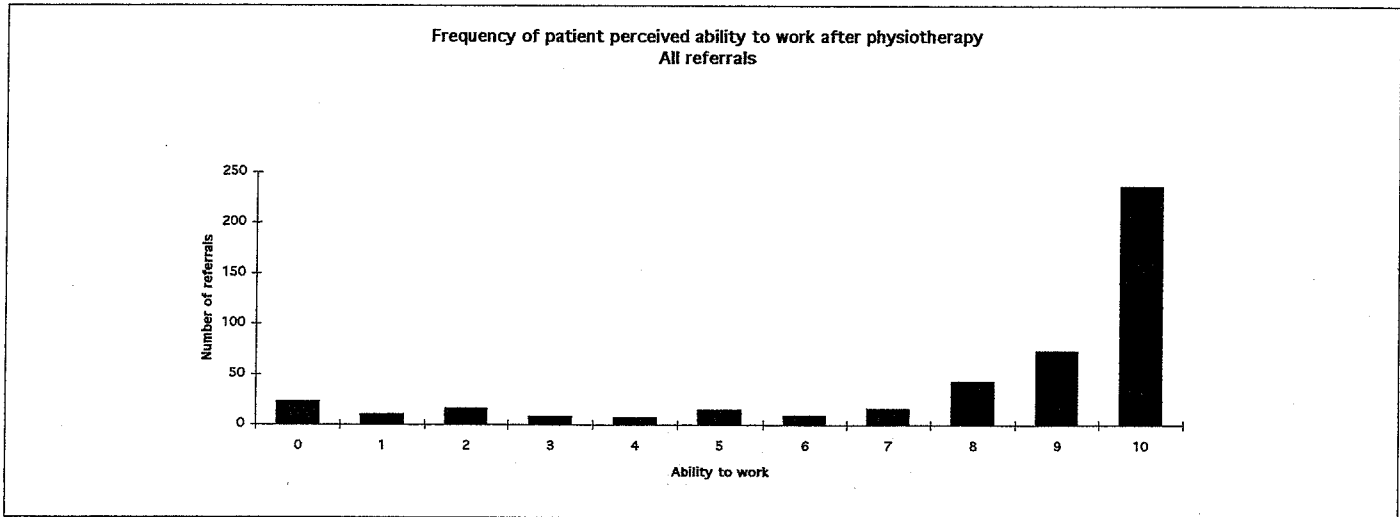


Table 43b Frequency of patient perceived ability to work after physiotherapy - Patients discharged normally

Ability to work	Number	Percent
0	14	3.9%
1	9	2.5%
2	9	2.5%
3	4	1.1%
4	1	0.3%
5	7	1.9%
6	5	1.4%
7	11	3.0%
8	31	8.6%
9	58	16.0%
10	213	58.8%
Total	362	100.0%

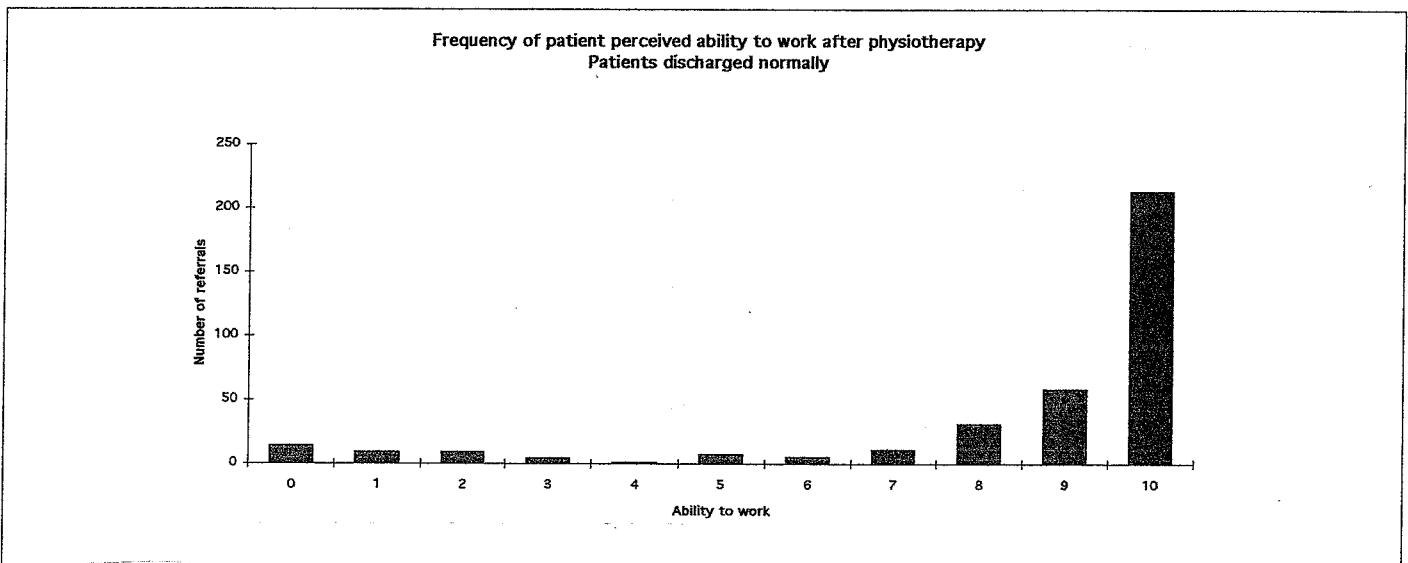


Table 44 Occupation of patients with missing data - All referrals

OCCUPATION	Number	Percent
Associate Professional	12	6.6%
Clerical/ Secretarial	6	3.3%
Craft & Related	11	6.0%
Houseperson> 2 years	31	16.9%
Manager/Administrator	6	3.3%
Other	7	3.8%
Plant/Machine Operator	4	2.2%
Professional	3	1.6%
Retired>2yrs	78	42.6%
Sales	5	2.7%
School Person	1	0.5%
Service	5	2.7%
Student HE/FE	3	1.6%
Unemployed >2 years	11	6.0%
Total	183	100.0%

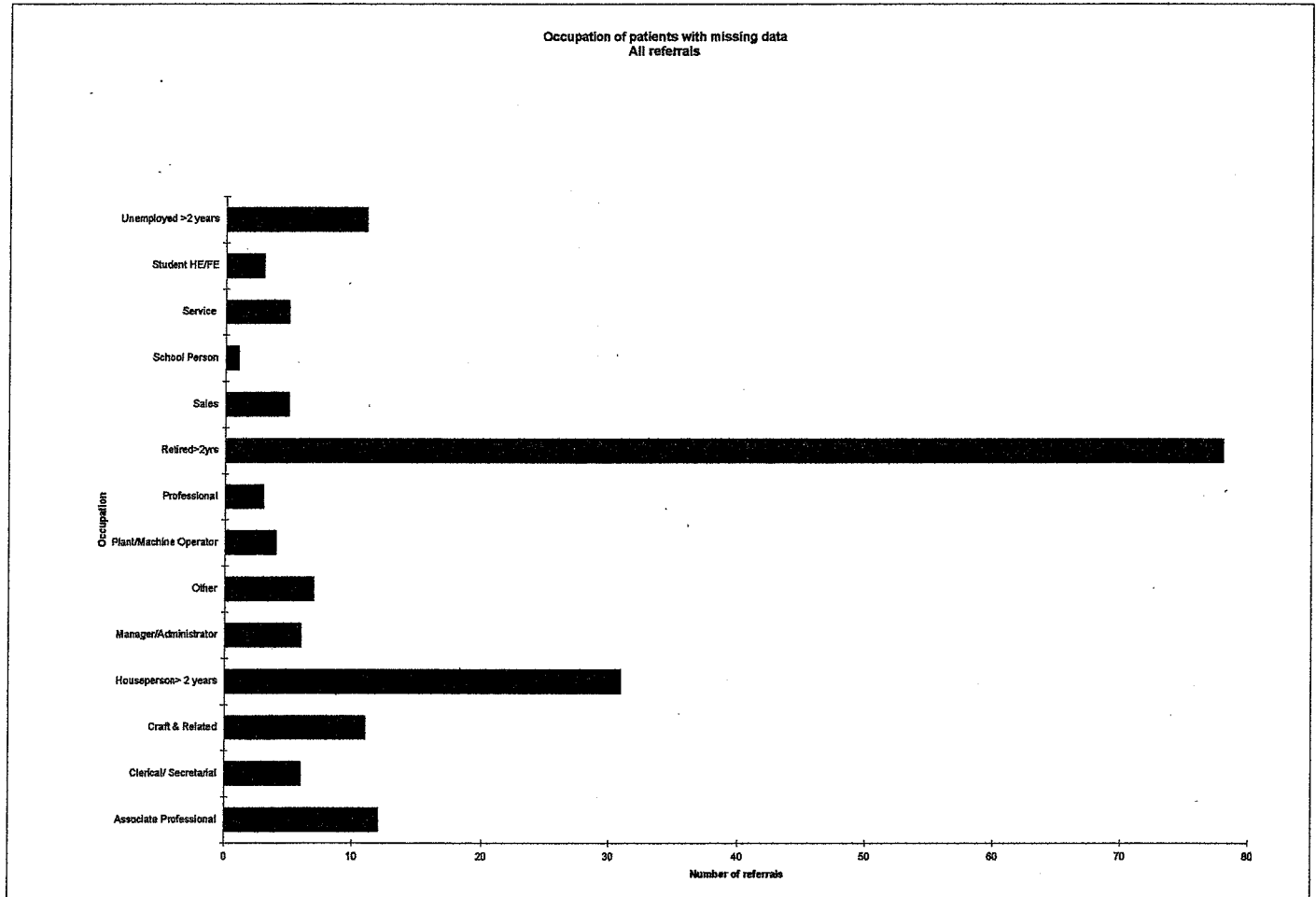


Table45a Improvement in quality of life. How many gave a negative response - All referrals

Negative	Number	Percent
Yes	29	5.2%
No	533	94.8%
Total	562	100.0%

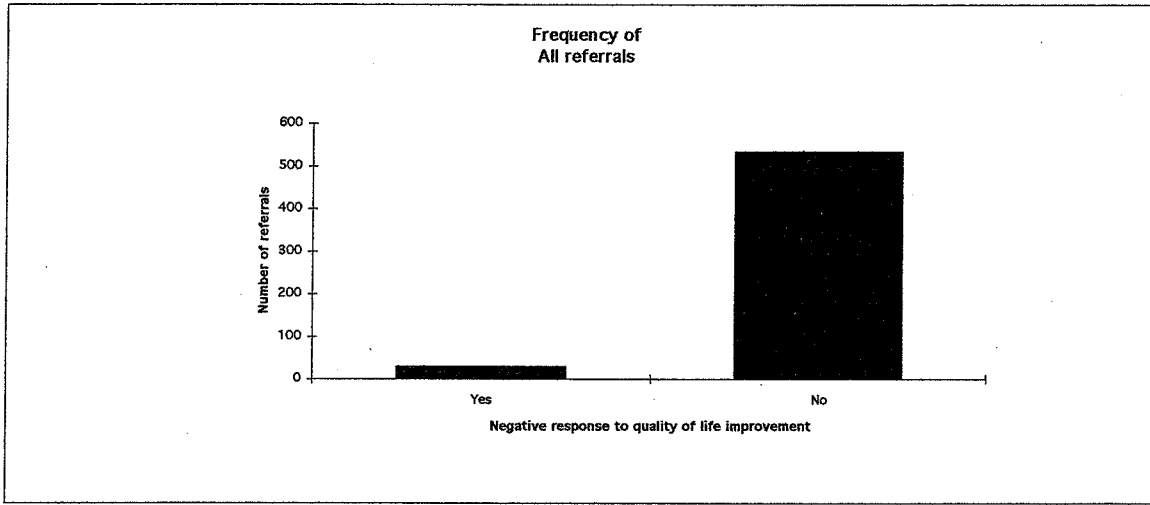


Table 45b Improvement in quality of life. How many gave a negative response - Patients discharged normally

Negative	Number	Percent
Yes	5	1.1%
No	440	98.9%
Total	445	100.0%

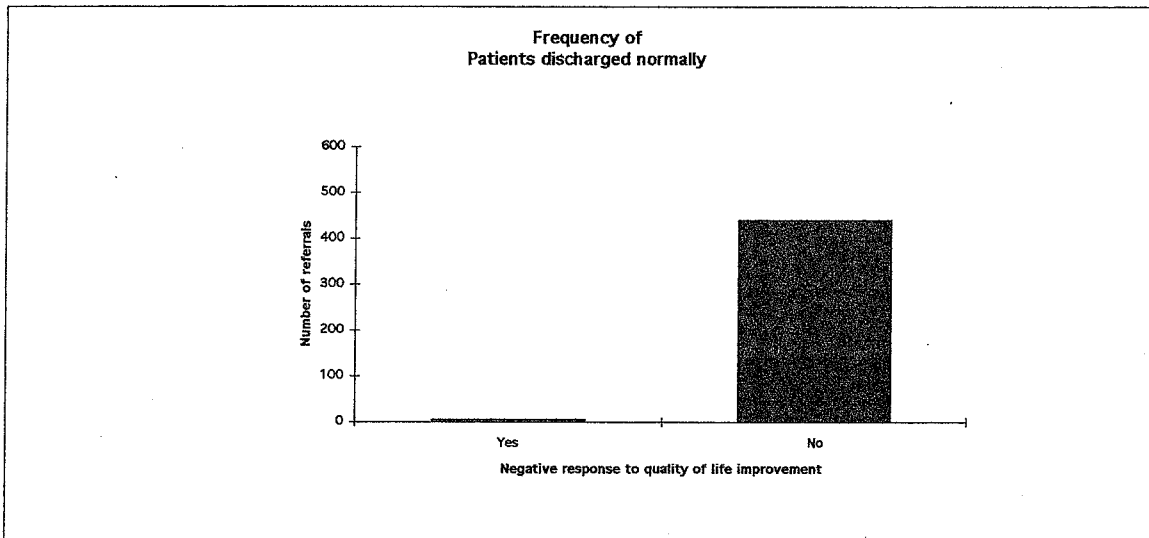


Table 46a Improvement (in 10% bands) for those who gave a positive response- All referrals

Quality	Number	Percent
0 to 9	12	2.3%
10 to 19	19	3.6%
20 to 29	23	4.4%
30 to 39	13	2.5%
40 to 49	10	1.9%
50 to 59	43	8.2%
60 to 69	41	7.8%
70 to 79	53	10.1%
80 to 89	93	17.7%
90 to 99	133	25.4%
100 to 109	84	16.0%
Total	524	100.0%

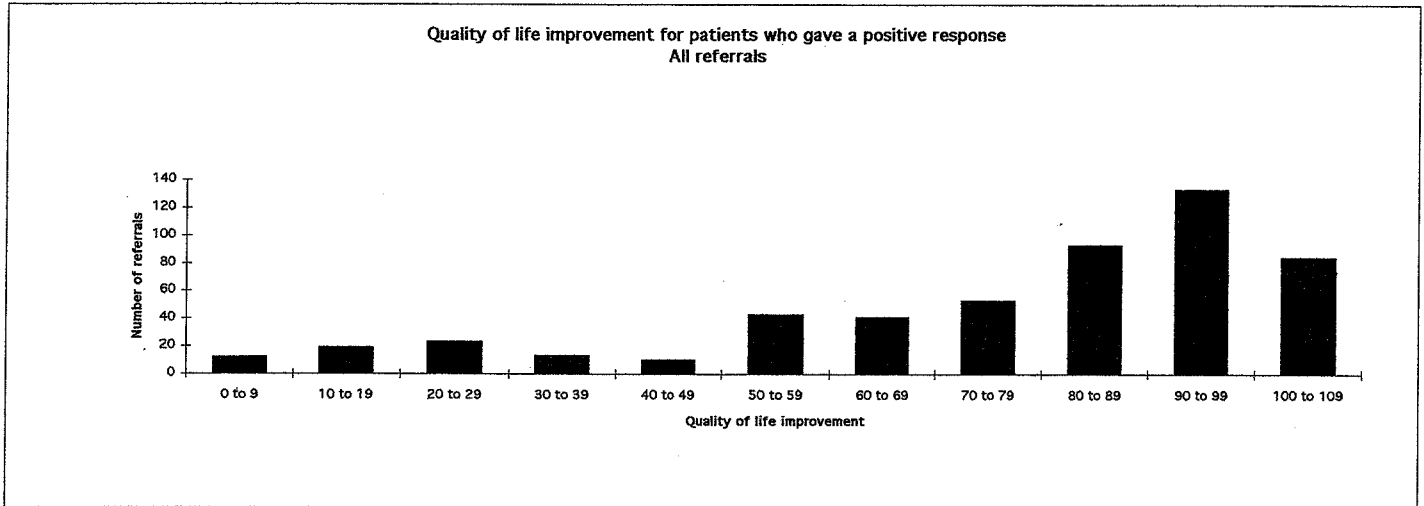


Table 46b Improvement (in 10% bands) for those who gave a positive response- Patients discharged normally

Quality	Number	Percent
0 to 9	4	0.9%
10 to 19	9	2.1%
20 to 29	14	3.2%
30 to 39	9	2.1%
40 to 49	7	1.6%
50 to 59	34	7.8%
60 to 69	28	6.4%
70 to 79	44	10.1%
80 to 89	87	19.9%
90 to 99	124	28.4%
100 to 109	77	17.6%
Total	437	100.0%

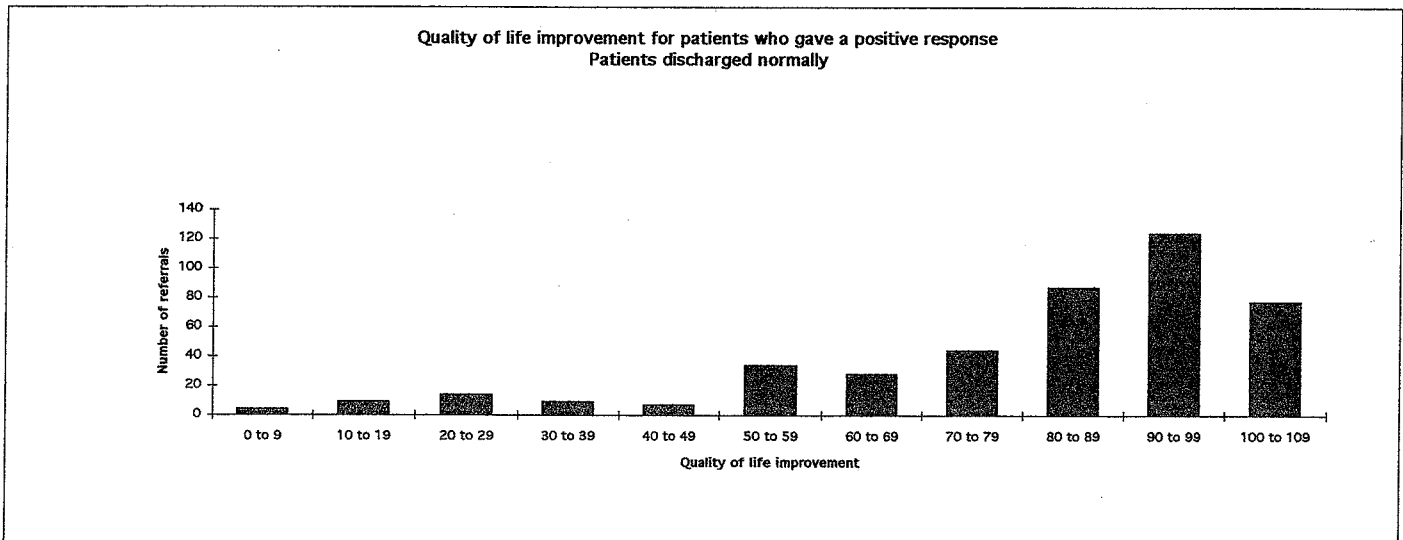


Table 47a Goal achievement -All referrals

Goal achievement	Number	Percent
1	58	10.0%
2	8	1.4%
3	4	0.7%
5	212	36.4%
6	69	11.9%
7	4	0.7%
8	1	0.2%
9	79	13.6%
10	28	4.8%
11	6	1.0%
13	35	6.0%
14	22	3.8%
15	6	1.0%
16	1	0.2%
17	27	4.6%
18	12	2.1%
19	1	0.2%
20	1	0.2%
21	6	1.0%
22	2	0.3%
Total	582	100.1%

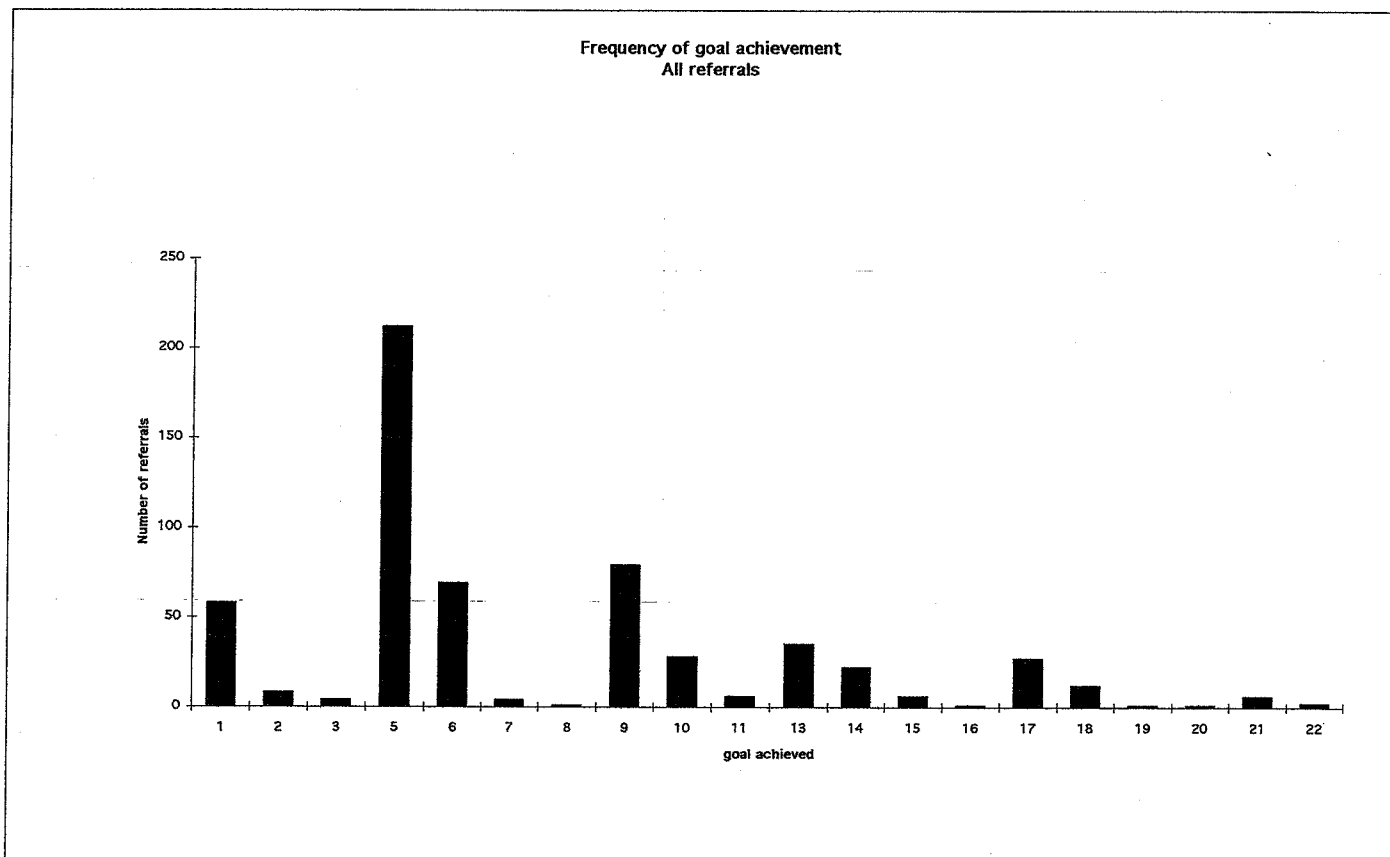


Table 47b Goal achievement - Patients discharged normally

Goal achievement	Number	Percent
1	53	11.6%
2	8	1.8%
3	2	0.4%
5	200	44.0%
6	63	13.8%
7	4	0.9%
8	1	0.2%
9	61	13.4%
10	25	5.5%
11	3	0.7%
13	16	3.5%
14	8	1.8%
15	2	0.4%
16	1	0.2%
17	2	0.4%
18	5	1.1%
20	1	0.2%
Total	455	100.0%

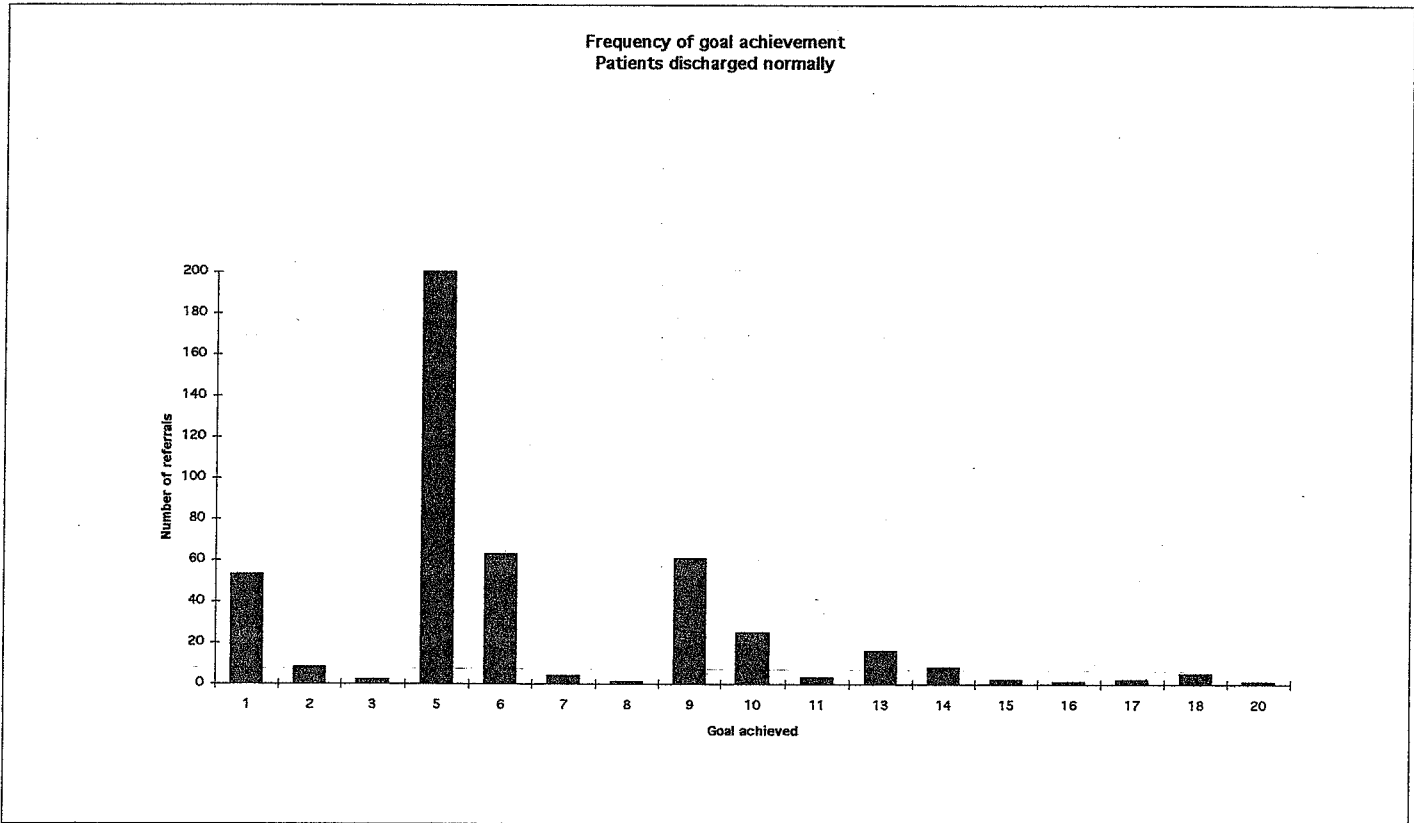


Table 47c Goal achievement by number of treatments

Goal Achievement	Treatments				Total
	1 to 6	7 to 12	13 to 18	19+	
1	52	1	0	0	53
2	0	8	0	0	8
3	0	0	2	0	2
5	197	2	0	0	199
6	3	59	0	0	62
7	0	1	3	0	4
8	0	0	0	1	1
9	58	3	0	0	61
10	2	23	0	0	25
11	0	0	3	0	3
13	16	0	0	0	16
14	1	7	0	0	8
15	1	0	1	0	2
16	0	1	0	0	1
17	2	0	0	0	2
18	0	5	0	0	5
20	1	0	0	0	1
Excluded 27.0	1	0	0	0	1
Excluded 65.0	3	0	0	0	3
Excluded 67.0	0	0	1	0	1
Total	337	110	10	1	458

NB Exclusion = wrongly entered data

Table 47d Length of wait from referral to commencement of physiotherapy by goal achievement

Wait in weeks	Goal Achievement															Total	
	1.0	2.0	3.0	5.0	6.0	7.0	8.0	9.0	10.0	11.0	13.0	14.0	15.0	17.0	18.0		20.0
0 to 2	22	1	1	88	32	3	0	24	8	2	4	3	2	0	2	0	192
3 to 5	9	4	0	52	12	1	1	12	5	0	5	1	0	1	1	1	105
6 to 8	13	2	1	23	7	0	0	15	2	0	5	0	0	0	1	0	69
9 to 11	5	0	0	18	4	0	0	2	3	0	1	3	0	0	0	0	36
12 to 14	2	0	0	9	2	0	0	4	1	0	0	1	0	0	1	0	20
15 to 17	0	0	0	3	2	0	0	0	2	0	0	0	0	0	0	0	7
18 to 20	0	1	0	2	1	0	0	1	0	0	0	0	0	1	0	0	6
21 to 23	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	3
24 to 26	0	0	0	1	0	0	0	0	2	0	1	0	0	0	0	0	4
39 to 41	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Total	51	8	2	197	62	4	1	58	24	2	16	8	2	2	5	1	443

Table 48 Frequency of referrals by specific diagnosis -Traumatic patients

Specific diagnosis	Number	Percent
ACUTE TORTICOLLIS	2	1.3%
BONY INJURY	3	2.0%
DISC LESION	1	0.7%
DISC LESION AND NEURO	1	0.7%
JOINT DYSFUNCTION PAIN	4	2.6%
JOINT INJURY	2	1.3%
MUSCLE DYSFUNCTION PAIN	6	3.9%
NERVE IMPINGEMENT	2	1.3%
NEURODYNAMIC PROBLEM	3	2.0%
OTHER TRAUMA	5	3.3%
SOFT TISSUE, JOINT & BONE	7	4.6%
SOFT TISSUE INJURY	8	5.2%
SPONDYLOSIS & ARTHROSIS	1	0.7%
SPONDYLOSIS	3	2.0%
WHIPLASH	105	68.6%
Total	153	100.0%

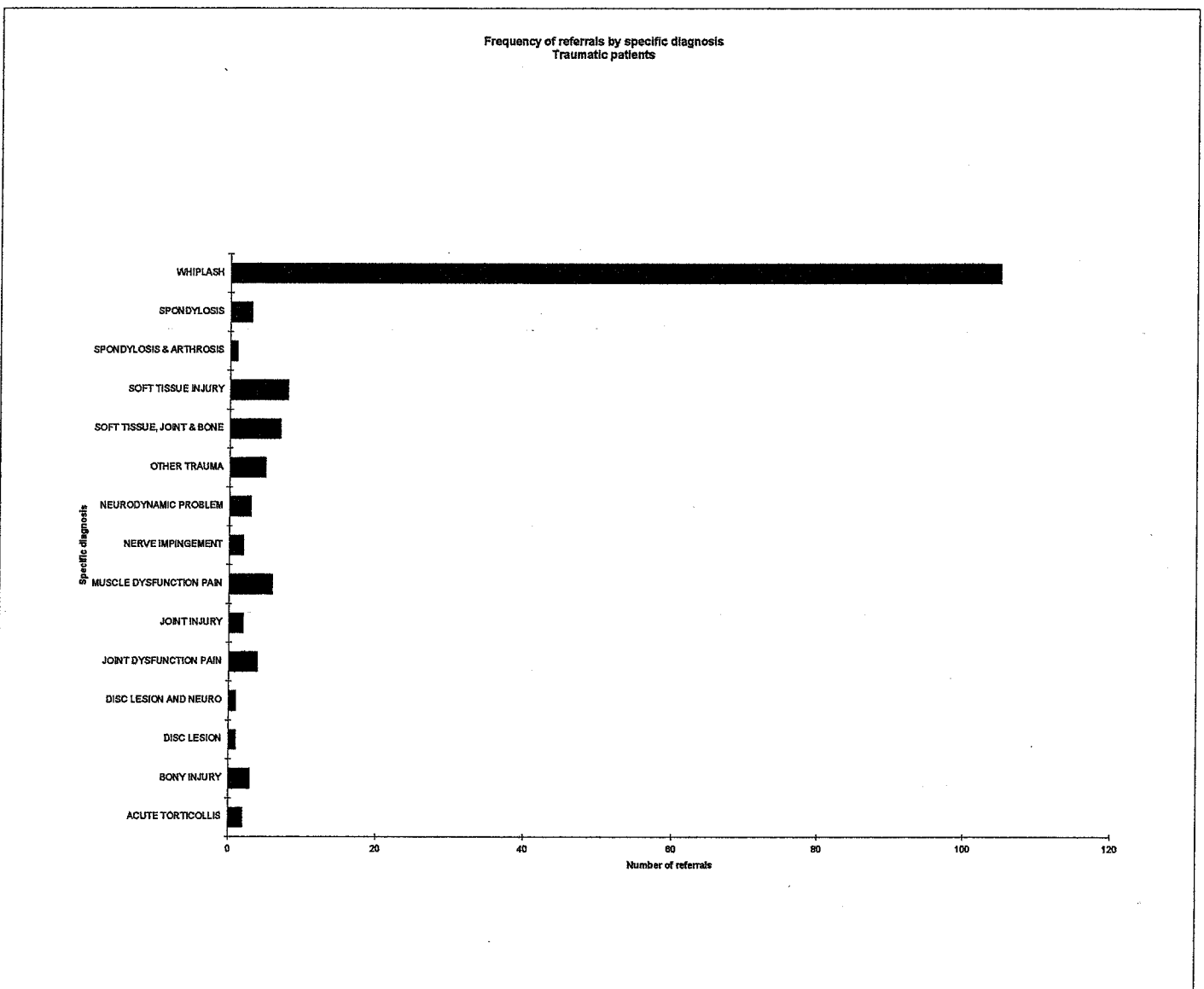
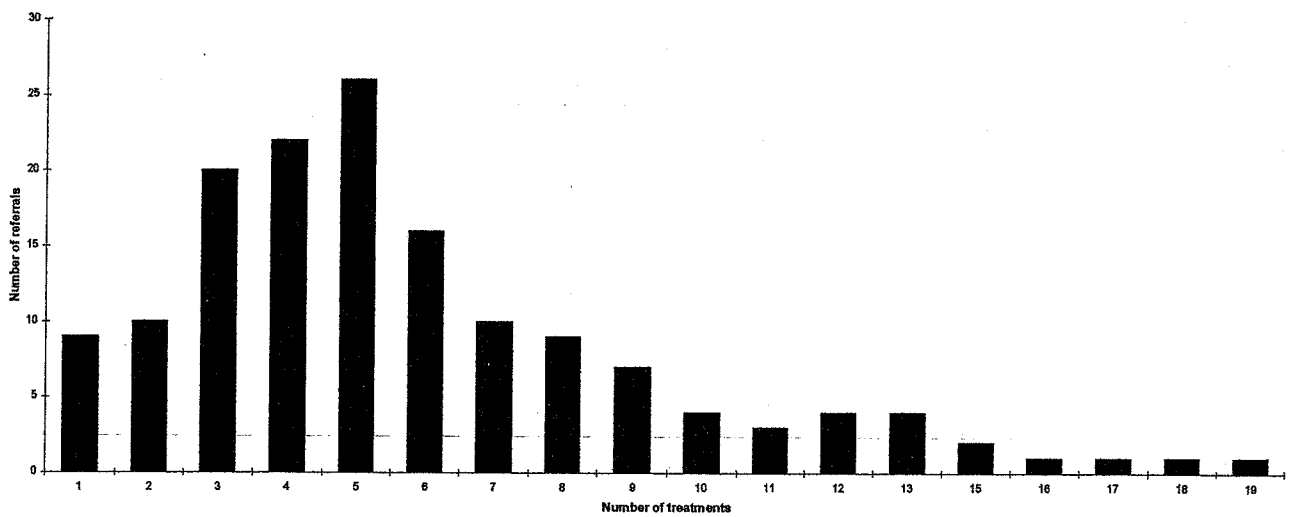


Table 49 Frequency of number of treatments - Traumatic patients

Number treat.	Number	Percent
1	9	6.0%
2	10	6.7%
3	20	13.1%
4	22	14.7%
5	26	17.3%
6	16	10.7%
7	10	6.7%
8	9	6.0%
9	7	4.7%
10	4	2.7%
11	3	2.0%
12	4	2.7%
13	4	2.7%
15	2	1.3%
16	1	0.7%
17	1	0.7%
18	1	0.7%
19	1	0.7%
Total	150	100.0%

Frequency of number of treatments
Traumatic patients



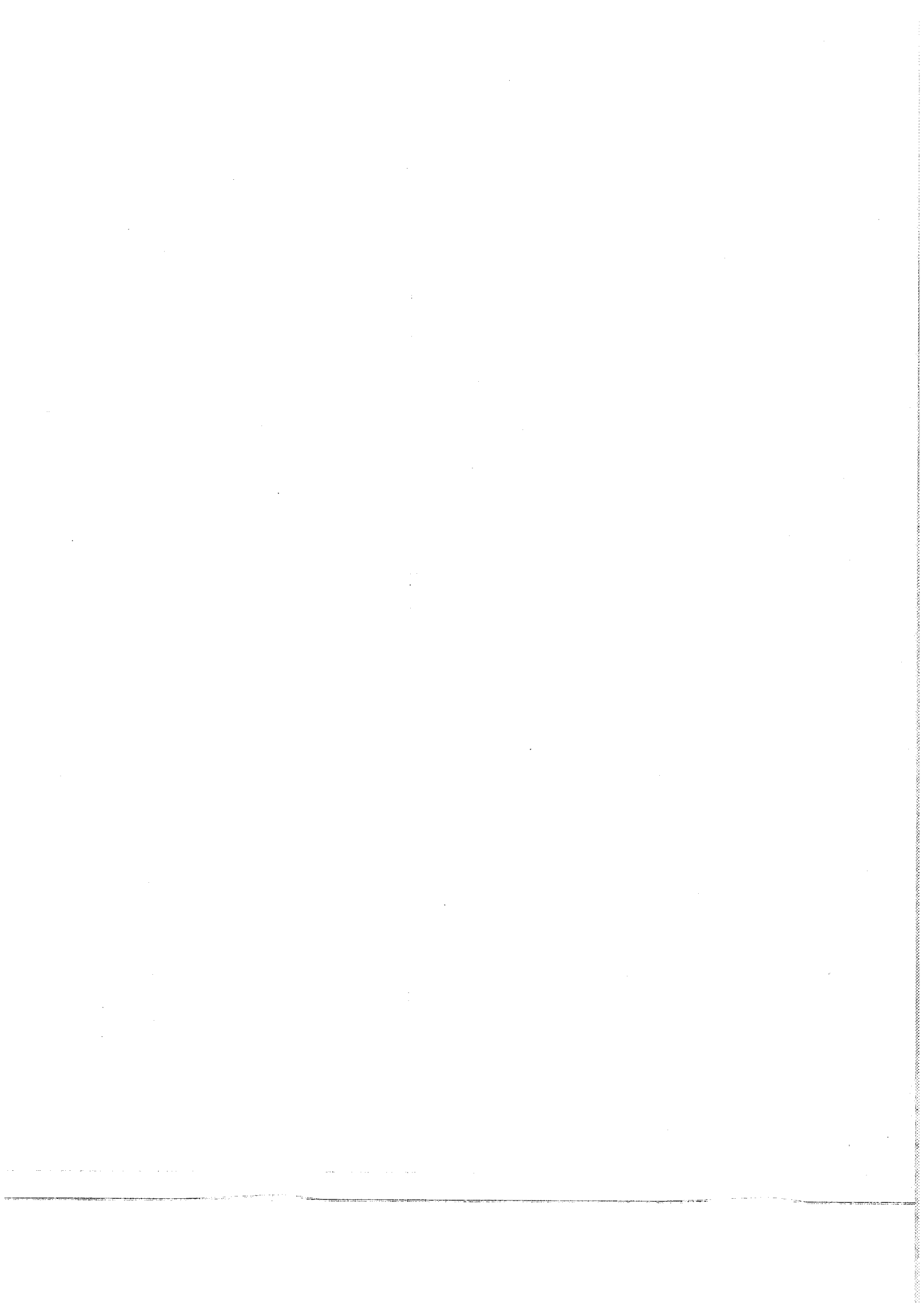


Table 50 Frequency of number of treatments - Patients with whiplash

Number treat.	Number	Percent
1	6	5.6%
2	6	5.6%
3	18	16.7%
4	15	13.9%
5	15	13.9%
6	14	13.0%
7	7	6.5%
8	7	6.5%
9	4	3.7%
10	3	2.8%
11	3	2.8%
12	4	3.7%
13	3	2.8%
16	1	0.9%
18	1	0.9%
19	1	0.9%
Total	108	100.0%

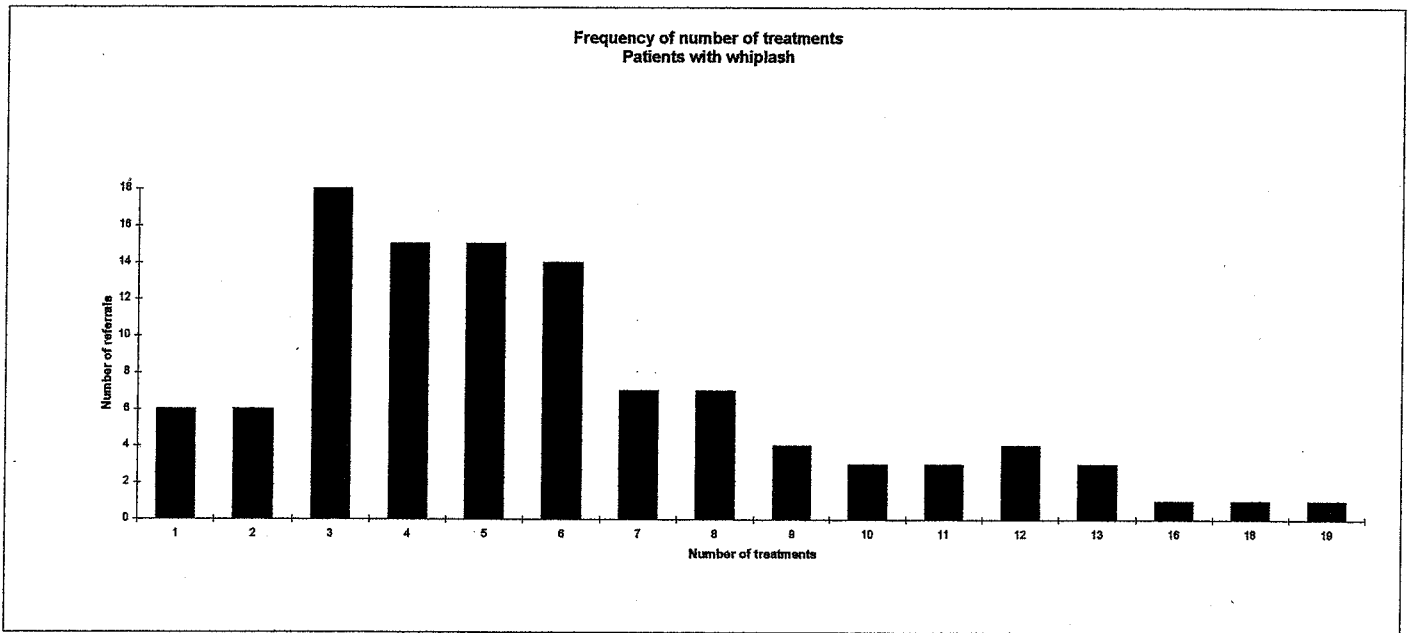


Table 51 Frequency of referrals by episode group - Patients with whiplash

Episode	Number	Percent
1ST EPISODE	83	78.3%
RECURRENT	23	21.7%
Total	106	100.0%

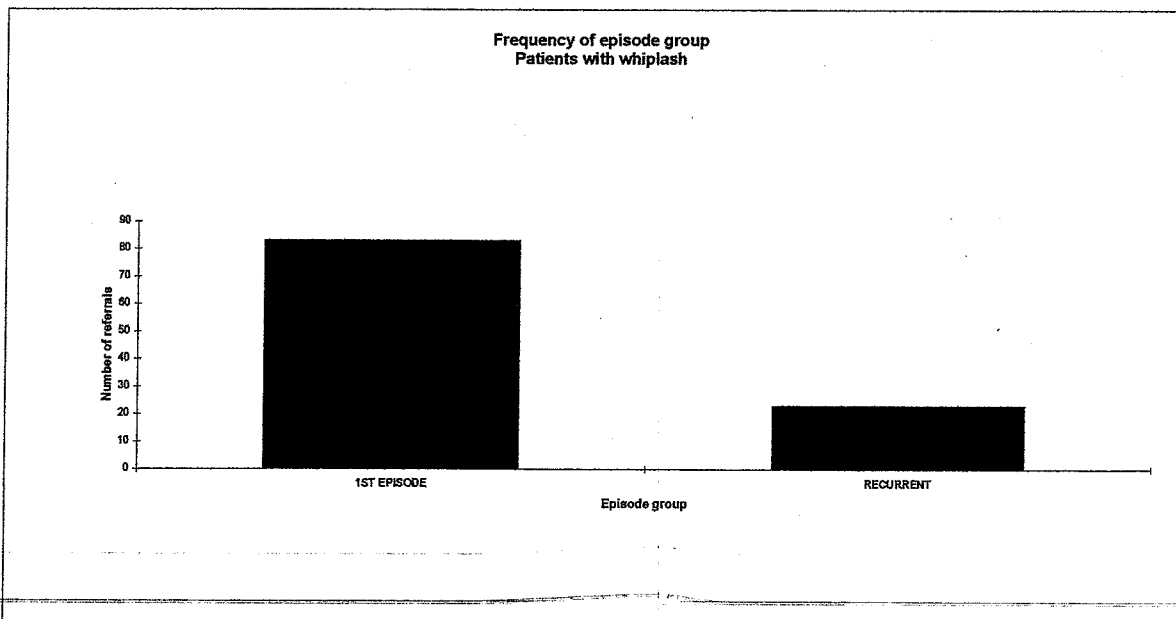


Table 52 Frequency of number of treatments v episode group - Patients with whiplash

Number treat.	1st episode	Recurrent	Total
1	2	2	4
2	5	1	6
3	14	3	17
4	13	2	15
5	12	2	14
6	10	4	14
7	4	3	7
8	6	1	7
9	2	2	4
10	3	0	3
11	1	2	3
12	4	0	4
13	3	0	3
16	1	0	1
18	1	0	1
19	1	0	1
Total	82	22	104

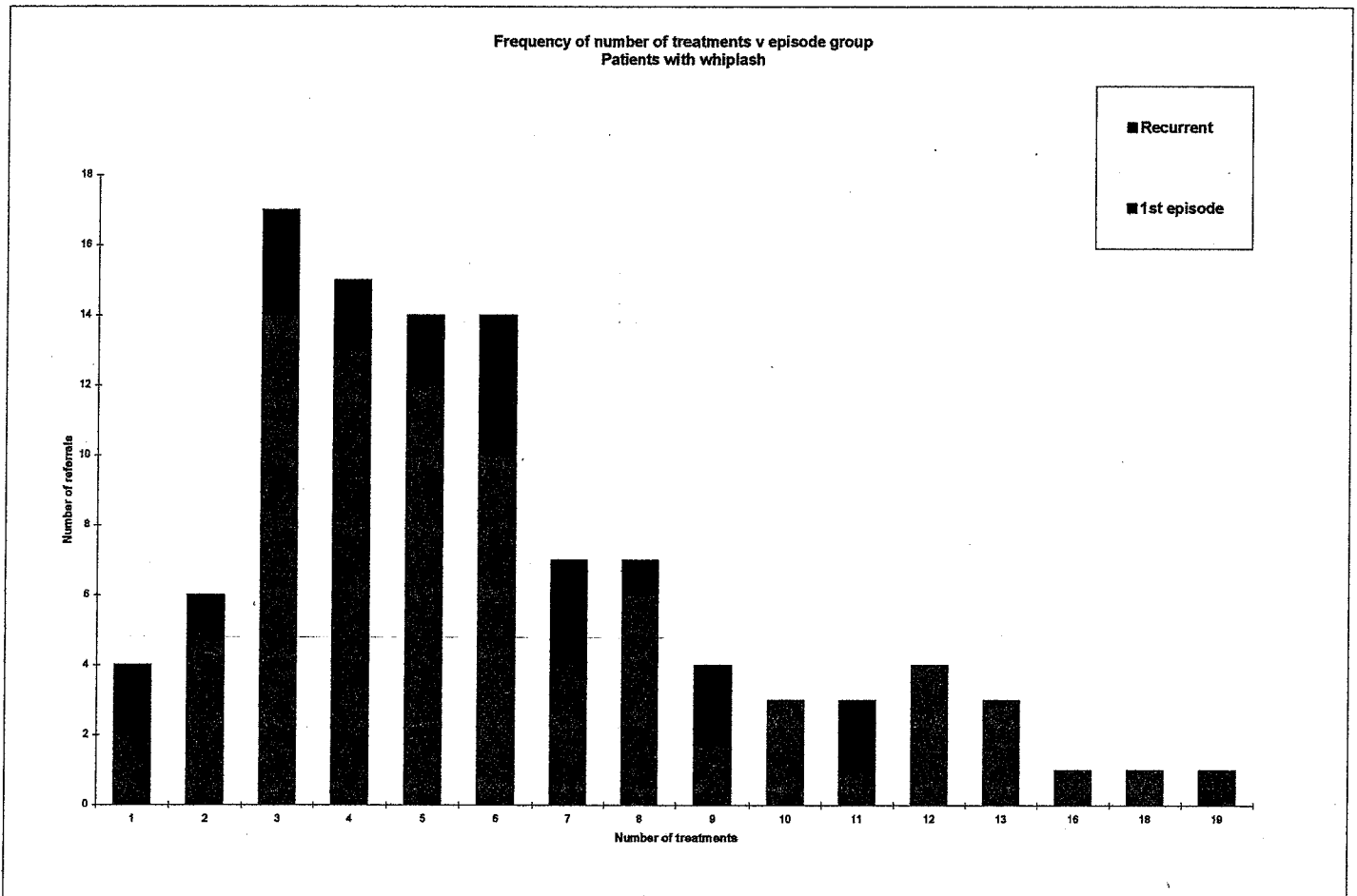


Table 53 Frequency of other factors influencing outcomes - Patients with whiplash

Other factors	Number	Percent
CASED TO ATTEND	14	14.0%
CHANGED GRADE PT	1	1.0%
EXACERBATION	1	1.0%
GENERAL STATE	17	17.0%
LIFESTYLE INFLUEN.	11	11.0%
NO OTHER FACTORS	46	46.0%
OTHER MED.COND.	3	3.0%
OTHER MED.INTERV.	3	3.0%
REFERRAL TO CON/GP	1	1.0%
TIME,PROG,NO TREAT.	3	3.0%
Total	100	100.0%

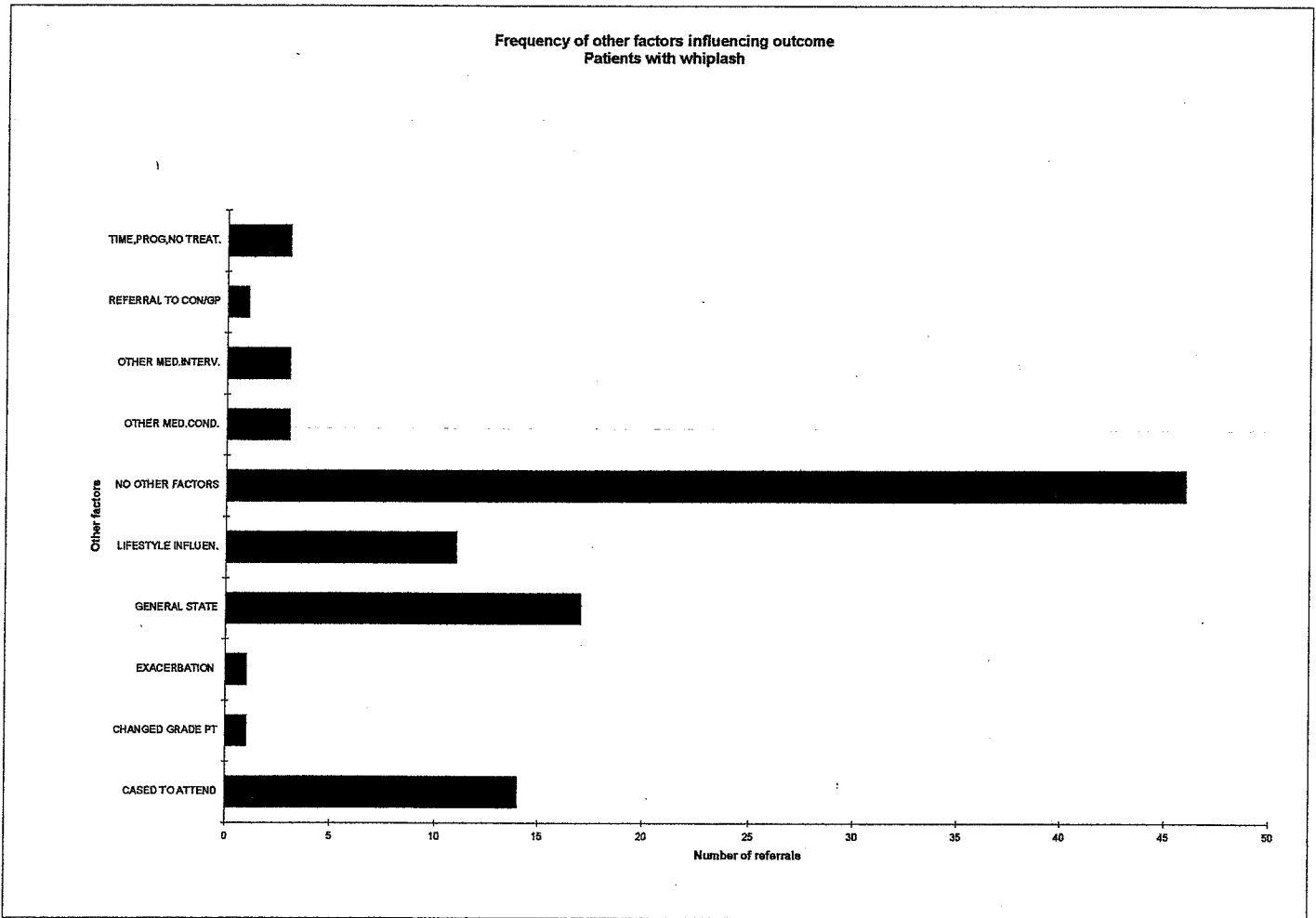


Table 54 Frequency of number of treatments - Patients with spondylosis

Number treat.	Number	Percent
1	4	3.3%
2	11	9.1%
3	13	10.7%
4	24	19.8%
5	24	19.8%
6	14	11.6%
7	18	14.9%
8	4	3.3%
9	5	4.1%
11	2	1.7%
15	1	0.8%
16	1	0.8%
Total	121	100.0%

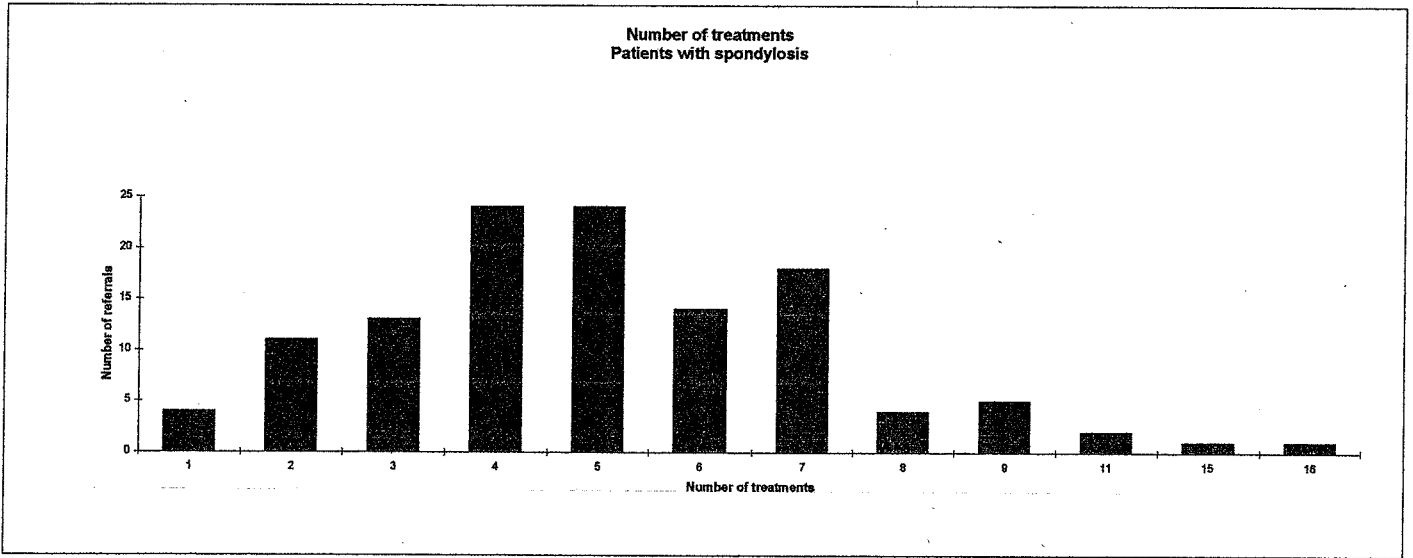
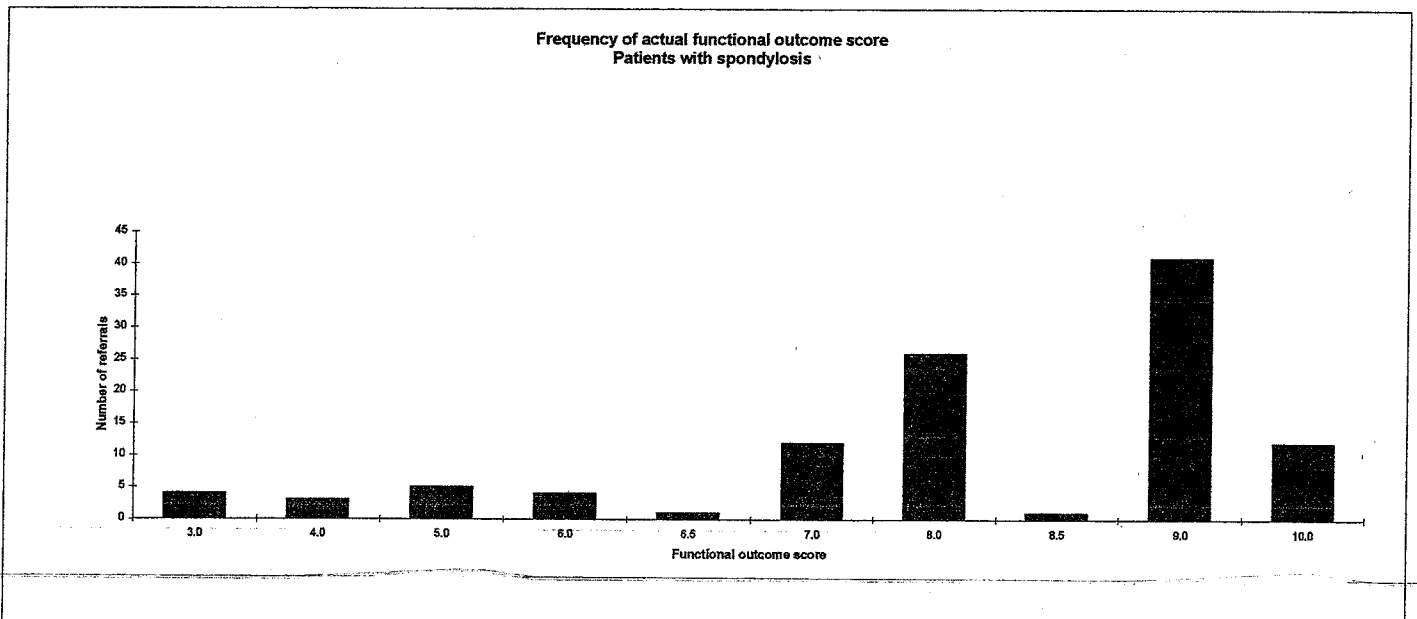


Table 55 Frequency of actual functional outcome - Patients with spondylosis

Actual funct.	Number	Percent
3.0	4	3.7%
4.0	3	2.8%
5.0	5	4.6%
6.0	4	3.7%
6.5	1	0.9%
7.0	12	11.0%
8.0	26	23.9%
8.5	1	0.9%
9.0	41	37.6%
10.0	12	11.0%
Total	109	100.0%



Physiotherapy OPD
Mid Kent Healthcare Trust
Discharge Summary Sheet

1. Unit Location of O.P.D. SURNAME _____

2. Occupation

3. Patient Identification No

4. Date of Birth 5. Age 6. Gender

7. Primary Diagnosis (I.T.C.D.)

8. Secondary Diagnosis (Physiotherapy)

9. Tertiary Diagnosis

10. Body Site 1. 2. 3. 4.

11. Laterality of Symptoms 12. Date of Referral

13. Date of Commencement

14. Length of Wait from 1st GP contact to Referral (in Weeks)

15. Length of Wait from Referral to Commencement of PT (in weeks)

16. Reason for Referral

17. Weighting of Psycho-social and Physical Factors

18. Initial Assessment of Functional Ability

19. Assessment of Expected Functional Outcome

20. Actual Functional Outcome Score

21. Date PT terminated

22. Outcome of Referral

23. Treatment Details

24. Total Effort Score

25. Goal Achievement at Discharge

26. Other Factors Influencing Outcome

27. Number of Treatments

28. Physiotherapist

29. Grade

30. Patient Perceived		
<u>Pain</u>	<u>Function</u>	<u>Ability to Work</u>
<input type="text"/>	<input type="text"/>	<input type="text"/>
At initial examination		
<input type="text"/>	<input type="text"/>	<input type="text"/>
At completion of treatment		

1. Unit location of O.P.D. Hospital Pat ID
2. Occupation 3. Study ID No 4. Date of Birth
5. Gender 6. Episode
7. Secondary diagnosis (Physiotherapy) _____
8. Body site 1. 2. 3. 4.
9. Laterality of symptoms 10. Date of referral
11. Date of commencement
12. Length of wait from 1st GP contact to referral (in weeks)
- 13 Length of wait from referral to commencement of PT (in weeks)
14. Weighting of Psycho-social and physical factors
15. Initial assessment of Functional Ability
16. Assessment of Expected Functional Outcome
17. Actual functional Outcome Score
18. Date PT terminated
19. Outcome of referral _____
20. Treatment details 21. Total Effort Score
22. Goal achievement at discharge
23. Other Factors influencing outcome
24. Number of treatments 25. Grade of Physiotherapist
26. Patient perceived
 Initial examination
 Pain Function Ability to work
 At completion of treatment
 Pain Function Ability to work
27. Referral source

CODINGS FOR DISCHARGE SUMMARY SHEETS

1. Unit/Location of O.P.D.

1	6
2	7
3	8
4	9
5	10

2. Occupation

1	= Professional
2	= Employer/Manager
3	= Intermediate & junior non manual
4	= Skilled Manual & own account non professional
5	= Semi skilled manual and personal service
6	= Unskilled manual
7	= Unemployed (more than 2 years)
8	= Retired (if more than 2 years)
9	= Housewife /husband if more than 2 years)
10	= School person
11	= Student

NB Use categories 1 - 6 if employment ceased for less than 2 years for reasons stated in 7 - 9.

3. Study ID No.

4. Date of Birth

5. Gender

1	= Female
2	= Male

6. Episode

1	= 1st episode
2	= recurrent

7. Secondary Diagnosis

10	= Respiratory
20	= Neurological
21	= UMN
22	= LMN
30	= Surgical
31	= Pre Op
32	= Post Op
40	= Medical
50	= Neuro Musculo Skeletal
51	= Traumatic

52	= Degenerative
53	= Inflammatory
54	= Pathological
55	= Postural
56	= R.S.I.
60	= Obstetrics & Gynaecology
61	= Stress Incontinence
62	= Unstable Bladder
70	= Dermatological
80	= Oedema
90	= Stress

8. Body Site Codes (use more than 1 code if appropriate)

Head	01	
Neck	02	
Neck + Referral	03	
Thoracic	04	
Thoracic + Referral	05	
Lumbar	06	
Lumbar + Referral	07	
Sacroiliac	08	
Shoulder	09	
Shoulder Girdle	10	
Upper Arm	11	
Elbow	12	
Forearm	13	
Wrist	14	
Hand	15	
Finger	16	
Thumb	17	
Hip	18	
Thigh	19	
Knee	20	
Lower Leg	21	
Ankle	22	
Foot	23	
Chest	24	
Abdomen	25	
Upper Limb	26	
Lower Limb	27	
Whole Body	28	
Multiple Regions	29	
Skin	30	
Nerve	31	
TMJ	32	
Face	33	
Pelvic Floor	34	
Bladder	35	
Ribs	36	
Coccyx	37	
Other	38	
Lumbar + Neuro signs	39	(ie dermatomal and/or myotomal and/or reflex loss)

9. Laterality of Symptoms

Unilateral	=	1
Bilateral	=	2

10. Date of referral

11. Date of commencement
12. Length of wait from 1st GP contact to referral (in weeks)
13. Length of wait from referral to commencement of PT (in weeks)
14. Weighting of Psycho-social and physical factors

	1	2	3	4	5	TOTAL
		Mild	Moderate	Quite Severe	Severe	
1. Problem	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Communication /Sensory	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. Mobility	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. Other Conditions	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Social Circumstances	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Categories 2 - 5 should all have a direct impact on ease or difficulty of Physiotherapy treatment

GRAND TOTAL

MAXIMUM POSSIBLE TOTAL SCORE = 25

MINIMUM POSSIBLE TOTAL SCORE = 0

Items 15, 16 and 17 on the Summary Sheet: Functional, Physical and Subjective Outcomes

Scores should be completed by the Therapist and also by the patient for the initial assessment of functional ability, the expected functional outcome and the actual functional outcome.

10 = Normal lifestyle, fully independent, able to work, no pain or disability, participate fully in sporting activities. Joint range equivalent to 90/100% of available active physiological movement. Normal healthy individual.

9.5

9 = Independent, able to work but some slight discomfort or dysfunction. Not able to carry out competitive sport but is able to attend and participate in training sessions. 80/90% of normal active physiological movement range is available.

8.5

8 = Independent to a large degree without walking aids. Able to return to non manual work but only to modified manual work. Very modified sports training is accomplished. Some aspects of ADL slightly restricted. Some

mild pain present for periods during the day. Joint range restricted to between 70% and 80% of normal available range.

7.5

7 = Mobile with minimum support and walking aid. e.g. walking stick. Able to return to non manual work part time but not to manual work. Some general marked functional limitation. 60% - 70% of normal active physiological range of movement is available in one or more limbs or region. Mild to moderate pain levels exist.

6.5

6 = Unable to work due to moderate pain levels and disability. Marked functional limitation in one limb or region. 50% - 60% of normal active physiological range of movement is available.

5.5

5 = Able to carry out most ADL but needs occasional help. Dependent upon aids for mobility but walks unsupervised. Unable to work. Moderate limitation of joint range with 40% - 50% of the normal active physiological range of movement available. Moderate pain levels with some postures and/or at rest.

4.5

4 = Independent for some ADL but needs some help either by one professional or by one lay person for one or more activities. Walks with an aid and standby supervision. Severe limitation of joint range between 30% to 40% of normal active range of movement is available. High levels of pain on movement.

3.5

3 = Performs minimal ADL with help. Needs moderate physical help with walking and transferring. i.e. uses a walking aid and one helper. Has severe pain at rest worse with movement. Active range of movement is limited to 20% to 30% of normal range of movement available.

2.5

2 = Dependent on help for most ADL due to mental or physical disabilities. e.g. following multiple injuries. Unable to walk or needs maximal help i.e. two helpers. Active range of physiological movement is limited to zero or has less than 20% of range available.

1.5

1 = Totally dependent, helpless, unable to perform any ADL, e.g. Unconscious.

18. Date PT terminated

19. Outcome of Referral

Inappropriate referral	01
Treatment not commenced (department informed)	02
Treatment not commenced (department not informed) (D.N.A.)	03
Treatment interrupted (F.T.A)	
Department not informed	04
Treatment interrupted (U.T.A.)	
Department informed (Includes self discharges)	05
Transferred within district	06
Transferred outside district	07

Assessment completed no Physiotherapy required	08	
Assessment completed. Advice re self care given		
Review arranged	09	
Treatment completed. Regular discharge	10	
Died	11	
Referred back to GP/Consultant	12	
Patient non compliant	13	
Physiotherapy not effective	14	
Other		
	15	
20. Treatment Details		
Advice re self management or advice to carer	01	
Interferential	02	
S.W.D.	03	
TENs	04	
Ultrasound	05	
Local heat (I.R. packs pad)	06	
Active exercises	07	
Passive exercises	08	
Traction	09	
Mobilisations/manipulation	10	
Reflexology	11	
Aromatherapy	12	
Ice	13	
Hydrotherapy	14	
Wax	15	
Faradism	16	
Massage	17	
Frictions	18	
C.T. Massage	19	
Strapping	20	
Education	21	
Appliance fitting	22	
Ultra violet	23	
Laser	24	
P.N.F.	25	
Electro diagnosis	26	
Facilitatory/re-education techniques	27	
Gait re-education	28	
Re-Education of Muscle Imbalance	29	
Neuro dynamic facilitation	30	
Active exercises and advice	31	
Mobilisations and active exercises	32	
Frictions and Ultrasound and S.W.D.	33	
Mobilisations, active exercises and advice	34	
Mobilisations, traction and active exercises	35	
Mobilisations and advice	36	
Mobilisations, passive exercises and S.W.D.	37	
Mobilisations, Ultrasound, S.W.D. and advice	38	
S.W.D., active exercises, passive exercises and mobilisations	39	
Active and passive exercises and advice	40	
Mobilisations, S.W.D. and education	41	47
Re-education of muscle, active exercises, mobilisations and advice	42	48
Active exercises, education and advice	43	49
Mobilisations, advice and Ultrasound	44	Back rehab class
S.W.D., active exercises and advice	45	
Acupuncture	46	

21. Total Effort Score (O.P.D. only)

<u>Activity</u>	<u>Approx Time Taken</u>	<u>Score</u>
Patient Interview no treatment, short letter	5 mins	1
US/IR/SWD/Laser Traction/TNS/Trophic Stimulation/Mobilisations/ Exercises/Thoraktin/Normal Administration /Wax	10 mins	2
Acupuncture/IF/Mobilisations Traction	15 mins	3
Mobilisations/UVR Education/Advice	15 mins	4
Mobilisations/simple peripheral joint examination & assessment	20 mins	5
Moderately complex peripheral joint examination & assessment	20 mins	6
Complex peripheral joint examination & assessment	30 mins	7
Simple neck/back/shoulder examination & assessment. Basic neurological treatment e.g. Brachial Plexus, lesion, facial palsy	30 mins	8
Moderately complex back/neck.shoulder examination & assessment Complex Brachial plexus lesion	45 mins	9
Complex back.neck/Shoulder/neurological examination	60 mins	10

1 extra point for each extra member of staff involved in the treatment

1 extra point for each extra modality e.g. simple mobilisations
+ U.S + exercises = 4

Classes

60 min class 12) then divide by the number of patients
90 min class 18)

If more than one Physiotherapist involved then double class score i.e. 2 Physiotherapists doing 1 hour class with 12 patients each patient scores 2.

Effort is a mixture of:-

Knowledge application	Skill application
Vigour	Time expended
Self motivation	Physical and mental exertion
Strength	Concentration
Conviction	Motivation of others

Effort is graded 1 - 10 and is recorded at the end of each contact with the service as the clinical records are updated. Total effort score for whole treatment period is recorded on discharge sheet.

22. Goal Achievement at Discharge (in terms of patient and therapist goal achievement)

Note: goals should include pain, range of movement, function, patient's interpretation of subjective perceived improvement and the ability to work.

a. -	Goals exceeded	[	1 - 5	Treatments	1
			6 - 10	Treatments	2
			11 - 15	Treatments	3
			16 +	Treatments	4

When the goal/outcomes expected at the initial assessment have been surpassed by the actual achievements attained by the patient, i.e. symptom free, increased range of movement compared to other limb before incident, function better than before. Able to work fully.

b. -	Goals fully achieved	[	1 - 5	Treatments	5
			6 - 10	Treatments	6
			11 - 15	Treatments	7
			16 +	Treatments	8

All goals/outcomes achieved to 100%. i.e. symptom free, full range of movement, no pain, function as before incident. 100% perceived improvement. If during assessment it is clear that advice only is needed or that the aim of intervention was to assess mobility and this is achieved then the goal is fully achieved. A non physiotherapy goal may be set e.g. to involve other agencies, if this is done then the goals are fully achieved. Also, if goal was to achieve 80% recovery at discharge, for the patient to achieve 100% recovery with appropriate home management strategy, then goals have been fully achieved.

c. -	Goals significantly achieved	[	1 - 5	Treatments	9
			6 - 10	Treatments	10
			11 - 15	Treatments	11
			16 +	Treatments	12

When 50% or more of the agreed goals are achieved or the patient is half way to the expected outcome, i.e. there may be a 50% improvement in subjective and objective findings, one or more problems still present but are resolving slowly but majority of problems have already been resolved. Patient able to work in a restricted or modified way.

d. -	Goals partially achieved	[	1 - 5	Treatments	13
			6 - 10	Treatments	14
			11 - 15	Treatments	15
			16 +	Treatments	16

Less than 50% of the goals set are achieved, there is minimal improvement of subjective and/or objective findings based on the initial assessment, some problems still outstanding, some initial improvement which has failed to continue. Patient unable to work but will manage some domestic tasks and contemplate return to work in a highly modified way.

e. -	Goals not achieved	[	1 - 5	Treatments	17
			6 - 10	Treatments	18
			11 - 15	Treatments	19
			16 +	Treatments	20

No change in the objective or subjective finding, inappropriate goals set and were not a measure of true potential, or when goals were not met due to influences outside the therapists control the reasons for this should be linked with the other factors and stated in the patient's notes. In all circumstances the signs and symptoms for this group of patients functions will have remained static. Patient unable to contemplate work.

f. -	Other i.e. worse poor referral additional problems etc	[	1 - 5	Treatments	21
			6 - 10	Treatments	22
			11 - 15	Treatments	23
			16 +	Treatments	24

Any eventualities not covered in the above sections use 'other factors' as a linkage and state what other factors were involved in the patient's notes. In this circumstance there may have been increase in local pain, decreased range of movement, increased local swelling, the development of referred pain and/or decreased function. Reduced and/or inability to work. In the assessment of goals between the therapist and the patient a linear visual analogue could be used using the 10 cm line, 0 - 10 for pain, range of movement, function, subjective improvement and the ability to work.

23. Other Factors Influencing Outcome in terms of rate/nature of recovery

1. Pain free at first visit.
2. Inappropriate referral.
3. Re-referred to consultant or GP
4. Other medical intervention, e.g. drugs, injection, osteopath, chiropractor, homeopath, collar, corset, surgery, etc.
5. General state, e.g. compensation case, stress levels, level of intelligence, attitude of patient, motivation, social circumstances, understanding of condition, smoking, drinking, etc.
6. Lifestyle influences, e.g. job, home circumstances, age, sport, etc.
7. Other medical conditions, e.g., cardiac.
8. Time, natural progression of condition, lack of treatment, e.g. patient moves from the area or is unwilling to attend for treatment.
9. Ceased to attend.
10. Requires educational advice only.
11. Teamwork.
12. Transfer to another hospital.
13. RIP.
14. No other factors.
15. Exacerbation of condition

24. Number of Treatments

25. Physiotherapist Grade

1. = Junior
2. = Senior 2
3. = Senior 1
4. = Superintendent IV
5. = Superintendent III
6. = Superintendent II
7. = Superintendent I
8. = Student

26. Patient Perceived Pain, Function and Ability to Work

Instructions to therapists on the completion of patient perceived pain levels, functional ability and ability to work.

The patient is asked to indicate their level of pain, functional ability and ability to work before treatment commences and when treatment is terminated. In order for this outcome measure to be reliable it is important that all patients are asked for information in the same way. The following statement should be made by all therapists in respect of each patient that they assess:-

"In order to monitor the effectiveness of your treatment, it is important that we find out about your levels of pain, your functional ability and your ability to work at the present time. Please choose a number on the scale of 0 to 10 which indicates:-

1. *Your present level of pain when it is at its worst where 0 = the least amount of pain you could envisage and 10 = the worst pain that you could imagine.*
2. *Ability to work where 0 = complete absence of ability to work and 10 = working normally.*
3. *Functional ability where 0 = total absence of ability to carry out functional tasks at home and in the social setting and 10 = maximum or normal ability to carry out functional tasks."*

The questions are asked again on completion of physiotherapy treatment.

27. Referral Source

- 1 = General Practitioner
- 2 = Consultant
- 3 = Orthopaedic Practitioner
- 4 = Other

**Audit of the Outcome of Physiotherapy Intervention for Outpatients
with cervical spine pain and dysfunction**

1. Unit location of O.P.D. Hospital Pat ID

2. Occupation 3. Study ID No 4. Date of Birth

5. Gender 6. Episode 7. Acute/Chronic

8. General Diagnosis / Aetiology 9. Specific Diagnosis

10. Physiotherapy diagnosis statement _____
(Please attempt to complete)

11. Body site 1. 2. 3. 4. 12. Origin of symptoms

13. Level 14. Laterality of symptoms 15. Date of referral

16. Date of commencement

17. Length of wait from 1st GP contact to referral this episode (in weeks)

18 Length of wait from referral to commencement of PT (in weeks)

19. Weighting of Psycho-social and physical factors a. The problem

b. Communication c. Mobility d. Social e. Other conditions

20. Initial assessment of Functional Ability

21. Assessment of Expected Functional Outcome 22. Actual functional Outcome Score

23. Date PT terminated 24. Outcome of referral

25. Treatment details 26. Total Effort Score

27. Goal achievement at discharge 28. Other Factors influencing outcome

29. Number of treatments 30. Grade of Physiotherapist(s)

31. How many therapists involved in treatment to date

32. Patient perceived

At Initial examination Pain Function Ability to work

At completion of treatment Pain Function Ability to work

33. Referral source 34 Improvement in quality of life

CODINGS FOR DISCHARGE SUMMARY SHEETS

1. Unit/Location of O.P.D.

1	6
2	7
3	8
4	9
5	10

2. Occupation

1	=	Managers and Administrators (inc. officers in UK armed forces, senior police officers, senior prison officers, senior fire service officers)
2	=	Professional Occupations (inc. Judges, teachers, psychologists, librarians)
3	=	Associate Professional and Technical Occupations (inc. nurses, authors, physiotherapists, computer programmers, professional athletes, actors)
4	=	Clerical and Secretarial Occupations
5	=	Craft and Related Occupations (inc. builders, butchers, mechanics)
6	=	Personal and Protective Service Occupations (inc. armed forces, police, fire and prison officers, waiters, hairdressers, assistant nurses, dental nurses)
7	=	Sales Occupations (inc. floral arrangers, buyers)
8	=	Plant and Machine Operatives (inc. bus conductors, taxi drivers)
9	=	Unemployed (more than 2 years)
10	=	Retired (more than 2 years)
11	=	Housewife/husband (if more than 2 years)
12	=	School person, Junior/Secondary school
13	=	Student HE/FE other
14	=	Other Occupations (inc. farm workers, postal workers, window cleaners)

11. NB Use categories 1-8 or 14 if employment ceased for less than 2 years for reasons stated in 9-

3. Study ID No.

4. Date of Birth

5. Gender

1	=	Female
2	=	Male

6. Episode

1	=	1st episode
2	=	recurrent

7. Acute or chronic

1	=	Acute less than 6 weeks duration
2	=	Chronic more than 6 weeks duration

8. General Diagnosis/aetiology

01	=	Traumatic
02	=	Degenerative
03	=	Inflammatory
04	=	Congenital
05	=	Pathological
06	=	Postural
07	=	Spontaneous onset
08	=	Psychogenic (Malingering, compensationitis, hysteria)

9. **Specific Diagnosis**

01	=	Whiplash
02	=	Direct soft tissue injury
03	=	Direct joint injury
04	=	Direct bony injury eg fracture
05	=	Direct injury to nerve
06	=	Direct soft tissue, joint and bony injury
07	=	Other trauma
08	=	Spondylosis
09	=	Arthrosis
10	=	Spondylosis and arthrosis
11	=	Rheumatoid arthritis
12	=	Cervical rib
13	=	Spondylolisthesis
14	=	Congenital torticollis
15	=	Osteoporosis
16	=	Osteomyelitis
17	=	Osteochondritis
18	=	Acute torticollis
19	=	Lordosis
20	=	Kyphosis
21	=	Scoliosis
22	=	Kypholordosis
23	=	Muscular dysfunction/pain
24	=	Nerve impingement
25	=	Joint dysfunction/pain
26	=	Disc lesion
27	=	Disc lesion with neural impingement
28	=	Instability
29	=	Neurodynamic problems

10. You have 62 characters in order to record your individual physiotherapy diagnosis. Please complete if possible. eg. facet joint impingement

11. **Body Site Codes** (use more than 1 code if appropriate)

Occipital	01
Temporal	02
Parietal	03
Maxillary	04
Mandibular	05
Occipito Frontal	06
Cervical spine	07
Cervical spine + referral to shoulder	08
Cervical spine + referral to elbow	09
Cervical spine + referral to wrist	10
Cervical spine + referral to hand	11
Cervical spine + referral to head and/or face	12
Upper thoracic	13
Upper thoracic + referral to upper limb(s)	14
Upper thoracic + referral to mid and lower thorax	15
Lumbar spine	16
Lumbar spine + referral to buttock	17
Lumbar spine + referral to mid thigh	18
Lumbar spine + referral to knee	19
Lumbar spine + referral to mid calf	20
Lumbar spine + referral to heel	21
Lumbar spine + referral to foot and toes	22

12. **Origin of referred symptoms**

1	=	Neural origin - Nerve root/peripheral in origin
2	=	Neural origin - Spinal cord/cauda Equina
3	=	Other origin

13. Symptomatic Level (State up to 3 or state 27 = Multiple)

1	=	C0 - C1
2	=	C1 - C2
3	=	C2 - C3
4	=	C3 - C4
5	=	C4 - C5
6	=	C5 - C6
7	=	C6 - C7
8	=	C7 - T1
9	=	T1 - T2
10	=	T2 - T3
11	=	T3 - T4
12	=	T4 - T5
13	=	T5 - T6
14	=	T6 - T7
15	=	T7 - T8
16	=	T8 - T9
17	=	T9 - T10
18	=	T10 - T11
19	=	T11 - T12
20	=	T12 - L1
21	=	L1 - L2
22	=	L2 - L3
23	=	L3 - L4
24	=	L4 - L5
25	=	L5 - S1
26	=	Sacroiliac joint
27	=	Multiple

14. Laterality of Symptoms

Unilateral	=	1
Bilateral	=	2

15. Date of referral for treatment

16. Date of commencement of treatment

17. Length of wait from 1st GP contact to referral for this episode (in weeks)

18. Length of wait from referral to commencement of PT (in weeks)

19. Psycho-social and physical factors. Please rate on the scale below as an ongoing assessment any factors which may have or had an effect on physiotherapy management and/or patient recovery.

- | | | |
|---|---|--------------|
| 1 | = | None |
| 2 | = | Mild |
| 3 | = | Moderate |
| 4 | = | Quite severe |
| 5 | = | Severe |

19a. Problem

Please give an indication of the severity of the problem ie in terms of pathology and/or dysfunction.

19b. Communication/sensory

Please give an indication of the severity of communication or sensory difficulties eg. inability to communicate, hearing impairment, co existing central nervous system problem or language problems.

19c. Mobility

Please give an indication of severity of any co-existing mobility problems eg. difficulties with sitting, necessity for a walking aid for an allied or co-existing problem, transportation difficulties.

19d. Social circumstances

Please give an indication of severity of any social circumstances which may impact on treatment strategy. These could include single parent, bereavement, financial problems, unemployment etc.

19e. Other conditions

Please give an indication of severity of other conditions which might impact on the management of this patient eg. patient with a heart condition, respiratory condition and any other co-existing medical or orthopaedic condition.

Items 20,21 and 22 on the Summary Sheet: Functional , Physical and Subjective Outcomes

Scores should be completed by the Therapist in conjunction with the patient for the initial assessment of functional ability, the expected functional outcome and the actual functional outcome.

- 10 = No central spinal pain, no referral of symptoms, no functional restriction, no working restriction, no sin factors present (ie severity, irritability in nature) patient able to participate in all sport, leisure and social activities taking no medication. Patients expected range of movement = 100% in all ranges
- 9 = Very low severity and irritability, symptoms occurring very infrequently. Able to work fully and carry out leisure, sports and social activities with only a minimal restriction from time to time. 90% range of motion available in one or more ranges. 100% ranges of motion available in all other ranges. Has no need to resort to simple analgesia.
- 8 = Low severity, irritability and nature factors, sleep unaffected. Infrequent symptoms, working full time. Some aspects of work slightly modified, some minimal restriction of social, leisure and sports activities from time to time. 80% range of movement in one or two physiological ranges. All others 100%. Needs analgesia and anti-inflammatories minimally from time to time when symptoms present.
- 7 = Moderately low sin factors, working full time in a modified way. Sleeps well in the main. Symptoms felt occasionally. Leisure, sport and social activities unaffected in the main. 70% range of motion available in one physiological range of motion. All others 100%. Some analgesia necessary when symptoms at their worst.
- 6 = Moderate to mild severity and irritability. Symptoms felt regularly. Working almost full time in a modified way. Leisure and social activities affected occasionally. Contemplating returning to sport. 60% range of motion available in one or two ranges of motion. All others 100%. More than occasional use of analgesia.
- 5 = Moderate severity and irritability in nature. Moderate symptoms felt intermittently, almost daily. Some sleep loss occasionally. Working part time in a modified way. No sport activities. Leisure and social activities possible if careful. Able to do most daily living activities unaided. One range of motion reduced to 50%. Regular use of analgesia.
- 4 = Moderate sin factors. Sleep disturbed once or twice a-week. Moderate symptoms daily, pain moderately intense. Working on a very part time basis. Pain local and/or referred. Participating in leisure and social activities at a restricted level. The majority of functional tasks provoke symptoms. Less than 40% range of motion in one physiological range of movement. Analgesia used most days.
- 3 = Moderately high sin factors. Local and/or referral of pain. Intermittent severe and intense pain but felt regularly throughout the day. Unable to work due to symptoms. Sleep disturbed. Performing some functional tasks with some restriction. No sporting activities possible. Leisure activities somewhat curtailed. Under 30% range of movement available in one or more ranges. Analgesia taken regularly throughout the day.
- 2 = High sin factors. Severe and intense pain almost constant. Local and/or referral. Sleep disturbed every night. Performs minimal functional tasks at home. Leisure and social activities curtailed by symptoms by a large degree. No sporting activity possible. Range of movement reduced to 20% or less in one range of motion. Heavy reliance on analgesia.
- 1 = Very high sin factors. Severe and intense pain felt constantly. Unable to sleep, work or participate in leisure and social activities in any form. Range of movement less than 20% in one or more direction. Completely reliant on drug therapy for minimal pain relief.

24. Outcome of Referral

Inappropriate referral	01
Treatment not commenced (department informed)	02
Treatment not commenced (department not informed) (D.N.A.)	03
Treatment interrupted (F.T.A) Department not informed	04
Treatment interrupted (U.T.A.) Department informed (Includes self discharges)	05
Transferred within district	06
Transferred outside district	07
Assessment completed no Physiotherapy required	08
Assessment completed. Advice re self care given	09
Review arranged	10
Treatment completed. Regular discharge	11
Died	12
Referred back to GP/Consultant	13
Patient non compliant	14
Physiotherapy not effective	15
Other	15

25. Treatment Details

Advice re self management or advice to carer	01
Interferential	02
S.W.D.	03
TENS	04
Ultrasound	05
Local heat (I.R. packs pad)	06
Active exercises	07
Passive exercises	08
Traction	09
Mobilisations (Maitland concept)	10
Manipulation grade 5 (Maitland concept)	11
McKenzie approach	12
Combined movements (Edwards)	13
SNAGS	14
Cyriax Manipulation	15
Reflexology	16
Aromatherapy	17
Ice	18
Hydrotherapy	19
Massage	20
Frictions	21
C.T. Massage	22
Strapping	23
Appliance fitting eg. cervical collar/ lumbar support	24
Laser	25
P.N.F.	26
Re-Education of Muscle Imbalance	27
Neuro dynamic facilitation	28
Acupuncture	29
Trigger point release	30
Soft tissue stretches	31
Back school	32
Back rehabilitation class	33
Education + advice	34
Injection Therapy	35

Advice refers to simple instructions eg. sleeping postures, advice about pillows, advice about sitting and working postures.

Education in this context means giving the patient formal instruction into the anatomy, pathology of the region together with the underlying principles involved in management which may occur on an individual or group basis.

26.. Total Effort Score (O.P.D. only)

<u>Activity</u>	<u>Approx Time Taken</u>	<u>Score</u>
Patient Interview no treatment, short letter	5 mins	1
US/IR/SWD/Laser Traction/TNS/Trophic Stimulation/Mobilisations/ Exercises/Thoraktin/Normal Administration /Wax	10 mins	2
Acupuncture/IF/Mobilisations Traction	15 mins	3
Mobilisations/UVR Education/Advice	15 mins	4
Mobilisations/simple peripheral joint examination & assessment	20 mins	5
Moderately complex peripheral joint examination & assessment	20 mins	6
Complex peripheral joint examination & assessment	30 mins	7
Simple neck/back/shoulder examination & assessment. Basic neurological treatment e.g. Brachial Plexus, lesion, facial palsy	30 mins	8
Moderately complex back/neck.shoulder examination & assessment Complex Brachial plexus lesion	45 mins	9
Complex back.neck/Shoulder/neurological examination	60 mins	10
1 extra point for each extra member of staff involved in the treatment		
1 extra point for each extra modality e.g. simple mobilisations + U.S + exercises = 4		

Classes

60 min class 12) then divide by the number of patients
90 min class 18)

If more than one Physiotherapist involved then double class score i.e. 2 Physiotherapists doing 1 hour class with 12 patients each patient scores 2.

Effort is a mixture of:-

Knowledge application	Skill application
Vigour	Time expended
Self motivation	Physical and mental exertion
Strength	Concentration
Conviction	Motivation of others

Effort is graded 1 - 10 and is recorded at the end of each contact with the service as the clinical records are updated. Total effort score for whole treatment period is recorded on discharge sheet.

27. **Goal Achievement at Discharge** (in terms of patient and therapist goal achievement)
 Note: goals should include pain, range of movement, function, patient's interpretation of subjective perceived improvement and the ability to work.

a.-	Goals exceeded	-	1 - 6	Treatments	1
		-	7 - 12	Treatments	2
		-	13 - 18	Treatments	3
		-	19+	Treatments	4

When the goal/outcomes expected at the initial assessment have been surpassed by the actual achievements attained by the patient, i.e. symptom free, increased range of movement compared to other limb before incident, function better than before. Able to work fully.

b.-	Goals fully achieved	-	1 - 6	Treatments	5
		-	7 - 12	Treatments	6
		-	13 - 18	Treatments	7
		-	19+	Treatments	8

All goals/outcomes achieved to 100% i.e. symptom free, full range movement, no pain, function as before incident. 100% perceived improvement. If during assessment it is clear that advice only is needed or that the aim of intervention was to assess mobility and this is achieved then the goal is fully achieved. A non physiotherapy goal may be set e.g. to involve other agencies, if this is done then the goals are fully achieved. Also, if goal was to achieve 80% recovery at discharge, for the patient to achieve 100% recovery with appropriate home management strategy, then goals have been fully achieved.

c.-	Goals significantly achieved	-	1 - 6	Treatments	9
		-	7 - 12	Treatments	10
		-	13 - 18	Treatments	11
		-	19+	Treatments	12

When 50% or more of the agreed goals are achieved or the patient is half way to the expected outcome, i.e. there may be a 50% improvement in subjective and objective findings, one or more problems still present but are resolving slowly but majority of problems have already been resolved. Patient able to work in a restricted or modified way.

d.-	Goals partially achieved	-	1 - 6	Treatments	13
		-	7 - 12	Treatments	14
		-	13 - 18	Treatments	15
		-	19+	Treatments	16

Less than 50% of the goals set are achieved, there is minimal improvement of subjective and/or objective findings based on the initial assessment, some problems still outstanding, some initial improvement which has failed to continue. Patient unable to work but will manage some domestic tasks and contemplate return to work in a highly modified way.

e.-	Goals not achieved	-	1 - 6	Treatments	17
		-	7 - 12	Treatments	18
		-	13 - 18	Treatments	19
		-	19+	Treatments	20

No change in the objective or subjective findings, inappropriate goals set and were not a measure of true potential, or when goals were not met due to influences outside the therapists control the reasons for this should be linked with the other factors and stated in the patient's notes. In all circumstances the signs and symptoms for this group of patients functions will have remained static. Patient unable to contemplate work.

f.-	Other ie. worse poor referral additional problems etc	-	1 - 6	Treatments	21
		-	7 - 12	Treatments	22
		-	13 - 18	Treatments	23
		-	19+	Treatments	24

Any eventualities not covered in the above sections use 'other factors' as a linkage and state what other factors were involved in the patients's notes. In this circumstance there may have been increase in local pain, decreased range of movement, the development of referred pain and/or decreased function. Reduced and/or inability to work. In the assessment of goals between the therapist and the patient a linear visual analogue could be used using the 10cm line, 0-10 for pain, range of movement, function, subjective improvement and the ability to work.

Other Factors Influencing Outcome in terms of rate/nature of recovery

1. Pain free at first visit.
2. Inappropriate referral.
3. Re-referred to consultant or GP
4. Other medical intervention, e.g. drugs, injection, osteopath, chiropractor, homeopath, collar, corset, surgery, etc.
5. General state, e.g. compensation case, stress levels, level of intelligence, attitude of patient, motivation, social circumstances, understanding of condition, smoking, drinking, etc.
6. Lifestyle influences, e.g. job, home circumstances, age, sport, etc.
7. Other medical conditions, e.g., cardiac.
8. Time, natural progression of condition, lack of treatment, e.g. patient moves from the area or is unwilling to attend for treatment.
9. Ceased to attend.
10. Requires educational advice only.
11. Teamwork.
12. Transfer to another hospital.
13. RIP.
14. No other factors.
15. Exacerbation of condition
16. Transport difficulties
17. Parking difficulties
18. Access to treatment area difficulties
19. Change in grade of therapist

29. Number of treatments**30. Physiotherapist Grade**

- | | | |
|----|---|--------------------|
| 1. | = | Junior |
| 2. | = | Senior 2 |
| 3. | = | Senior 1 |
| 4. | = | Superintendent IV |
| 5. | = | Superintendent III |
| 6. | = | Superintendent II |
| 7. | = | Superintendent I |
| 8. | = | Student |

There may be more than one physiotherapist involved in the treatment of this patient, please indicate all grades giving treatment in the boxes provided. Please list grades in order of input.

31. Please state how many therapists in total were involved in the treatment of this patient.**32. Patient Perceived Pain, Function and Ability to Work**

Instructions to therapists on the completion of patient perceived pain levels, functional ability and ability to work.

The patient is asked to indicate their level of pain, functional ability and ability to work before treatment commences and when treatment is terminated. In order for this outcome measure to be reliable it is important that all patients are asked for information in the same way. The following statement should be made by all therapists in respect of each patient that they assess:-

"In order to monitor the effectiveness of your treatment, it is important that we find out about your levels of pain, your functional ability and your ability to work at the present time. Please choose a number on the scale of 0 to 10 which indicates:-

1. *Your present level of pain when it is at its worst where 0 = the least amount of pain you could envisage and 10 = the worst pain that you could imagine.*
2. *Ability to work where 0 = complete absence of ability to work and 10 = working normally.*
3. *Functional ability where 0 = total absence of ability to carry out functional tasks at home and in the social setting and 10 = maximum or normal ability to carry out functional tasks."*

The questions are asked again on completion of physiotherapy treatment.

33. Referral Source

- | | | |
|---|---|--------------------------|
| 1 | = | General Practitioner |
| 2 | = | Consultant |
| 3 | = | Orthopaedic Practitioner |
| 4 | = | Other |

34. Improvement in Quality of Life

Please ask the patient to determine the overall improvement/decrease in their quality of life following treatment taking all their personal factors and physical factors into consideration. eg. pain levels, ability to work, their social life, their sexual activity and general participation in leisure and sporting activities. Ask them to rate it on a 0-100% scale in terms of improvement. If 0% was the least improvement they could achieve and 100% was the most they could expect to have achieved, where would they rate themselves on a scale of 0-100 at this time.

The question to be asked should be:

Using a scale of 0 -100 with 0 being no improvement, minus numbers (such as -10 etc) getting worse and positive numbers being an improvement (100 being the best you could have achieved), could you tell me how you would rate your improvement or decrease in quality of life now compared to when you first started coming for treatment. Take into account, how much pain you have, your ability to work, your social life, sporting activities and your sex life (if appropriate).

Asking the question in a standardised way will increase the validity and reliability of responses.

REC STATEMENT

1	CERVICAL SPONDYLOSIS
2	NECK PAIN AND HEADACHE DUE TO ARTHRITIS C1 T1
3	MUSCULAR TIGHTNESS AND PAIN IN CERVICAL SPINE C2 C4 FACET PROBLEMS
4	ADVERSE NEURAL TENSION 1 MEDIAN NERVE
5	CERVICAL SPONDYLOSIS
6	PAINFUL R SHOULDER REFERRED FROM CX FACET JOINTS C4 C5
7	PINS AND NEEDLES IN 1 HAND, PAIN IN 1 ARM, REFERRED CX FACET JOINT
8	-
9	FACET JOINT C4, CAME ON AFTER LIFTING
10	PAIN IN NECK, BOTH SHOULDERS, BOTH ELBOWS, WRIST, FINGERS, WEAK MUSCLES
11	POSTURAL ORIGIN UPPER CERVICAL SPINE DYSFUNCTION
12	EXACERBATION SPONDYLOSIS LOCAL C5 6 DYSFUNCTION NERVE ROOT
13	PSYCHOSOCIAL CERVICAL SPINE PAIN
14	CERVICAL SPINE SPONDYLOSIS NON SPECIFIC LEVEL
15	DEGENERATION CERVICAL SPINE 1 FACET JOINT DYSFUNCTION ESP C6/7
16	WHIPLASH INJURY WITH ACUTE MUSCULAR SPASMS, PAIN STIFF SPINE
17	WHIPLASH INJURY ON A CHRONIC NECK CONDITION
18	WHIPLASH INJURY EXACERBATING EXISTING DEGENERATIVE NECK PAIN
19	-
20	MUSCLE PAIN, STIFFNESS IN TRAPEZIUS, PAINFUL SPINOUS PROCESS UPPER CERVICAL REGION
21	POSITIONAL CHANGES LEADING TO ARTHOGENIC CHANGES
22	V.B.I. POSSIBILITY OR T.I.A.
23	RESID NPD IN 1 ULTP WITH TIME TRIGGER POINT IN UPPER TRAPEZIUS BILATERALLY
24	DEGENERATIVE SPONDYLOSIS
25	C5 AND 6 NERVE IMPINGEMENT
26	MUSCLE STRAIN
27	FACET JOINT IMPINGEMENT DUE TO SLEEPING POSTURE
28	CERVICO GENIC HEADACHES
29	-
30	DEGENERATIVE CERVICAL CHANGES WITH FACET DYSFUNCTION
31	-
32	-
33	-
34	-
35	CERVICO THORACIC HYPOMOBILITY
36	-
37	NEURODYNAMIC PROBLEMS
38	GENERALISED JOINT STIFFNESS CX - UPPER SPINE MULTILEVER MUSCLE WEAKNESS
39	WIDESPREAD DEGENERATIVE CHANGES
40	OA WITH ACUTE DEGENERATIVE CHANGES IN CERVICAL SPINE CREPITUS, NO HISTORY TRAUMA
41	DISC PROLAPSE C5
42	NEURODYNAMIC PROBLEM
43	DEGENERATIVE CERVICAL SPINE WITH NERVE ROOT IMPINGEMENT
44	-
45	-
46	POSTURALLY RELATED DEGENERATIVE CERVICAL SPINE
47	NERVE ROOT IMPINGEMENT C4 C5
48	-
49	DEGENERATIVE DISC DISEASE
50	-
51	CERVICAL SPONDYLOSIS WITH T4 SYNDROME/ADVERSE NEURODYNAMIC PROBLEM
52	WHIPLASH
53	-
54	JOINT DYSFUNCTION
55	DERANGEMENT OF CERVICAL VERTEBRA
56	CERVICAL SPONDYLOSIS AND ACROMIAL BONY SPUR
57	DEGENERATIVE SPONDYLOSIS
58	POOR POSTURE AND MUSCLE SPASM
59	TORTICOLLIS
60	-
61	POSTURE AND SPONDYLOSIS NERVE IMPINGEMENT
62	TRAUMA WHIPLASH SOFT TISSUE DYSFUNCTION
63	2ND DEGREE SOFT TISSUE DYSFUNCTION
64	WHIPLASH

65 -
66 CERVICAL DERANGEMENT
67 -
68 -
69 -
70 SPONDYLOSIS WITH INSTABILITY AND SOME NEUROPATHODYNAMIC SIGNS
71 POSTURE INDUCED PAIN
72 ACUTE FACET
73 GENERALISED OA WITH CERVICAL SPINE AND GLENOHUMERAL JOINT PROBLEMS
74 BILATERAL SH. ADHESIVE CAPSULITIS
75 UPPER THORACIC ZYGOPHYSEAL JOINT IRRITATION WITH REST, CERVICAL SPINE
76 CERVICO THORACIC JUNCTION HYPERMOBILITY
77 CHRONIC MUSCLE TENSION
78 MUSCULAR TENSION CAUSING ANY SYMPTOMS
79 -
80 UPPER THORACIC SPINE DYSFUNCTION
81 LOWER CERVICAL SPINE EXTENSION DYSFUNCTION
82 DEGENERATIVE CERVICAL SPINE
83 RESOLVING MUSCULAR FACET JOINT DYSFUNCTION
84 MODERATE CERVICAL SPONDYLOSIS - POOR POSTURE
85 CERVICAL DISC LESION
86 MID THORACIC AND CERVICOTHORACIC STIFFNESS
87 -
88 OA CERVICAL SPINE
89 OA CERVICAL SPINE
90 STIFFNESS IN CERVICAL SPINE, 2 DEGREE DEGENERATIVE CHANGES AND POOR POSTURE
91 POOR CERVICAL SPINE/THORACIC SPINE/JUNCTION POSTURE, FACET JOINT DEGENERATION
92 IMPINGEMENT ANY PROBLEM
93 -
94 PATIENT FELL OVER AND JARRED HER NECK WHICH HAS PRECIPITATED SPONDYLOSIS
95 WHIPLASH
96 -
97 CERVICAL SPONDYLOSIS WITH FACET JOINT IMPINGEMENT OF NERVE
98 FACET JOINT IMPINGEMENT
99 -
100 -
101 JOINT DYSFUNCTION
102 -
103 OA C7 T1 VERTEBRAE
104 DISCECTOMY 1 YEAR AGO. CERVICAL SPINE C7/T1
105 SOFT TISSUE AND FACET JOINT INVOLVEMENT
106 -
107 -
108 PAIN AND STIFFNESS IN LOW CERVICAL SPINE REFN IN 1RFT ARM
109 REFERRED PAIN FROM C7 FACET JOINT
110 CERVICAL FACET JOINT DYSFUNCTION FOLLOWING WHIPLASH 1 YEAR AGO
111 FACET JOINT DYSFUNCTION
112 TRAUMATIC WHIPLASH NOW CAUSING ANY
113 FACET JOINT DYSFUNCTION
114 CX DYSFUNCTION WITH ASSOCIATED ACTIVE TRIGGER POINTS DUE TO POOR POSTURE
115 1973, FELL ON NECK FROM HEIGHT. 1994, REAR SHUNT RTA DEGENERATION
116 CERVICAL SPONDYLOSIS
117 ROM WITH ASSOCIATED TRIGGER POINTS
118 CHRONIC NECK PAIN
119 DEFINITE SIGNS NERVE ROOT IMPINGEMENT, VERY STIFF CERVICAL DORSAL SPINE
120 VERY STIFF C7 AND D1 AS A RESULT OF DEGENERATIVE CHANGE
121 WHIPLASH
122 -
123 1ST CERVICAL SPINE WHIPLASH INJURY RTA
124 MUSCULAR SPASM CERVICAL SPINE EARLY OA
125 WHIPLASH RTA EXACERBATING CHRONIC PROBLEM
126 FACET JOINT IMPINGEMENT
127 EXACERBATION OF PAIN CAUSED BY POOR POSTURE AND WORK
128 OSTEOPOROSIS, OSTEOARTHRITIS DISC DEGENERATION POLYMYALGIA
129 STIFF SORE CS AND UPPER THR END OF RANGE OF MOTION ON PALPATION
130 POOR POSTURE AND NERVE IMPINGEMENT
131 FACET JOINT DYSFUNCTION WITH NEURODYNAMIC ELEMENT

132 POOR POSTURE, LONG TERM DYSFUNCTION AND IMPINGEMENT
133 DEGENERATIVE SPONDYLOSIS
134 HEADACHES FROM CERVICAL SPONDYLOSIS
135 -
136 DEGENERATIVE SPONDYLOSIS AND POOR POSTURE
137 NECK PAIN AND STIFFNESS DUE TO OA
138 CERVICAL SPONDYLOSIS REFERRAL PAIN 1 SIDE OF HEAD AND FACE. PINS AND NEEDLES
139 -
140 CHRONIC WHIPLASH WITH NEURAL TENSION
141 -
142 -
143 DEGENERATIVE CERVICAL SPINE WITH REFERRED PAIN
144 CERVICAL SPONDYLOSIS WITH VERTEBRAL ARTERY INVOLVEMENT
145 -
146 -
147 -
148 -
149 CERVICAL ARTHRITIS
150 -
151 -
152 C1/2 FACET JOINT DYSFUNCTION
153 RESTRICTED JOINT MOVEMENT C2/3 SEGMENT
154 CERVICAL SPINE SPONDYLOSIS AND ARTHROSIS
155 MUSCULAR DYSFUNCTION OF SCALENES CAUSING NECK AND SHOULDER PAIN
156 STIFFNESS UPPER THORACIC SPINE AND ANY
157 MID C SPINE ARTICULAR AND SOFT TISSUE PROBLEM
158 PARESTHESIA BOTH HANDS AND SLIGHT NECK PAIN DUE TO OA CX
159 ACUTE NECK PAIN WITH MUSCULAR SPASM PAIN ON PALPATION, CERVICAL SPINE
160 C3/C4 FACET JOINT DYSFUNCTION
161 UNDERLYING DEGENERATION
162 WHIPLASH INJURY
163 TRAUMATIC INDUCED FACET JOINT DYSFUNCTION
164 GENERAL DYSFUNCTION
165 -
166 EXACERBATION RA
167 WHIPLASH WITH NERVE ROOT IRRITATION
168 CERVICAL SPONDYLOSIS WITH POSTURAL DYSFUNCTION
169 STIFFNESS FOLLOWING IMPACT INJURY TO HEAD C4/5
170 C5/6 DYSFUNCTION
171 ACUTE C5/6 NERVE ROOT IMPINGEMENT SECONDARY TO DEGENERATIVE PROBLEMS
172 ACUTE C5/6 NERVE ROOT IMPINGEMENT SECONDARY TO DEGENERATIVE POSTURE
173 CHRONIC POSTURAL DYSFUNCTION CX
174 POSTURAL PAIN AND INFLAMMATORY COMPONENT
175 ONGOING POOR POSTURE
176 FACET JOINTS IMPINGEMENT
177 C/SPINE SPONDYLOSIS CAUSING HEADACHES
178 WHIPLASH WITH NERVAL IRRITATION
179 WHIPLASH WITH NERVE ROOT IRRITATION
180 C5/6 JOINT DYSFUNCTION AND SCIATIC REFERRAL
181 NERVE ROOT ENTRAPMENT C6/7
182 C5/6 HYPERMOBILITY WITH STIFF CT JUNCTION
183 STIFF CT JUNCTION WTH HYPERMOBILITY AT C5/6
184 CERVICAL SPONDYLOSIS
185 (1) ROTATION DYSFUNCTION PAIN L SHOULDER
186 PREVIOUS TRAUMA EXACERBATED BY RECENT INCREASED ACTIVITY
187 -
188 -
189 RTA CAUSING C4/5 SUBLUXATION WITH FRACTURE
190 FACET JOINT IMPINGEMENT AND STENOSIS
191 NECK PAIN WITH ACUTE MUSCULAR SPASMS RADIATING TO SHOULDERS
192 CERVICAL SPONDYLOSIS
193 DISC DEGENERATION AND OSTEOPHYTES
194 RHEUMATOID ARTHRITIS
195 RECURRENT DISC PROBLEMS RELEVANT TO WORK
196 -
197 -
198 FACET JOINT PROBLEM OA C/SP

199 WHIPLASH CERVICAL THORACIC JUNCTION STIFFNESS
200 -
201 C6 DYSFUNCTION/VERTIGO
202 ADVERSE NEURAL DYNAMICS
203 -
204 OVERUSE C/SPINE, UNDERUSE THORACIC SPINE
205 -
206 -
207 OCCIPITAL HEADACHES FROM C1/2
208 -
209 CERVICAL THORACIC STIFFNESS AND PAIN
210 PAGETS DISEASE
211 OA AT C5/6, C6/7
212 SOFT TISSUE DYSFUNCTION
213 SUB OCCIPITAL SP AND UPPER TSP - POOR POSTURE CONTRIBUTING CON
214 MARKED CERVICAL UPPER DORSAL STIFFNESS DUE TO SOFT TISSUE SHORTENING
215 WHIPLASH 17 YEARS AGO - WEAR AND TEAR PROBLEMS
216 CERVICAL SPINE
217 SOFT TISSUE TRAUMA NERVE IMPINGEMENT
218 SOFT TISSUE TRAUMA
219 FACET JOINT LOCK BUT ALSO REFERRED PAIN FROM TRIGGER POINTS
220 T4/5 COSTOVERTEBRAL JOINT INFLAMMATION
221 -
222 -
223 ACUTE ON PRE EXISTING WHIPLASH
224 MID CERVICAL JOINT STIFFNESS/DYSFUNCTION
225 UPPER CERVICAL DYSFUNCTION
226 C/T FACET JOINT DYSFUNCTION
227 SCALENE MUSCLE SPRAIN
228 TRAUMA FACET JOINT IRRITATION AND NERVE ROOT SIGN
229 C8/T JOINT DYSFUNCTION
230 C6/7 FACET JOINT ARTHROSIS AND NERVE ROOT IRRITATION
231 DEGENERATIVE UPPER CERVICAL SPINE
232 FACET JOINT IMPINGEMENT
233 ARTHROSIS WITH BILATERAL REFERRAL OF PAIN ACROSS SHOULDERS
234 ACHE IN 1 TRAPEZIUS WITH MOVEMENT TORTICOLLIS
235 R ARM WEAKNESS DUE TO JOINT SPACES C5/6/7 POSTERIOR OSTEOPHYTES
236 LONG STANDING CERVICAL SPONDYLOSIS CAUSING FACET JOINT IMPINGEMENT
237 MECHANICAL NECK PAIN RELATED TO OLD INJURY AND POOR POSTURE
238 WHIPLASH INJURY
239 RECURRENT ATTACK OF ACUTE PAIN, L TRAPEZIUS WORK RELATED
240 DYSFUNCTION CERVICAL THORACIC JUNCTION POSTURE
241 SPONDYLOSIS EXACERBATED BY POSTURE AT WORK
242 DEGENERATIVE FACET PAIN
243 CERVICAL SPONDYLOSIS X RAY REVEALED RUDIMENTARY CERVICAL RIB
244 PREVIOUS CERVICAL SPONDYLOSIS
245 -
246 FELL OFF BATH EDGE, HIT HEAD ON TAPS
247 WHIPLASH AND EXACERBATION OF OLD BACK PROBLEM
248 TORTICOLLIS
249 -
250 DEQUERVAINES WITH A NEURODYNAMIC SPINAL COMPONENT
251 POST WHIPLASH CHRONIC STIFFNESS DUE TO POOR POSTURE
252 -
253 POSTURAL HYPOMOBILITY
254 7 MONTHS POST WHIPLASH WITH T6 L FACET JOINT STIFFNESS
255 R C4/5 FACET JOINT DYSFUNCTION
256 DEGENERATIVE FACET UPPER CERVICAL
257 -
258 SOFT TISSUE WHIPLASH INJURY
259 CERVICAL SPONDYLOSIS
260 SOFT TISSUE MAINLY/WHIPLASH INJURY
261 MARKED LOSS OF MOBILITY ON ROTATION WITH CONSIDERABLE SOFT TISSUE
262 SPONDYLOSIS
263 ADVERSE NEURAL TENSION
264 CERVICAL SPONDYLOSIS NO C/SPINE PAIN, BUT PINS AND NEEDLES
265 SPONDYLOSIS AND MYOFASCIAL PAIN

266 SPONDYLOSIS C SPINE
267 DYSFUNCTION JOINT AND MUSCULAR
268 MUSCLE SPASM/SPONTANEOUS TORTICOLLIS
269 NERVE IMPINGEMENT FROM LOWER CERVICAL SPINE
270 L SIDE FACET IMPINGEMENT
271 -
272 NPD SIGNS SECONDARY TO DEGENERATIVE CHANGES IN C SPINE
273 CERVICAL SPINE EXT ROTATION DYSFUNCTION
274 -
275 -
276 UPPER TRAPEZIUS DYSFUNCTION
277 EXACERBATION AT CERVICAL SPONDYLOSIS
278 LOWER CERVICAL FACET AND CERVICO
279 MID THORACIC DYSFUNCTION WITH ASSOCIATED MUSCULAR TIGHTNESS
280 -
281 TIGHT UPPER TRAPEZIUS WITH TRIGGER POINTS AND C6 T1 FACET DYS
282 NERVE ROOT ENTRAPMENT
283 DEGENERATIVE CHANGES IN CERVICAL SPINE
284 TIGHT UPPER TRAPEZIUS FROM POOR POSTURE
285 -
286 -
287 ARTHRITIS AND OSTEOPHYTES IN CS DECREASE MOVEMENT TIGHT MUSCULATURE
288 WHIPLASH
289 COMPRESSION FLEXION STRAIN
290 RESIDUAL DULL ACHE IN UPPER CERVICAL SPINE
291 C6 NERVE ROOT IRRITATION WITH UNDERLYING DEGENERATION
292 OA DEGENERATIVE CHANGES R UPPER CS JOINT DESTRUCTION
293 R SIDED LIGAMENTOUS TIGHTNESS
294 CERVICAL SPONDYLOSIS
295 SOFT TISSUE INJURY DUE TO FALL
296 WHIPLASH
297 CERVICAL SPONDYLOSIS
298 WHIPLASH
299 -
300 WHIPLASH
301 CERVICAL SPONDYLOSIS
302 CERVICAL SPONDYLOSIS
303 WHIPLASH
304 ACUTE WHIPLASH
305 OA CERVICAL SPINE
306 LOW CERVICAL PAIN WITH PINS AND NEEDLES IN BOTH ARMS
307 CERVICAL SPONDYLOSIS
308 ACUTE TORTICOLLIS
309 PAIN DUE TO DEGENERATIVE CHANGES IN THE NECK
310 PAINFUL MIDDLE TRAPEZIUS
311 ACUTE WHIPLASH
312 SPASM IN THE L STERNOCLEIDOMASTOID MUSCLE
313 IRRITATION C7C2 AND 3 FACET JOINTS
314 CERVICAL SPONDYLOSIS
315 CERVICAL SPONDYLOSIS
316 FACET JOINT IMPINGEMENT
317 ACUTE TORTICOLLIS
318 T1/1 SCOLIOSIS, WHIPLASH INJURY 7 YEARS AGO C/SPINE
319 FACET JOINT IMPINGEMENT
320 MUSCLE SPASM
321 CHANGE OF BED TO HARD - PAIN SINCE
322 NEURO PROBLEM SECONDARY TO OLD WHIPLASH, SOME DISCOGENIC RESTRICTION
323 -
324 -
325 POSTUREAL EXACERBATION OF C5 TRAUMATIC INFLAMMATION
326 POOR SCAPULAR STABILITY SECONDARY TO MUSCLE IMBALANCE EXACERBATED BY WORK
327 DERANGEMENT 5
328 CERVICAL SPINE DERANGEMENT 3
329 SOFT TISSUE DYSFUNCTION NECK AND SHOULDER
330 CERVICAL-SPINE DERANGEMENT 3
331 -
332 FACET JOINT C5/6

333 -
334 FACET JOINT DYSFUNCTION
335 -
336 HYPOMOBILE C T FUNCTION
337 WHIPLASH INJURY
338 FACET JOINT IMPINGEMENT
339 ROTATOR CUFF IMPINGEMENT 1 DEG ACUTE LOWER C/SPINE NERVE ROOT R IRRITATION
340 POSITIONAL VERTIGO
341 -
342 -
343 THORACIC NERVE IMPINGEMENT
344 DEGENERATIVE C/SPINE AGGRIVATED BY POOR POSTURE
345 CHRONIC CHANGES WITH TRAPEZIUS TRIGGER JOINT
346 CHRONIC WHIPLASH WITH NEURAL TENSION
347 CERVICAL OSTEOARTHRITIS
348 SUPRASPIRATUS TENDINITIS TRIGGER POINTS
349 -
350 -
351 -
352 -
353 -
354 -
355 -
356 -
357 -
358 -
359 MYOFACIAL PAIN TRAPEZIUS, SOME C4/5 JOINT DYSFUNCTION
360 POST TRAUMATIC DYSFUNCTION
361 -
362 SLE SOFT TISSUE DYSFUNCTION
363 CERVICAL SPONDYLOSIS
364 C6/C7 DISCOGENIC AND NERVE ROOT IMPINGEMENT
365 POSTURAL DYSFUNCTION MUSCLE IMBALANCE POKING CHIN POSTURE
366 JOINT DYSFUNCTION CAUSED BY LONG TERM POSTURAL PROBLEMS
367 EARLY RESISTANCE / STIFFNESS CX LOWER AND UPPER THORACIC SPINE
368 POSTURAL NECK PAIN
369 FACET JOINT IMPINGEMENT
370 DERANGEMENT CERVICAL SPINE
371 WHIPLASH / DEGENERATIVE CERVICAL SPINE
372 SPONDYLOSIS CERVICAL SPINE OA SHOULDER
373 CX SPONDYLOSIS
374 SPONDYLOSIS WITH NERVE IMPINGEMENT
375 SYRRINGOMYELIA OP SINCE ORIGINAL REFERRAL
376 VERY STIFF NECK COAD
377 MECHANICAL NECK PAIN WITH NERVE IMPINGEMENT
378 -
379 NEURODYNAMIC PROBLEMS SECONDARY TO POOR POSTURE
380 -
381 POSSIBLE SPINAL STENOSIS
382 PID SECONDARY TO POSTURAL CHANGES WITH ADVANCING PREGNANCY
383 RIGHT COMPRESSION PATTERN PATHONEURODYNAMIC (POSTURAL)
384 FACET JOINT IMPINGEMENT ACUTE
385 NERVE ROOT ENTRAPMENT DUE TO KYPHOSIS AND POOR POSTURE
386 FACET JOINT IMPINGEMENT
387 ONGOING UPPER THORACIC PAIN WITH SUPERIMPOSED LOWER C/SPINE PID
388 MECHANICAL NECK PAIN WITH NERVE IMPINGEMENT
389 WHIPLASH TYPE NECK STRAIN SECONDARY TO LIFTING ACCIDENT
390 LEFT SIDED COMPRESSION PATTERN WITH PND - PATHONEURODYNAMICS
391 ANNULAR DISC BULGE
392 OA NECK AND POSTURAL PROBLEMS
393 FACET LESION / POSTURAL SYNDROME AND ANY
394 POSTERIOR INTERVERTEBRAL DISC BULGE C/SPINE
395 REFERRAL NERVE ROOT PAIN LEFT SHOULDER
396 CERVICAL SPONDYLOSIS
397 ACUTE C7 NERVE IMPINGEMENT
398 NERVE ROOT IRRITATION DUE TO POOR POSTURE
399 ACUTE INJURY 11MONTHS AGO - SOFT TISSUE SHORTENING JOINT DYSFUNCTION

400 SEVERAL INJURIES RELATING IN NECK PAIN FOR 6 YEARS, TRAUMA WEAR AND TEAR
401 -
402 -
403 -
404 -
405 C/T JUNCTION HYPO AND T4 SYNDROME
406 25 PLUS 29
407 FACET JOINT DYSFUNCTION PLUS DISC DEGENERATION
408 C/SPINE SPONDYLOSIS C5 - T1
409 POSTURAL PROBLEM, STIFFNESS UPPER C/SPINE AND C/T AND T/SPINE
410 C/SPINE SPONDYLOSIS WITH SORE ARTHROSIS
411 FACET JOINT LOCKING
412 NEUROGENIC WRIST/ELBOW PAIN
413 POSTURAL RELATED C/SPINE PAIN AND ARM PAIN
414 -
415 SPONDYLOTIC CHANGES IN C4 TO C7 AND DISC SPACE NARROWING
416 CERVICAL SPINE FACET JOINT STIFFNESS C1 FACET JOINT STIFFNESS
417 T4 SYNDROME
418 HYPERMOBILE LOW C/SPINE
419 6/7 FACET JOINT IRRITATION
420 C/SPINE SPONDYLOSIS
421 POSTURAL NECK PAIN
422 RECURRENT TORTICOLLIS C3/4 FACET JOINT RESIDUAL STIFFNESS
423 WEIGHT AND MUSCLE IMBALANCE
424 DEGENERATIVE CERVICAL SPINE LEADING TO HEADACHES
425 VERY POOR POSTURE LEADING TO DEGENERATIVE CHANGES
426 FACET JOINT POOR POSTURE
427 KYPHOTIC THORACIC SPINE PREVIOUS WHIPLASH X 2
428 PROTRACTED CERVICAL SPINE
429 RESOLVING DISC LESION AND NEURAL IMPINGEMENT
430 CERVICAL SPONDYLOSIS PLUS VISUAL PROBLEMS AND DIZZINESS, LIGHT HEADED
431 TENDER C34 SPASM POST CERVICAL MUSCLES
432 WHIPLASH 11 MONTHS AGO
433 ACUTE TORTICOLLIS
434 POSTURAL NATURE - UPPER CERVICAL PAIN HEADACHES
435 WHIPLASH, NEUROLOGICAL SYMPTOMS IN ARM OF PERIPHERAL ORIGIN
436 RESOLVING AT TIME OF ASSESSMENT
437 POSTURE RELATED C5/6 JOINT PAIN WITH DOWAGERS AND UPPER CERVICAL STIFFNESS
438 SOMATIC NECK PAIN FROM MID C SPINE AND STIFFNESS BELOW
439 C2 FACET JOINT DYSFUNCTION AND FIRST UB STIFFNESS
440 DEGENERATIVE CERVICAL / THORACIC SPINE KYPHOSIS WITH FACET JOINT DYSFUNCTION
441 CERVICAL SPONDYLOSIS
442 DEGENERATIVE C5-7
443 DEGENERATIVE CERVICAL SPINE GREATEST C7 JOINT
444 DEGENERATIVE CERVICAL SPINE WITH ASSOCIATED
445 POSTURAL RELATED C/SPINE PAIN AND TEMPORAL HEADACHES
446 WHIPLASH INJURY AGGRAVATED BY POOR POSTURE
447 POSTURAL KYPHOSIS C3/4 REFERRED PAIN AND CERVICAL THORACIC STIFFNESS
448 C8 NERVE IRRITATION WITH G/H SIGNS
449 DEGENERATIVE CHANGES IN C/SPINE AGGRAVATED BY POSTURE
450 CHRONIC RECURRENT C6 NERVE ROOT IMPINGEMENT
451 UNKNOWN CAUSE FOR MUSCULAR SPASM
452 HEAD/NECK INJURY 25 YEARS AGO - STIFF SINCE
453 C3, C7 NERVE ROOT SYMPTOMS DUE TO CERVICAL RIB
454 -
455 NERVE IMPINGEMENT
456 -
457 CERVICAL SPONDYLOSIS 45 YEARS, TWO OPS TO FUSE CERVICAL VERTEBRA
458 TRAPEZIUS SPASM LEADING TO NECK STIFFNESS
459 LOCKED FACET JOINT
460 -
461 CERVICAL SPONDYLOSIS WITH CERVICAL KYPHOSIS
462 CERVICAL SPONDYLOSIS
463 NECK DYSFUNCTION WITH NEURAL INVOLVEMENT
464 SOFT TISSUE DAMAGE AND HEADACHES POST RTA
465 SPONDYLOSIS POSTURAL DOWGERS HUMP
466 -

467 -
468 POKING CHIN POSTURE WITH OA CHANGES - MYOFACIAL WITH REF HEAD
469 CERVICAL FACET JOINT DYSFUNCTION
470 WHIPLASH INJURY NEVER RESOLVED
471 -
472 DEGENERATIVE CERVICAL SPINE, CERVICAL SPONDYLOSIS
473 WHIPLASH SOFT TISSUE INJURY
474 HYPERVENTILATOR - ACCESSORY WORK - ACTIVE TRIGGER POINTS
475 4 MONTHS OLD WHIPLASH
476 PAINFUL STIFF NECK FOLLOWING FALL
477 CERVICAL SPONDYLOSIS WITH MILD OSTEOPHYTE FORMATION C6/7
478 PAINFUL C/SPINE WITH RESTRICTED MOVEMENT
479 WHIPLASH RADIATING ACROSS LS NECK SHOULDERS AND FINGERS
480 ACUTELY PAINFUL C/SPINE WITH CONSTANT HEADACHES
481 CERVICAL AND THORACIC STIFFNESS
482 NEURAL TENSION CERVICAL SPINE
483 FACET JOINT IMPINGEMENT
484 CERVICAL SPONDYLOSIS
485 CERVICAL SPONDYLOSIS WITH LEFT FROZEN SHOULDER
486 CHRONIC SOFT TISSUE AND JOINT DYSFUNCTION
487 SPONDYLOSIS, ANY MYOFACIAL PAIN
488 -
489 POSTURAL INSUFFICIENCY
490 POSTURAL CHANGES LEADING TO OTHER CHANGES
491 STIFFNESS AND PAIN ON PALPATION FOR T2-6, C2-3, POSS NEURODYNAMICS
492 POOR MUSCLE BALANCE, POOR POSTURE
493 SIDE FLEXION INJURY AND POOR POSTURE
494 INCREASED MUSCLE TENSION POSTURAL SYNDROME
495 RESIDUAL HYPOMOBILITY FOR WHIPLASH
496 PAIN IN L ARM AND ANTERIOR POSITION OF SHOULDER
497 C/SPINE NERVE IMPINGEMENT, C5 WITH NO NECK INVOLVEMENT
498 HAS RECURRENT TORTICOLLIS
499 HYPOMOBILITY OF LOWER C/SPINE WITH POSTURAL COMPONENTS
500 JOINT DYSFUNCTION
501 WHIPLASH
502 DEGENERATIVE / POSTERIOR CERVICAL FACET JOINT DYSFUNCTION
503 NERVE ROOT IRRITATION
504 LOCKED FACET JOINT / DISCOGENIC
505 C4/5 FACET DYSFUNCTION CAUSING NERVE ROOT IRRITATION
506 C3 SPINE WHIPLASH AND SOFT TISSUE STRAIN L SP
507 EARLY DEGENERATIVE CHANGES POOR POSTURE CAUSING NECK PAIN
508 -
509 -
510 DEGENERATIVE MID CX
511 ACUTE WHIPLASH
512 NERVE ROOT IRRITATION SETTING
513 DEGENERATIVE C/SPINE
514 POSTURAL NERVE ROOT ISCHAEMIA
515 C4/5 NERVE ROOT COMPRESSION
516 C6 NERVE ROOT IRRITATION
517 UPPER LIMB PROBLEM SECONDARY AUTONOMIC DYSFUNCTION DELAYED ONSET 1 YEAR
518 1 CERVICAL ROOT IMPINGEMENT
519 -
520 POSTURAL PAIN DUE TO WORK POSITION
521 POSTURAL
522 PROBLEM NOT AMENABLE TO PT
523 -
524 RECURRENT PERICARDITIS
525 HAD FALL, SHOULDER PAIN AND WHIPLASH
526 -
527 RTA 75 NECK INJURIES
528 INERMITTENT TORTICOLLIS DUE TO C7/T1 FACET DYSFUNCTION
529 WHIPLASH 10 MONTHS AGO, PAINFUL NECK FACET JOINTS C5/T1 TIGHT
530 -
531 -
532 LOWER CERVICAL SPINE/SOFT TISSUE INJURY
533 DYSFUNCTION T1/T4

534 -
535 WHIPLASH JUNE 1998
536 DEGENERATIVE CHANGES CERVICAL SPINE
537 WATER SKIING ACCIDENT, WHIPLASH TYPE INJURY AUGUST 98
538 ACUTE TORTICOLLIS L SIDE FLEXION R ROOT
539 DEGENERATIVE CHANGES
540 NERVE ROOT IRRITATION
541 ARTHRITIC JOINT WITH NERVE IRRITATION
542 GENERAL 4TH THORACIC DEGENERATION
543 MILD OA
544 SPONDYLOSIS 4/5/6
545 SHOULDER DYSFUNCTION ALSO
546 C6/7 DISC LESION
547 MINOR REAR IMPACT, WHIPLASH
548 CHRONIC NECK PAIN AND STIFFNESS
549 NERVE ROOT IRRITATION
550 -
551 DEGENERATIVE CERVICAL SPINE AND ADAPTIVE SHORTENING MUSCLES
552 POSTURAL AND NEURAL IMPINGEMENT
553 DYSFUNCTION AND ANT UPPER UNITS
554 INFLAMMATORY CONDITION AND POOR POSTURE
555 CERVICAL SPINE SPONDYLOSIS AND BILATERAL HAND SYMPTOMS, NEUROLOGICAL
556 WHIPLASH
557 A/C JOINT INJURY
558 WHIPLASH AND PREVIOUS TREATMENT ANOTHER HOSPITAL
559 RA NECK WITH STRESS INDUCED HEADACHES
560 POSTURAL INSUFFICIENCY
561 MUSCLE SPASM THORACIC REGION
562 WHIPLASH
563 SOFT TISSUE SHORTENING, SOME SPASM WITH SIGNS FO POST DEGENERATION
564 WHIPLASH HAS CERVICAL RIBS C5/6 FUSION REFERRED TO HEAD HAND
565 CERVICAL SPINE DISC LESION
566 TRIGGER PAIR MM SPASM
567 WHIPLASH DUE TO RTA
568 -
569 MUSCLE SPASM INDUCING JOINT IMMOBILITY
570 TRAUMA TO UPPER FIBRES TRAPEZIUS
571 TORTICOLLIS C5/6 FACET
572 ACUTE TORTICOLLIS
573 DEGENERATIVE JOINT DYSFUNCTION, CERVICOTHORACIC
574 -
575 -
576 CERVICAL SPONDYLOSIS
577 POSTURAL DYSFUNCTION WITH NERVE ROOT IRRITATION
578 CERVICAL SPONDYLOSIS WITH FACET JOINT DYSFUNCTION
579 OA NECK ANY
580 JOINT DYSFUNCTION ANY
581 WHIPLASH 7 MONTHS OVER LONG TERM SPONDYLOSIS
582 WHIPLASH SOFT TISSUE
583 VERTIGO ASSOCIATED WITH SPONDYLOSIS AND ARTHRITIS
584 FACET JOINT PROBLEM WITH SPASM
585 WHIPLASH INJURY
586 DISC WITH NERVE IMPINGEMENT
587 C3/4 FACET JOINT PROBLEM
588 UPPER THORACIC STIFFNESS HYPERMOBILE LOWER C/SPINE
589 FACET JOINT IMPINGEMENT
590 FACET JOINT IMPINGEMENT
591 SEVERE KYPHOSIS FROM OSTEOPOROSIS
592 FACET JOINT STRAIN WITH SHORTENING
593 POOR POSTURE WITH IMBALANCE AND TRAPEZIUS PAIN
594 WHIPLASH ON TOP OF CERVICAL SPONDYLOSIS
595 SECONDARY TENNIS ELBOW DUE TO PRIMARY CERVICAL THORACIC HYPOMOBILITY
596 -
597 -
598 -
599 C5/6 EXTENSION DYSFUNCTION
600 CHRONIC WHIPLASH COMPLICATED BY ODL C4 FACET FRACTURE

601 RADICAL NERVE PATHODYNAMICS
602 CERVICOGENIC HEADACHES
603 POSTURAL C/SPINE PAIN, JOINT DYSFUNCTION, MUSCLE IMBALANCE
604 -
605 -
606 ONE YEAR HISTORY INCREASING TORTICOLLIS
607 C7/T1 NERVE ROOT LIMITATION, POSTURAL DEGENERATION
608 C5 NEURAL IRRITATION DUE TO STRAIN AGGRAVATED BY POSTURE DEGENERATIVE CHANGES
609 C3/4 FACET JOINT DYSFUNCTION
610 GENERALISED C/SPINE DYSFUNCTION, NO SPECIFIC LEVEL
611 CHRONIC NERVE IRRITATION - POOR POSTURE
612 CERVICAL SPONDYLOSIS ACUTE EPISODE FALL
613 C7 DISC WITH NEURAL IRRITATION
614 THORACIC KYPHOSIS LUMBER CORDOSIS DYSFUNCTION
615 SOFT TISSUE DYSFUNCTION RIGHT SHOULDER
616 CERVICAL SPONDYLOSIS AND NEURAL INVOLVEMENT
617 ALIGNMENT OF C/SPINE POST TRAUMATIC RECURRENT NECK PAIN
618 STIFFNESS OF CERVICAL SPINE POST WHIPLASH
619 JOINT DYSFUNCTION LOWER CERVICAL REGION
620 CERVICAL JOINT AND SOFT TISSUE DYSFUNCTION
621 C/SPINE DYSFUNCTION
622 SCOLIOSIS OF T/S AND L/S POSTURAL DYSFUNCTION
623 -
624 -
625 -
626 -
627 CERVICAL SPINE DERANGEMENT
628 CERVICAL SPINE AND GLENOHUMERAL JOINT DYSFUNCTION WITH NERVE ROOT PAIN
629 -
630 CERVICAL SPINE DERANGEMENT
631 -
632 CERVICAL SPINE MULTIDIRECTIONAL DYSFUNCTION
633 POSTURAL DYSFUNCTION
634 -
635 DEGENERATIVE HYPERMOBILE CERVICAL FACET JOINT
636 -
637 DEGENERATIVE CHANGES AND ROM
638 -
639 -
640 -
641 WHIPLASH AND NEURAL IMPINGEMENT
642 RTA SIDEWAYS IMPACT, WHIPLASH
643 DEGENERATIVE C/SPINE
644 INTERMITTANT L SIDED NECK PAIN RADIATING TO HEAD
645 FELL ONTO BACK OF HEAD
646 WHIPLASH MARCH 98, NO PHYSIO, ACCIDENT WHICH JARRED SPINE 1/12
647 RTA MARCH 98
648 RESOLVING C/SPINE DYSFUNCTION WITH NERVE IMPINGEMENT
649 FACET JOINT AGGRAVATED BY POSTURE AND NEURAL
650 POSTURAL DYSFUNCTION PLUS WEAR AND TEAR
651 MULTIPLE JOINT RESISTENCE AND TENSION AND HYPERVENTILATING
652 FACET JOINT DYSFUNCTION C5 C6 AND RESISTENCE C2 HEADACHES
653 BILATERAL FROZEN SHOULDER AND CERVICAL PAIN
654 DYSFUNCTION OF UPPER C/SPINE AND C5/6 DISC LESION
655 C8/T NERVE ROOT
656 CERVICAL NERVE ROOT COMPRESSION
657 CERVICAL SPONDYLOSIS
658 LEVATOR SCAPULAE PAIN
659 CERVICAL SPINE AND BRACHIAL PLEXUS TRAUMA
660 UNDERLYING WHIPLASH INJURY, EPISODE OF JOINT INFLAMMATION
661 -
662 HYPEREXTENDED CERVICAL SPINE, POOR SLEEPING POSTURE, COPD
663 -
664 #C7 FACET JOINT
665 CERVICAL SPONDYLOSIS WITH NERVE ROOT IMPINGEMENT
666 -
667 -

668 POSTURAL PAIN
669 IMPINGEMENT DUE TO POOR POSTURE
670 C6 NERVE ROOT SIGNS, SYMPTOMS SECONDARY TO DEGENERATION BUT OLD

Combination of treatment modalities for those having 3 or 4 modalities

CASE

TREATMENT 1

- 1 CYRIAX MANIPS
- 2 TRACTION
- 3 S.W.D.
- 5 CYRIAX MANIPS
- 6 S.W.D.
- 7 TRACTION
- 9 MOBILISATIONS MAITLAND
- 11 ADVICE SEL MAN/CARER
- 12 ADVICE SEL MAN/CARER
- 13 ACTIVE EXERCISES
- 15 MOBILISATIONS MAITLAND
- 16 S.W.D.
- 17 MOBILISATIONS MAITLAND
- 18 ACTIVE EXERCISES
- 19 TRACTION
- 20 INTERFERENTIAL
- 21 ADVICE SEL MAN/CARER
- 23 TRACTION
- 24 ADVICE SEL MAN/CARER
- 25 TRACTION
- 26 ADVICE SEL MAN/CARER
- 28 ADVICE SEL MAN/CARER
- 30 ACTIVE EXERCISES
- 31 ADVICE SEL MAN/CARER
- 35 MOBILISATIONS MAITLAND
- 36 MOBILISATIONS MAITLAND
- 37 MOBILISATIONS MAITLAND
- 38 ADVICE SEL MAN/CARER
- 40 ULTRASOUND
- 42 ACTIVE EXERCISES
- 43 MOBILISATIONS MAITLAND
- 44 MOBILISATIONS MAITLAND
- 45 ULTRASOUND
- 46 MOBILISATIONS MAITLAND
- 47 MOBILISATIONS MAITLAND
- 48 TEN'S
- 49 ADVICE SEL MAN/CARER
- 50 ADVICE SEL MAN/CARER

TREATMENT 2

- INTERFERENTIAL
- S.W.D.
- CYRIAX MANIPS
- MOBILISATIONS MAITLAND
- MOBILISATIONS MAITLAND
- S.W.D.
- ACTIVE EXERCISES
- ACTIVE EXERCISES
- TEN'S
- PASSIVE EXERCISES
- TRACTION
- ULTRASOUND
- S.W.D.
- MOBILISATIONS MAITLAND
- S.W.D.
- S.W.D.
- ACTIVE EXERCISES
- ACUPUNCTURE
- INTERFERENTIAL
- ADVICE SEL MAN/CARER
- ULTRASOUND
- ACTIVE EXERCISES
- MOBILISATIONS MAITLAND
- TEN'S
- ACTIVE EXERCISES
- SOFT TISSUE STRETCHES
- COMBINED MOVEMENTS
- ACTIVE EXERCISES
- MOBILISATIONS MAITLAND
- TRACTION
- RE-EDUCATION OF MUSCLES
- ULTRASOUND
- ACTIVE EXERCISES
- NEURODYNAMIC FACILITIES
- ACTIVE EXERCISES
- MOBILISATIONS MAITLAND
- ACTIVE EXERCISES
- ACTIVE EXERCISES

TREATMENT 3

- S.W.D.
- SNAGS
- MOBILISATIONS MAITLAND
- INTERFERENTIAL
- CYRIAX MANIPS
- MOBILISATIONS MAITLAND
- ULTRASOUND
- MOBILISATIONS MAITLAND
- SNAGS
- MOBILISATIONS MAITLAND
- EDUCATION AND ADVICE
- CYRIAX MANIPS
- ADVICE SEL MAN/CARER
- SNAGS
- MOBILISATIONS MAITLAND
- SNAGS
- MOBILISATIONS MAITLAND
- NEURODYNAMIC FACILITIES
- ACTIVE EXERCISES
- INTERFERENTIAL
- ACTIVE EXERCISES
- MOBILISATIONS MAITLAND
- EDUCATION AND ADVICE
- MCKENZIE APPROACH
- PASSIVE EXERCISES
- ACTIVE EXERCISES
- NEURODYNAMIC FACILITIES
- RE-EDUCATION OF MUSCLES
- ACTIVE EXERCISES
- NEURODYNAMIC FACILITIES
- EDUCATION AND ADVICE
- ACTIVE EXERCISES
- MOBILISATIONS MAITLAND
- EDUCATION AND ADVICE
- STRAPPING
- SNAGS
- TRACTION
- TRACTION

TREATMENT 4

- MOBILISATIONS MAITLAND
- ACTIVE EXERCISES
- SNAGS
- EDUCATION AND ADVICE
- MCKENZIE APPROACH
- SNAGS
- ULTRASOUND
- SNAGS
- MOBILISATIONS MAITLAND
- TRACTION
- ACTIVE EXERCISES
- EDUCATION AND ADVICE
- MOBILISATIONS MAITLAND
- ADVICE SEL MAN/CARER
- EDUCATION AND ADVICE
- ACTIVE EXERCISES
- MOBILISATIONS MAITLAND
- EDUCATION AND ADVICE
- ACTIVE EXERCISES
- EDUCATION AND ADVICE
- ACTIVE EXERCISES
- ACTIVE EXERCISES
- ACTIVE EXERCISES
- EDUCATION AND ADVICE
- ACTIVE EXERCISES
- ACTIVE EXERCISES
- EDUCATION AND ADVICE
- EDUCATION AND ADVICE
- STRAPPING
- SNAGS
- TRACTION
- TRACTION

Appendix 5

118	MOBILISATIONS MAITLAND	MESSAGE	TRIGGER POINT RELEASE	EDUCATION AND ADVICE
119	MESSAGE	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ACTIVE EXERCISES
120	SOFT TISSUE STRETCHES	MESSAGE	MANIPULATION GRADE 5	MOBILISATIONS MAITLAND
122	RE-EDUCATION OF MUSCLES	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	ACTIVE EXERCISES
123	ADVICE SEL MAN/CARER	ULTRASOUND	ACTIVE EXERCISES	MOBILISATIONS MAITLAND
125	S.W.D.	INTERFERENTIAL	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
127	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	SOFT TISSUE STRETCHES
128	ADVICE SEL MAN/CARER	S.W.D.	ACTIVE EXERCISES	RE-EDUCATION OF MUSCLES
131	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	COMBINED MOVEMENTS	
132	TRACTION	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	
135	TEN'S	EDUCATION AND ADVICE	ACTIVE EXERCISES	
136	TRACTION	ACTIVE EXERCISES	INTERFERENTIAL	
137	INTERFERENTIAL	MCKENZIE APPROACH	SNAGS	
138	TRACTION	INTERFERENTIAL	MOBILISATIONS MAITLAND	NEURODYNAMIC FACILITIES
140	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	
141	PASSIVE EXERCISES	MOBILISATIONS MAITLAND	ULTRASOUND	
143	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	
144	ADVICE SEL MAN/CARER	LOCAL HEAT (IR PP)	EDUCATION AND ADVICE	
145	ADVICE SEL MAN/CARER	MESSAGE	ACTIVE EXERCISES	PASSIVE EXERCISES
146	ADVICE SEL MAN/CARER	ULTRASOUND	ACTIVE EXERCISES	MOBILISATIONS MAITLAND
147	TEN'S	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS
149	TRACTION	MOBILISATIONS MAITLAND	MESSAGE	EDUCATION AND ADVICE
151	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	MASSAGE
153	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	COMBINED MOVEMENTS	
154	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES	ACTIVE EXERCISES	SNAGS
155	P.N.F.	TRIGGER POINT RELEASE	HYPERVENTILATION	
156	MOBILISATIONS MAITLAND	NEURODYNAMIC FACILITIES	EDUCATION AND ADVICE	
157	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	MOBILISATIONS MAITLAND
159	CYRIAX MANIPS	SNAGS	MOBILISATIONS MAITLAND	STRAPPING
160	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	SOFT TISSUE STRETCHES	EDUCATION AND ADVICE
161	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	EDUCATION AND ADVICE	
163	MOBILISATIONS MAITLAND	INTERFERENTIAL	RE-EDUCATION OF MUSCLES	TRIGGER POINT RELEASE
166	INTERFERENTIAL	ULTRASOUND	ACTIVE EXERCISES	
168	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	MOBILISATIONS MAITLAND
169	ACTIVE EXERCISES	PASSIVE EXERCISES	TRACTION	
170	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	EDUCATION AND ADVICE	
171	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS	ADVICE SEL MAN/CARER
2	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS	ADVICE SEL MAN/CARER
173	ACTIVE EXERCISES	RE-EDUCATION OF MUSCLES	EDUCATION AND ADVICE	
174	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	ACTIVE EXERCISES	
175	ADVICE SEL MAN/CARER	RE-EDUCATION OF MUSCLES	MOBILISATIONS MAITLAND	SNAGS
176	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND

179	ULTRASOUND	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	
180	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	PASSIVE EXERCISES
181	ADVICE SEL MAN/CARER	TENS	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
182	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS	STRAPPING
183	MOBILISATIONS MAITLAND	SNAGS	EDUCATION AND ADVICE	EDUCATION AND ADVICE
184	MOBILISATIONS MAITLAND	NEURODYNAMIC FACILITIES	ULTRASOUND	
185	MCKENZIE APPROACH	SNAGS	EDUCATION AND ADVICE	
187	ADVICE SEL MAN/CARER	NEURODYNAMIC FACILITIES	ULTRASOUND	
189	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	
191	S.W.D.	SNAGS	TRACTION	
192	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	TRACTION	S.W.D.
193	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	TRACTION
194	S.W.D.	ADVICE SEL MAN/CARER	EDUCATION AND ADVICE	
195	ADVICE SEL MAN/CARER	ULTRASOUND	STRAPPING	
196	ACTIVE EXERCISES	TRACTION	EDUCATION AND ADVICE	INTERFERENTIAL
198	TENS	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	
199	MOBILISATIONS MAITLAND	S.W.D.	MESSAGE	
202	NEURODYNAMIC FACILITIES	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	EDUCATION AND ADVICE
203	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	PASSIVE EXERCISES	TRACTION
207	MESSAGE	MOBILISATIONS MAITLAND	TRACTION	ACTIVE EXERCISES
209	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	
212	TRIGGER POINT RELEASE	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	EDUCATION AND ADVICE
213	LOCAL HEAT (IR PP)	MCKENZIE APPROACH	SNAGS	ACTIVE EXERCISES
214	SOFT TISSUE STRETCHES	MOBILISATIONS MAITLAND	MANIPULATION GRADE 5	EDUCATION AND ADVICE
215	INTERFERENTIAL	ACTIVE EXERCISES	EDUCATION AND ADVICE	ACTIVE EXERCISES
216	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES	EDUCATION AND ADVICE	MCKENZIE APPROACH
217	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES	EDUCATION AND ADVICE
218	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	EDUCATION AND ADVICE	ACTIVE EXERCISES
219	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES	MANIPULATION GRADE 5
220	RE-EDUCATION OF MUSCLES	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	
221	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	ACTIVE EXERCISES	ADVICE SEL MAN/CARER
222	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER
223	ULTRASOUND	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	STRAPPING
225	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	MOBILISATIONS MAITLAND
226	SNAGS	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
227	ADVICE SEL MAN/CARER	ULTRASOUND	PASSIVE EXERCISES	MOBILISATIONS MAITLAND
230	ADVICE SEL MAN/CARER	TRACTION	SNAGS	MOBILISATIONS MAITLAND
231	MOBILISATIONS MAITLAND	SNAGS	EDUCATION AND ADVICE	
232	MANIPULATION GRADE 5	ACTIVE EXERCISES	EDUCATION AND ADVICE	
235	TRACTION	S.W.D.	SNAGS	
236	MOBILISATIONS MAITLAND	ULTRASOUND	EDUCATION AND ADVICE	MOBILISATIONS MAITLAND
237	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	ADVICE SEL MAN/CARER	

238	MOBILISATIONS MAITLAND ULTRASOUND	ADVICE SEL MAN/CARER MOBILISATIONS MAITLAND ULTRASOUND	ACTIVE EXERCISES ADVICE SEL MAN/CARER ACTIVE EXERCISES
239	EDUCATION AND ADVICE	ULTRASOUND	ACTIVE EXERCISES
240	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	ACTIVE EXERCISES
241	EDUCATION AND ADVICE	MOBILISATIONS MAITLAND	TRACTION
242	ACTIVE EXERCISES	S.W.D.	EDUCATION AND ADVICE
243	MCKENZIE APPROACH	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
244	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	TEN'S
245	ACTIVE EXERCISES	EDUCATION AND ADVICE	PASSIVE EXERCISES
246	ULTRASOUND	ACTIVE EXERCISES	MCKENZIE APPROACH
247	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	PASSIVE EXERCISES
248	ADVICE SEL MAN/CARER	ULTRASOUND	MCKENZIE APPROACH
249	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	PASSIVE EXERCISES
250	MOBILISATIONS MAITLAND	SNAGS	MANIPULATION GRADE 5
251	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	SOFT TISSUE STRETCHES
252	MOBILISATIONS MAITLAND	ULTRASOUND	ADVICE SEL MAN/CARER
253	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ACTIVE EXERCISES
254	ADVICE SEL MAN/CARER	SNAGS	MOBILISATIONS MAITLAND
255	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	EDUCATION AND ADVICE
256	MOBILISATIONS MAITLAND	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
257	MOBILISATIONS MAITLAND	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
258	INTERFERENTIAL	ADVICE SEL MAN/CARER	RE-EDUCATION OF MUSCLES
259	NEURODYNAMIC FACILITIES	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
260	TRIGGER POINT RELEASE	ADVICE SEL MAN/CARER	ACTIVE EXERCISES
261	MESSAGE	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
262	SNAGS	EDUCATION AND ADVICE	ACTIVE EXERCISES
263	NEURODYNAMIC FACILITIES	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES
264	ADVICE SEL MAN/CARER	ULTRASOUND	MCKENZIE APPROACH
265	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	ACTIVE EXERCISES
266	TRACTION	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE
267	MOBILISATIONS MAITLAND	TRACTION	ULTRASOUND
268	ULTRASOUND	S.W.D.	MOBILISATIONS MAITLAND
269	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE
270	MOBILISATIONS MAITLAND	INTERFERENTIAL	NEURODYNAMIC FACILITIES
271	ADVICE SEL MAN/CARER	LOCAL HEAT (IR PP)	ACTIVE EXERCISES
272	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SOFT TISSUE STRETCHES
273	ULTRASOUND	MESSAGE	MOBILISATIONS MAITLAND
274	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	SOFT TISSUE STRETCHES
275	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	TRIGGER POINT RELEASE
276	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	ULTRASOUND
277	MOBILISATIONS MAITLAND	S.W.D.	CYRIAX MANIPS
278	ACTIVE EXERCISES	MCKENZIE APPROACH	SNAGS
279	MOBILISATIONS MAITLAND	MOBILISATIONS MAITLAND	S.W.D.
280	ADVICE SEL MAN/CARER	ULTRASOUND	ACTIVE EXERCISES
281	ADVICE SEL MAN/CARER	ULTRASOUND	ACTIVE EXERCISES
282	ULTRASOUND	ULTRASOUND	ULTRASOUND
283	MOBILISATIONS MAITLAND	ULTRASOUND	CYRIAX MANIPS
284	ADVICE SEL MAN/CARER	ULTRASOUND	SNAGS
285	MOBILISATIONS MAITLAND	ULTRASOUND	S.W.D.
286	MOBILISATIONS MAITLAND	ULTRASOUND	ACTIVE EXERCISES
287	MOBILISATIONS MAITLAND	ULTRASOUND	ACTIVE EXERCISES
288	ACTIVE EXERCISES	ULTRASOUND	ACTIVE EXERCISES
289	ULTRASOUND	ULTRASOUND	ACTIVE EXERCISES
290	ADVICE SEL MAN/CARER	ULTRASOUND	ACTIVE EXERCISES

291	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND	NEURODYNAMIC FACILITIES
292	TRACTION	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	SNAGS
293	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES	SNAGS
294	ACTIVE EXERCISES	EDUCATION AND ADVICE	MCKENZIE APPROACH	
295	ULTRASOUND	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES
296	S.W.D.	ICE	ACTIVE EXERCISES	EDUCATION AND ADVICE
297	MOBILISATIONS MAITLAND	TRACTION	SNAGS	ULTRASOUND
298	MOBILISATIONS MAITLAND	ULTRASOUND	MCKENZIE APPROACH	ACTIVE EXERCISES
299	ADVICE SEL MAN/CARER	LOCAL HEAT (IR PP)	MCKENZIE APPROACH	ULTRASOUND
300	S.W.D.	SNAGS	ACTIVE EXERCISES	SOFT TISSUE STRETCHES
301	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	EDUCATION AND ADVICE	ULTRASOUND
302	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	EDUCATION AND ADVICE	
303	S.W.D.	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES
304	S.W.D.	ACTIVE EXERCISES	SOFT TISSUE STRETCHES	EDUCATION AND ADVICE
307	INTERFERENTIAL	EDUCATION AND ADVICE	ACTIVE EXERCISES	MOBILISATIONS MAITLAND
308	S.W.D.	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES
311	ACTIVE EXERCISES	ICE	SOFT TISSUE STRETCHES	EDUCATION AND ADVICE
312	ICE	SOFT TISSUE STRETCHES	TRACTION	ULTRASOUND
313	MCKENZIE APPROACH	MOBILISATIONS MAITLAND	ULTRASOUND	
314	ADVICE SEL MAN/CARER	S.W.D.	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
315	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	INTERFERENTIAL
316	S.W.D.	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	EDUCATION AND ADVICE
317	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS
318	S.W.D.	ULTRASOUND	MOBILISATIONS MAITLAND	
319	MOBILISATIONS MAITLAND	TRACTION	S.W.D.	
320	EDUCATION AND ADVICE	STRAPPING	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
322	NEURODYNAMIC FACILITIES	ACUPUNCTURE	TRIGGER POINT RELEASE	ACTIVE EXERCISES
323	TRACTION	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ACUPUNCTURE
325	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	TRIGGER POINT RELEASE
326	LOCAL HEAT (IR PP)	ACUPUNCTURE	RE-EDUCATION OF MUSCLES	EDUCATION AND ADVICE
329	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	ACTIVE EXERCISES	
331	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS
332	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ADVICE SEL MAN/CARER
333	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	RE-EDUCATION OF MUSCLES	EDUCATION AND ADVICE
334	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS
335	ADVICE SEL MAN/CARER	PASSIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS
336	MOBILISATIONS MAITLAND	SNAGS	EDUCATION AND ADVICE	LOCAL HEAT (IR PP)
337	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	EDUCATION AND ADVICE
338	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ULTRASOUND	
339	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	RE-EDUCATION OF MUSCLES	EDUCATION AND ADVICE
343	ADVICE SEL MAN/CARER	TRACTION	PASSIVE EXERCISES	ACTIVE EXERCISES
344	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	ULTRASOUND	EDUCATION AND ADVICE

346	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	ULTRASOUND	NEURODYNAMIC FACILITIES
347	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MASSAGE	
348	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	PASSIVE EXERCISES	
349	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND	
353	ULTRASOUND	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS
354	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND	
358	ADVICE SEL MAN/CARER	ULTRASOUND	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
359	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	MOBILISATIONS MAITLAND	COMBINED MOVEMENTS
360	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MCKENZIE APPROACH	SNAGS
361	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	ADVICE SEL MAN/CARER	ACTIVE EXERCISES
362	LOCAL HEAT (IR PP)	ACTIVE EXERCISES	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES
363	ACTIVE EXERCISES	LOCAL HEAT (IR PP)	ULTRASOUND	EDUCATION AND ADVICE
366	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	ADVICE SEL MAN/CARER	ACTIVE EXERCISES
367	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE
368	MCKENZIE APPROACH	EDUCATION AND ADVICE	REIKI	
369	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES	RE-EDUCATION OF MUSCLES	
370	MCKENZIE APPROACH	TRACTION	EDUCATION AND ADVICE	
371	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	TRACTION	ADVICE SEL MAN/CARER
372	TRACTION	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	EDUCATION AND ADVICE
373	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
374	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	
377	ULTRASOUND	ACTIVE EXERCISES	MCKENZIE APPROACH	MOBILISATIONS MAITLAND
378	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	ACTIVE EXERCISES
380	SNAGS	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	
384	INTERFERENTIAL	ULTRASOUND	EDUCATION AND ADVICE	
385	MOBILISATIONS MAITLAND	INTERFERENTIAL	EDUCATION AND ADVICE	ACTIVE EXERCISES
386	ADVICE SEL MAN/CARER	EDUCATION AND ADVICE	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
388	EDUCATION AND ADVICE	INTERFERENTIAL	TEN'S	ACTIVE EXERCISES
393	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	EDUCATION AND ADVICE	
395	EDUCATION AND ADVICE	MOBILISATIONS MAITLAND	ULTRASOUND	
396	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	
397	INTERFERENTIAL	ULTRASOUND	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
398	AROMATHERAPY	MCKENZIE APPROACH	SNAGS	
399	MOBILISATIONS MAITLAND	MANIPULATION GRADE 5	SNAGS	TRIGGER POINT RELEASE
400	ADVICE SEL MAN/CARER	TRACTION	SOFT TISSUE STRETCHES	
402	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	TRACTION	
403	ACTIVE EXERCISES	PASSIVE EXERCISES	TRACTION	
404	ACTIVE EXERCISES	PASSIVE EXERCISES	MOBILISATIONS MAITLAND	MOBILISATIONS MAITLAND
405	MOBILISATIONS MAITLAND	MANIPULATION GRADE 5	EDUCATION AND ADVICE	SNAGS
406	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES
407	MOBILISATIONS MAITLAND	SNAGS	RE-EDUCATION OF MUSCLES	
408	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	

409	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	EDUCATION AND ADVICE	RE-EDUCATION OF MUSCLES
410	SNAGS	ACTIVE EXERCISES	EDUCATION AND ADVICE	ADVICE SEL MAN/CARER
411	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES	ACTIVE EXERCISES	MOBILISATIONS MAITLAND
413	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SOFT TISSUE STRETCHES	ADVICE SEL MAN/CARER
415	MOBILISATIONS MAITLAND	SNAGS	ACTIVE EXERCISES	ADVICE SEL MAN/CARER
416	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	RE-EDUCATION OF MUSCLES	
418	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	EDUCATION AND ADVICE	
419	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	EDUCATION AND ADVICE	
420	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	
421	EDUCATION AND ADVICE	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	
422	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	EDUCATION AND ADVICE	ACTIVE EXERCISES
423	EDUCATION AND ADVICE	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	TRIGGER POINT RELEASE
424	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	RE-EDUCATION OF MUSCLES
425	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
427	EDUCATION AND ADVICE	TRACTION	ACTIVE EXERCISES	
428	ACTIVE EXERCISES	RE-EDUCATION OF MUSCLES	TRACTION	
429	ACTIVE EXERCISES	PASSIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
431	ADVICE SEL MAN/CARER	ULTRASOUND	TRACTION	MOBILISATIONS MAITLAND
432	ACTIVE EXERCISES	SOFT TISSUE STRETCHES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
433	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	MESSAGE
434	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES
435	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ULTRASOUND
436	TRACTION	CYRIAX MANIPS	ACTIVE EXERCISES	
437	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	SNAGS	EDUCATION AND ADVICE
438	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	
439	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	COMBINED MOVEMENTS	EDUCATION AND ADVICE
440	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS	EDUCATION AND ADVICE
441	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	
442	EDUCATION AND ADVICE	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND
443	SNAGS	EDUCATION AND ADVICE	ACTIVE EXERCISES	
444	EDUCATION AND ADVICE	TRACTION	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
445	EDUCATION AND ADVICE	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	
446	ADVICE SEL MAN/CARER	LOCAL HEAT (IR PP)	SNAGS	ACTIVE EXERCISES
447	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS	EDUCATION AND ADVICE
448	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	EDUCATION AND ADVICE
449	ADVICE SEL MAN/CARER	SNAGS	EDUCATION AND ADVICE	
450	EDUCATION AND ADVICE	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES
451	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES	
458	ULTRASOUND	LASER	MCKENZIE APPROACH	
459	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	
460	S.W.D.	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	
461	MOBILISATIONS MAITLAND	MCKENZIE APPROACH	ACTIVE EXERCISES	

462	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	LOCAL HEAT (IR PP)	EDUCATION AND ADVICE
463	MOBILISATIONS MAITLAND	STRAPPING	NEURODYNAMIC FACILITIES	MOBILISATIONS MAITLAND
464	TEN'S	MCKENZIE APPROACH	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
465	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES	MOBILISATIONS MAITLAND
467	LOCAL HEAT (IR PP)	ACTIVE EXERCISES	PASSIVE EXERCISES	EDUCATION AND ADVICE
469	LOCAL HEAT (IR PP)	ACTIVE EXERCISES	SNAGS	ACTIVE EXERCISES
470	EDUCATION AND ADVICE	TRIGGER POINT RELEASE	MOBILISATIONS MAITLAND	MOBILISATIONS MAITLAND
472	SNAGS	ACTIVE EXERCISES	EDUCATION AND ADVICE	ACTIVE EXERCISES
473	LOCAL HEAT (IR PP)	ACTIVE EXERCISES	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES
474	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	EDUCATION AND ADVICE
475	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES	EDUCATION AND ADVICE
476	ULTRASOUND	ACTIVE EXERCISES	EDUCATION AND ADVICE	EDUCATION AND ADVICE
477	EDUCATION AND ADVICE	MCKENZIE APPROACH	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE
478	LOCAL HEAT (IR PP)	MCKENZIE APPROACH	ACTIVE EXERCISES	EDUCATION AND ADVICE
479	ULTRASOUND	ACTIVE EXERCISES	MCKENZIE APPROACH	EDUCATION AND ADVICE
480	INTERFERENTIAL	LOCAL HEAT (IR PP)	MCKENZIE APPROACH	EDUCATION AND ADVICE
481	MCKENZIE APPROACH	SNAGS	EDUCATION AND ADVICE	EDUCATION AND ADVICE
483	MOBILISATIONS MAITLAND	SNAGS	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES
484	SOFT TISSUE STRETCHES	EDUCATION AND ADVICE	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES
485	ACTIVE EXERCISES	PASSIVE EXERCISES	TRACTION	INTERFERENTIAL
486	TRIGGER POINT RELEASE	SOFT TISSUE STRETCHES	MANIPULATION GRADE 5	SNAGS
488	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS	SOFT TISSUE STRETCHES
489	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	SNAGS	STRAPPING
490	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	SNAGS	MOBILISATIONS MAITLAND
491	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	TRACTION	ACUPUNCTURE
492	ADVICE SEL MAN/CARER	TEN'S	MOBILISATIONS MAITLAND	MOBILISATIONS MAITLAND
494	ADVICE SEL MAN/CARER	TEN'S	LOCAL HEAT (IR PP)	SNAGS
495	ADVICE SEL MAN/CARER	LOCAL HEAT (IR PP)	MOBILISATIONS MAITLAND	TRACTION
496	ADVICE SEL MAN/CARER	TEN'S	LOCAL HEAT (IR PP)	PASSIVE EXERCISES
497	TEN'S	FRICTIONS	INTERFERENTIAL	SOFT TISSUE STRETCHES
498	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	CYRIAX MANIPS	TRACTION
499	INTERFERENTIAL	ACTIVE EXERCISES	ACUPUNCTURE	SOFT TISSUE STRETCHES
500	ACTIVE EXERCISES	TEN'S	TRACTION	TRACTION
501	ADVICE SEL MAN/CARER	TEN'S	MOBILISATIONS MAITLAND	SNAGS
502	EDUCATION AND ADVICE	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	MOBILISATIONS MAITLAND
503	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	LOCAL HEAT (IR PP)
504	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	EDUCATION AND ADVICE	
505	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ULTRASOUND	
506	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	ULTRASOUND	
507	MOBILISATIONS MAITLAND	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	
509	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	TRACTION	MOBILISATIONS MAITLAND
511	ADVICE SEL MAN/CARER	INTERFERENTIAL	ACTIVE EXERCISES	MOBILISATIONS MAITLAND

512	MOBILISATIONS MAITLAND	SNAGS	LOCAL HEAT (IR PP)	EDUCATION AND ADVICE
513	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS
515	MOBILISATIONS MAITLAND	PASSIVE EXERCISES	ACTIVE EXERCISES	
516	MOBILISATIONS MAITLAND	NEURODYNAMIC FACILITIES	EDUCATION AND ADVICE	
518	PASSIVE EXERCISES	NEURODYNAMIC FACILITIES	EDUCATION AND ADVICE	
520	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND	
524	MOBILISATIONS MAITLAND	MASSAGE	STRAPPING	
525	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	ULTRASOUND	
526	TRACTION	MASSAGE	EDUCATION AND ADVICE	
527	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ULTRASOUND	
530	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	APPLIANCE FITTING	EDUCATION AND ADVICE
531	ULTRASOUND	ADVICE SEL MAN/CARER	TRIGGER POINT RELEASE	EDUCATION AND ADVICE
532	SNAGS	EDUCATION AND ADVICE	ACTIVE EXERCISES	
534	ADVICE SEL MAN/CARER	ULTRASOUND	ACTIVE EXERCISES	MOBILISATIONS MAITLAND
535	EDUCATION AND ADVICE	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	
539	MOBILISATIONS MAITLAND	MASSAGE	EDUCATION AND ADVICE	
545	RE-EDUCATION OF MUSCLES	INTERFERENTIAL	ULTRASOUND	LOCAL HEAT (IR PP)
546	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	EDUCATION AND ADVICE	ULTRASOUND
547	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	INTERFERENTIAL	TRACTION
549	S.W.D.	MOBILISATIONS MAITLAND	SNAGS	EDUCATION AND ADVICE
551	MCKENZIE APPROACH	CYRIAX MANIPS	SOFT TISSUE STRETCHES	ADVICE SEL MAN/CARER
552	EDUCATION AND ADVICE	MCKENZIE APPROACH	ACUPUNCTURE	
553	MOBILISATIONS MAITLAND	NEURODYNAMIC FACILITIES	TRACTION	TRIGGER POINT RELEASE
554	INTERFERENTIAL	EDUCATION AND ADVICE	ACUPUNCTURE	
555	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	ACUPUNCTURE	
556	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	TEN'S	EDUCATION AND ADVICE
557	ULTRASOUND	ACTIVE EXERCISES	RE-EDUCATION OF MUSCLES	
558	ADVICE SEL MAN/CARER	TEN'S	LOCAL HEAT (IR PP)	TRACTION
562	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	ULTRASOUND	
563	MASSAGE	MOBILISATIONS MAITLAND	MANIPULATION GRADE 5	SNAGS
564	TRACTION	SNAGS	MOBILISATIONS MAITLAND	
565	ADVICE SEL MAN/CARER	LOCAL HEAT (IR PP)	TRACTION	EDUCATION AND ADVICE
566	ADVICE SEL MAN/CARER	TRACTION	MASSAGE	EDUCATION AND ADVICE
567	S.W.D.	ACTIVE EXERCISES	MASSAGE	MOBILISATIONS MAITLAND
568	ADVICE SEL MAN/CARER	TRACTION	HYDROTHERAPY	MASSAGE
569	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	ULTRASOUND	EDUCATION AND ADVICE
570	ULTRASOUND	FRICTIONS	ADVICE SEL MAN/CARER	EDUCATION AND ADVICE
571	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	EDUCATION AND ADVICE	
572	ADVICE SEL MAN/CARER	LOCAL HEAT (IR PP)	TRACTION	PASSIVE EXERCISES
573	EDUCATION AND ADVICE	S.W.D.	MOBILISATIONS MAITLAND	ACTIVE EXERCISES
574	ADVICE SEL MAN/CARER	S.W.D.	ULTRASOUND	ACTIVE EXERCISES
575	ADVICE SEL MAN/CARER	PASSIVE EXERCISES	MOBILISATIONS MAITLAND	ULTRASOUND

576	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	NEURODYNAMIC FACILITIES	INTERFERENTIAL
577	ADVICE SEL MAN/CARER	ULTRASOUND	ACTIVE EXERCISES	MOBILISATIONS MAITLAND
578	ADVICE SEL MAN/CARER	TRACTION	SNAGS	ULTRASOUND
583	MOBILISATIONS MAITLAND	PASSIVE EXERCISES	EDUCATION AND ADVICE	
584	MOBILISATIONS MAITLAND	MESSAGE	TRIGGER POINT RELEASE	
585	MOBILISATIONS MAITLAND	TRIGGER POINT RELEASE	ULTRASOUND	
587	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES	EDUCATION AND ADVICE	
588	MOBILISATIONS MAITLAND	MESSAGE	ACTIVE EXERCISES	
590	SNAGS	TRIGGER POINT RELEASE	EDUCATION AND ADVICE	
591	MESSAGE	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	EDUCATION AND ADVICE
594	ADVICE SEL MAN/CARER	TEN'S	MOBILISATIONS MAITLAND	MESSAGE
595	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	NEURODYNAMIC FACILITIES	SNAGS
596	MOBILISATIONS MAITLAND	TRACTION	ACTIVE EXERCISES	ADVICE SEL MAN/CARER
597	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ULTRASOUND	
599	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	ACTIVE EXERCISES	
600	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	
601	SNAGS	NEURODYNAMIC FACILITIES	SOFT TISSUE STRETCHES	ACTIVE EXERCISES
602	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	ACUPUNCTURE
603	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS	TRIGGER POINT RELEASE
604	MCKENZIE APPROACH	ULTRASOUND	STRAPPING	
606	S.W.D.	SOFT TISSUE STRETCHES	ACTIVE EXERCISES	
607	MOBILISATIONS MAITLAND	TRACTION	SNAGS	EDUCATION AND ADVICE
608	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	
609	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS	EDUCATION AND ADVICE
610	TRACTION	ADVICE SEL MAN/CARER	EDUCATION AND ADVICE	MOBILISATIONS MAITLAND
611	ADVICE SEL MAN/CARER	SOFT TISSUE STRETCHES	S.W.D.	EDUCATION AND ADVICE
613	ULTRASOUND	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	MOBILISATIONS MAITLAND
615	ULTRASOUND	ACTIVE EXERCISES	EDUCATION AND ADVICE	EDUCATION AND ADVICE
616	ULTRASOUND	ACTIVE EXERCISES	PASSIVE EXERCISES	APPLIANCE FITTING
618	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND
619	TRACTION	SNAGS	ACTIVE EXERCISES	EDUCATION AND ADVICE
620	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	
622	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND
624	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	ACUPUNCTURE	TRACTION
628	MOBILISATIONS MAITLAND	NEURODYNAMIC FACILITIES	ACUPUNCTURE	
633	ACTIVE EXERCISES	SNAGS	NEURODYNAMIC FACILITIES	EDUCATION AND ADVICE
634	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	RE-EDUCATION OF MUSCLES	
635	ADVICE SEL MAN/CARER	SOFT TISSUE STRETCHES	NEURODYNAMIC FACILITIES	MOBILISATIONS MAITLAND
636	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	TRACTION	MOBILISATIONS MAITLAND
638	ACUPUNCTURE	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	
641	EDUCATION AND ADVICE	ULTRASOUND	MOBILISATIONS MAITLAND	
642	MCKENZIE APPROACH	S.W.D.	EDUCATION AND ADVICE	MCKENZIE APPROACH

643	MCKENZIE APPROACH	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	
645	S.W.D.	ACTIVE EXERCISES	EDUCATION AND ADVICE	
646	ACTIVE EXERCISES	EDUCATION AND ADVICE	P.N.F.	PASSIVE EXERCISES
647	LOCAL HEAT (IR PP)	TRACTION	RE-EDUCATION OF MUSCLES	
650	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	SNAGS
651	ADVICE SEL MAN/CARER	MOBILISATIONS MAITLAND	SNAGS	TRIGGER POINT RELEASE
652	MOBILISATIONS MAITLAND	SOFT TISSUE STRETCHES	ACTIVE EXERCISES	
654	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	
655	MOBILISATIONS MAITLAND	ACTIVE EXERCISES	ADVICE SEL MAN/CARER	
656	TRACTION	MOBILISATIONS MAITLAND	ULTRASOUND	
657	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	ACTIVE EXERCISES	
658	ADVICE SEL MAN/CARER	ACUPUNCTURE	ULTRASOUND	TEN'S
659	ULTRASOUND	SNAGS	S.W.D.	MOBILISATIONS MAITLAND
660	LOCAL HEAT (IR PP)	MOBILISATIONS MAITLAND	ULTRASOUND	ACTIVE EXERCISES
662	S.W.D.	MCKENZIE APPROACH	ADVICE SEL MAN/CARER	
663	ULTRASOUND	MCKENZIE APPROACH	MOBILISATIONS MAITLAND	
664	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	MOBILISATIONS MAITLAND	S.W.D.
665	TRACTION	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	
666	ADVICE SEL MAN/CARER	ACTIVE EXERCISES	TRIGGER POINT RELEASE	SNAGS
667	ULTRASOUND	ACTIVE EXERCISES	EDUCATION AND ADVICE	TRACTION
669	EDUCATION AND ADVICE	ULTRASOUND	ACTIVE EXERCISES	
671	MOBILISATIONS MAITLAND	EDUCATION AND ADVICE	TRACTION	
672	MOBILISATIONS MAITLAND	MCKENZIE APPROACH	EDUCATION AND ADVICE	ULTRASOUND

