

**Osteopathy and the NHS – a snapshot summary statement  
(Nov 2012)**

• **Key messages**

- Osteopathy is now featured in various clinical recommendations, notably for back pain, including the 2009 NICE guidelines for non-specific low back pain.
- A website has been developed which looks specifically at osteopathy in the NHS:  
<http://nhsosteopathy.co.uk>
- There are still very few osteopaths contracted to the NHS.
- The roll out of the Any Qualified Provider scheme means that osteopaths can apply to become service providers for back and neck pain services in the NHS. Guidance is available at the AQP Resource Centre:

<https://www.supply2health.nhs.uk/AQPResourceCentre/Pages/AQPHome.aspx>

**Context**

Published studies have documented that access to osteopathic treatment occurs through a variety of locations in addition to private practices including NHS hospital outpatient departments, General Practices (GPs) and clinics attached to osteopathic education institutions<sup>1,2,3</sup>. In 2009 The British Osteopathic Association (BOA)<sup>4</sup> gained and analysed information from each primary care trust in England regarding the provision of osteopathic treatment. They found that fewer than 100 osteopaths or practices were contracted to the NHS and that only 16% of PCTs allowed GPs to refer patients for osteopathic treatment on the NHS. The BOA found that in PCTs where osteopathy was offered as an option, the number of patients referred have increased each year, which may suggest that patients and GPs are happy with the service<sup>4</sup>.

Osteopathy has now featured in a range of clinical recommendations, notably for back pain<sup>5,6</sup>.

- Clinical Standards Advisory Group (CSAG).
- European back pain guidelines ([www.backpaineurope.org](http://www.backpaineurope.org))<sup>7,8</sup>.
- National Institute for Health and Clinical Excellence (NICE) – Non-specific low back pain.

The NICE guidelines reviewed evidence looking at the acute management of chronic non-specific low back pain; this looked specifically at back pain that lasting longer than six weeks but not more than thirteen months<sup>9</sup>. The guidelines produced information concerning a variety of different treatments and approaches for patients with non-specific low back pain. This includes up to 9 sessions of manual therapy treatment which includes osteopathy.

The inclusion of osteopathy in national and international guidelines has facilitated the work of osteopaths in the NHS. A new website has been developed which looks specifically at osteopathy in the NHS and can be found at <http://nhsosteopathy.co.uk>. This article will look at a small selection of more recently published studies related to osteopathic practise in the NHS.

Since April 2012 The Any Qualified Provider scheme has been in place to offer patients a choice of service providers for certain conditions<sup>10</sup>. Osteopaths can apply to become service providers for Back and Neck Pain services and this has been done in NHS North East Essex. Patients are able to choose from 20 different providers of manual therapy, five of which are osteopathy providers<sup>11</sup>.

## **Studies**

In 2003, medically-qualified osteopath, Nefyn William<sup>12</sup> undertook a pragmatic trial for spinal pain in primary care for patients experiencing back pain from between 2 and 12 weeks. The study concluded that a primary care osteopathy clinic improved short-term physical and longer term psychological outcomes, at little extra cost to normal GP care. Rigorous multicentre studies are now indicated to assess the generalisability of this approach. A cost-utility analysis was undertaken for this study concluding that a primary care osteopathy clinic may be a cost-effective addition to usual general practice (GP) care<sup>13</sup>. A relative improvement in the mean quality-adjusted life-years (QALYs) for

the osteopathy treatment group versus usual GP practice care was noted. This was associated with a small increase in mean health service costs. However, a larger scale study will be required to further investigate the economic benefits.

In 2004, funding was awarded by the Medical Research Council for the United Kingdom Back Pain, Exercise and Manipulation (UK BEAM) randomised trial<sup>14</sup>. This looked at how a package of care involving one or a combination of treatment approaches could improve low back pain in patients. The study concluded that the combination of spinal manipulation (delivered by osteopaths, physiotherapists or chiropractors) and exercise was more beneficial than when the treatments were used in isolation, and when compared to “best care” offered through general practice. An economic evaluation was made for this study and this concluded that adding spinal manipulation to “best care” was a cost effective way to manage back pain in general practice<sup>15</sup>. Further analysis of the UK BEAM trial data was undertaken by Froud *et al*<sup>16</sup>, who examined the number needed to treat (NNT) from this randomised controlled trial (RCT). This work identified that in contrast to the small mean differences originally reported, NNTs were small and could be attractive to clinicians, patients, and purchasers.

Osteopaths Mike Hopkins and Charles Peers<sup>17</sup> were involved in the study published by Gurry in 2004 which looked at a multidisciplinary setting within Plymouth Primary Care Trust (PCT). It found that the return to work time was quicker using this service, which included osteopaths, than GP and physiotherapy services alone. An audit of the service revealed that 84% of patients with low back pain can be managed without the need for hospital referral; this represents a considerable saving for the PCT. Charles Peers has described an NHS audit in detail in the *NCOR Audit Handbook for Practising Osteopaths* available via the O-zone.

Chown *et al*<sup>18</sup> more recently attempted to investigate the difference in outcome between patients being treated with group exercise, physiotherapy or osteopathy in a hospital setting. The interventions offered in this prospective study were group exercises led by a physiotherapist, a one-to-one session with a (predominantly manipulative) physiotherapist, and a one-to-one session with an osteopath. Outcome data was collected at baseline, 6 weeks and 12 months post discharge using the Oswestry Disability Index (ODI) the EuroQol EQ-5D (including a simple health status visual analogue scale), a shuttle walk test (SWT), and questions relating to life satisfaction and satisfaction with the intervention. Attendance levels were greatest for osteopathy (80%). The mean change in ODI score for osteopathy participants exceeded that of physiotherapy participants by 0.84 (95% CI -0.35 to 5.2). The drop-out rate at this stage of the study was found to be less among the osteopathy group; a number of reasons have been suggested for this including more flexible appointment schedule, patients' preference for hands-on treatment, personal characteristics, or past experience within private practice.

The creation of the recent fellowship by the British Osteopathic Association has seen another osteopath become involved in the NHS through work at the Queen's Medical Centre, Nottingham. Many of the osteopathic educational institutions have been involved also in NHS care for a number of years. The small, but growing band of osteopaths in the NHS will make osteopathic care increasingly more accessible to patients unable to attend private practice.

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