THE CONTRIBUTION OF PHYSIOTHERAPY TO COMMUNITY SERVICE PROVISION

Joint Publication between
Welsh Physiotherapy Leaders Advisory Group
Chartered Society of Physiotherapy Welsh Board

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Physiotherapy provides an important contribution to the successful delivery of community services, preventing ill health, providing intervention and rehabilitation when injury or ill health occurs, promoting independence and supporting those who live with chronic conditions. Physiotherapists deliver health care across the whole patient journey, in every community setting and from the cradle to end of life. Services work with partner organisations in social care and education to achieve optimum outcomes for each individual.

Work undertaken by the Welsh Physiotherapy Leaders Advisory Group in 2011 demonstrated that 67.6% of physiotherapy services, across the 7 health boards were found to be in level 1 and level 2 of the Welsh Chronic Conditions Model – i.e. health promotion and prevention, outpatient and community based services, including community beds.¹ ²

Defining ‘Community’

For the purpose of this paper ‘community’ services refers to all areas as set out in the Welsh Government Guidelines for the collection of Therapy Services Data in Wales (2010)³, in essence, all services which are external to the secondary care hospital environment. Services which ‘in-reach’ to acute hospitals, musculo skeletal (MSK) clinics (which might, by necessity be delivered out of a secondary care facility but will still be considered as community services), services in people’s own homes, in care homes (residential and nursing), services in local Government (leisure facilities), education facilities, services in partnership with local Government eg reablement and services provided within or from community hospitals.

The guidelines define a community patient as one who, whilst in receipt of services, is not an inpatient or day case patient. The contact may take place in the patient’s home, in a health centre, or other community setting, or in a department located in hospital premises. Community patients will also encompass those seen in schools and GP surgeries. Day hospital patients are included in this definition. A community patient is a patient previously referred to in therapy services as an out-patient.

² AWPM (2011) Briefing paper on the provision of physiotherapy services in NHS Wales (unpublished)
Describing Physiotherapy

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity; to support people in managing their own condition and maintaining their independence; and to prevent future episodes of ill health and disability. This may involve the provision of specialist equipment, mobility aids, splints and supports. The scope of practice for community physiotherapists has expanded. Examples include the use of intra-articular injection therapy for pain management in community MSK assessment and treatment services, the prescription of mechanical positive pressure devices to assist patients with acute respiratory illness or chronic neuromuscular conditions and the injection of botulinum toxin to help with the management of spasticity. Physiotherapists are also often key workers who pull together and coordinate multi-disciplinary community care for complex patients.

Physiotherapists and their teams work with a wide range of population groups (including children and young people, those of working age and older people); across sectors; and in hospital, schools, colleges, educational settings, community and workplace settings. Physiotherapists facilitate early intervention, support self-management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.

The Welsh Physiotherapy Leaders Advisory Group and CSP Welsh Board Community Services Contribution sub-group consider physiotherapy services in the community specifically address:

- Early recognition of problems and timely intervention
- Admission prevention and facilitated discharge
- Rehabilitation
- Prevention, education and self-management
- Support for chronic conditions
- Leadership of multi-agency/disciplinary teams.

Early Recognition of Problems and Timely Intervention

- Physiotherapists work with primary care in models which offer self-referral for patients to physiotherapy and which impact on the management of orthopaedic waiting lists and the management of pain and a range of MSK conditions.
- Services have progressed direct access for patients with the development of walk-in centres for direct physiotherapy access.
Physiotherapists within reablement teams respond rapidly to problems identified by families, carers, social workers, providing intervention and rehabilitation to prevent deterioration. Clinicians also signpost to other professions and third sector organisations as appropriate.

- Informing emerging diagnosis in paediatrics.
- Working with the education sector, providing physiotherapy input to schools.

Admission Prevention and Facilitated Discharge

- Physiotherapists are integral to teams developed to prevent admission to hospital such as:
  - Consultant led assessment teams
  - Therapy assessment teams in accident and emergency (A&E), clinical decision units (front door turnaround)
  - GP and consultant led frailty services
  - Rapid response, rapid access teams
  - Children’s continuing care teams
  - Complex needs clinics for children and young people.

- Development of early supported discharge (ESD) from hospital provides an opportunity for multidisciplinary teams, which include physiotherapy, to accelerate discharge and reduce hospital acquired complications. In the case of ESD for stroke this is supported by robust evidence that improves outcomes and patient/carer experience.

- Reablement teams are key to both admission prevention and facilitating early discharge. Physiotherapists form an essential element to the reablement team providing goal orientated physical rehabilitation to ensure people are able to remain as independent as possible in their own homes and return to their previous level of function e.g. walking independently to their local shops. This not only maintains their independence but has the added benefit of preventing secondary problems such as social isolation, which can have a negative effect on mental health.

- Physiotherapists work as part of MSK orthopaedic triage teams managing the orthopaedic waiting list and offering alternatives to surgery often leading to surgery avoidance. They may also work in primary care providing assessment and intervention to prevent unnecessary MSK referrals into secondary care.

- Service provision to residential and nursing care beds can prevent or delay hospital admission and maintain mobility and functional ability.

- Physiotherapists are integral to ‘intermediate care’ teams – ‘step-up’ (admission avoidance) – ‘step-down’ (rehabilitation prior to discharge from hospital) providing tailored rehabilitation.

Rehabilitation

- Physiotherapists have an important role in de-escalation of complexity for patients as described by the ANGEL taxonomy4. Improving strength, mobility,

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stamina, balance, functional skills and dexterity re-enabling independence will help people to achieve their maximal ability.

- Physiotherapy enables people of all ages (children, young people and adults) to move and function as well as they can, maximising their quality of life, potential for education and lifelong learning, social well-being, physical and mental health.
- Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity; to support people in managing their own condition and maintaining their independence; and to prevent future episodes of ill health and disability. This may involve the provision of specialist equipment, mobility aids, splints and supports.  
- People are being discharged from hospital earlier and, in many cases, may have greater (and more complex) rehabilitation needs in the community setting. This rehabilitation may be provided in a range of different settings including hydrotherapy pools, leisure centre, physiotherapy gym and treatment settings and in people’s own homes. There will be greater demands in the future for access to therapeutic exercise and rehabilitation and exercise for healthy lifestyle and wellbeing. Inadequate access to rehabilitation risks people becoming less able and also increased dependency may mean increased costs for larger care packages and greater equipment needs.

**Prevention, Education and Self-management**

- Physiotherapists interact with education services and can provide valuable support to improving a healthy lifestyle.
- Physiotherapists work with the leisure sector across a range of conditions (eg, cardiac rehabilitation, falls, back care) referring to the National Exercise Referral Scheme (NERS).
- Physiotherapists work in multidisciplinary/multi-agency falls teams. Falls management teams deliver evidence based falls and bone health programmes e.g. Otago exercise programme, to those identified as being at risk of falls. There is a strong evidence base that delivery of these programmes can prevent falls and the injuries associated with them. Physiotherapists have a strong role to play in increasing patients’ confidence in their own abilities and reducing their fear and risk of falling.

**Support for Chronic Conditions**

Chronic conditions are those which in most cases cannot be cured, only controlled, and are often life-long and limiting in terms of quality of life. Conditions can require differing levels of support due to disease progression or the fluctuating nature of the disease and require ways of dealing with them that are often quite different to acute and emergency health care.

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Many childhood illnesses develop into longer term chronic conditions, including progressive degenerative conditions now surviving into adulthood.

Physiotherapy support for people with chronic conditions takes place in any number of settings, e.g. patient’s home (including a nursing or residential home), day hospital, outpatient clinics, schools, nurseries and leisure facilities,

- Physiotherapists are key members of teams supporting people with chronic conditions in the community. They inform part of the transition process from child to adult services to support as seamless a change as possible.
- Physiotherapy teams bring skills and knowledge around complex medical, progressive degenerative conditions (MSK, neurological and respiratory) with expertise in physical symptom management, ergonomics, postural management and exercise.
- Physiotherapists play a key role in supported self management in terms of advice, education regarding trigger points for self referral, assessment, provision, monitoring and review of specialist equipment.
- People with chronic conditions are encouraged to self refer themselves back to the physiotherapist as soon as they recognise the need for further assessment and/or intervention for example, supporting people with Multiple Sclerosis (MS), which reduces the need for intervention by the GP.
- In addition to the core specialties of MSK, orthopaedics, respiratory, and neurology, physiotherapy services will be part of most specialities, including lymphoedema, cancer care, palliative care, learning disabilities, mental health, (adult, and child, adolescent and elderly). There are very few speciality areas in which physiotherapists will not be involved.
- Physiotherapy has a key role to play in supporting patients with chronic neurological conditions such as stroke, Parkinson’s disease, MS, brain injury and spinal cord injury. There will also be an important role in the conditions which are small in number e.g. Motor Neurone Disease (MND), and other conditions which will be palliative through to end of life care.
- In addition to exercise and rehabilitation, physiotherapy includes a range of modalities such as manual therapy, hydrotherapy, rebound therapy, reflex therapy and electrotherapy.
- Physiotherapy brings particular skills to community respiratory services with assessment skills, knowledge of the respiratory system and techniques employed to improve respiratory capacity and support patient self-management of their respiratory conditions. Independent prescribing will be of particular benefit to chronic respiratory conditions.
- A key element of working with people with chronic conditions will be support for families and carers. Physiotherapy offers education, practical and psychological advice and support e.g. manual handling training, motivational support. Education, advice and training are also given to formal carers in residential and nursing homes as well as to the third sector, local authority colleagues including education professionals and social service care workers.
- Community physiotherapists are expert in terms of supporting physical management programmes as part of integrating health, social, and psychological needs in a patient’s everyday life within their local community, across all ages.
- Physiotherapists can bring advice, particularly on exercise and injury prevention to lifestyle management e.g. obesity pathway, smoking cessation.
• Advanced physiotherapy practitioners in Wales are providing and leading spasticity management services for chronic neurological patients.

Leading on Multi-disciplinary/Multi-agency Teams

Physiotherapists have knowledge, skills and clinical experience to lead community teams and there are examples in practice in some key areas in Wales:

- Rehabilitation/reablement teams
- Spasticity management
- Falls management
- Complex needs clinic
- Bobath Outreach
- Hospital in-reach to accident and emergency.

What Does ‘Physiotherapy’ Bring to the Patient Experience?

• Physiotherapy training equips clinicians with an ability to assess body systems (neurological, MSK, respiratory). This, combined with sound clinical reasoning and a holistic approach, provides physiotherapists with the skills to diagnose and address patients’ problems as soon as they occur ensuring function is maintained.
• Set-up of training programmes and work experience (job rotations) within the NHS in Wales provides an opportunity for developing ‘holistic’ knowledge and skills. Whilst recognising limitations, this experience equips the physiotherapy workforce with transferable skills.
• Physiotherapy is cost effective. The profession’s ethos of restoring physical independence minimises the need for expensive adaptation and equipment. Physiotherapy intervention frequently means such equipment can be withdrawn. This approach is welcomed by patients and their families. Physical independence also reduces the frequency of secondary complications such as injuries after falls, prevents patients from becoming socially isolated.
• Physiotherapists work at all levels of clinical complexity across paediatrics and adults.
• Whilst working with others in a ‘social model of care’ physiotherapy brings a level of medical/clinical knowledge which is valuable to the team in the absence of dedicated medical staff and enhances the total management of patients and clients.
• Physiotherapy brings a ‘holistic’ assessment and functional goal planning with patients and those who care for them.
• Physiotherapists work as independent clinicians, taking referral from other clinicians or self-referral from patient and then diagnosis, treatment and management of an intervention eg MSK outpatients.
• Physiotherapists also work well as part of interdisciplinary/interagency teams. Clinicians are adept at working with others where boundaries may be blurred and roles shared to provide the best services for patients.
• Physiotherapists train other members of the multidisciplinary and multi-agency team where it is beneficial for colleague professionals to be supporting the physiotherapy programme for patients/clients. Physiotherapists also train carers and those who support patients, particularly in the area of moving and handling.
Where there is a need for 24 hour postural management programmes physiotherapists are key to advising, training, assessing and reviewing as part of a team approach for safe use of positioning, handling and using specialist equipment.

Physiotherapists working as supplementary prescribers are beneficial for patients enhancing the physiotherapy treatment and improving medicines management.

Physiotherapy brings an ‘enabling’ approach to patient care, empowering patients to manage their own condition ultimately aiming to improve quality of life.

Potential for the Future

Physiotherapists consider there are several areas where, with service development, different things can be done by the physiotherapy service in the future:

- Working with the education sector to improve knowledge in terms of symptom presentation/recognition e.g. children with co-ordination difficulties, healthy lifestyle, injury prevention and improving exercise.
- Independent prescribing for physiotherapists will bring opportunities within reablement for physiotherapists to be responsible for medicines management for patients and clients. Independent prescribing will also see physiotherapists leading in areas such as spasticity management and respiratory management. It will also bring benefits to falls and frailty teams.
- More can be done in relation to delegation of tasks to support workers, carers, third sector colleagues and others working as part of integrated teams. This should ensure the right person with the right skills treats the patient at the right time.
- As a long term goal, the profession considers physiotherapists should manage all MSK interventions in primary care. This would include working with other AHPs in signing off ‘fit notes’. Physiotherapists working in this way would free up time for GPs to concentrate on patients requiring medical intervention.
- Physiotherapists are well placed to lead on respiratory service management, following the patient pathway through community and primary care through to secondary care services. 7-day service patterns would need to be in place and are developing.
- The profession sees opportunities to be drivers in changing structures and processes that restrict services being truly patient/person/child centred. Physiotherapists already work in ‘Team around the Family’ models.
- More can be done in relation to contributing to implementation of carer’s strategies. This will bring opportunities to support carers in a more structured way with better recognition and supported delegation of tasks to carers.
- The profession aspires to make ‘transition’ seamless. From child to adult services, from primary to secondary care and back, from adult to older peoples’ services wherever the transfer, the profession considers it should be seamless.
- The profession sees opportunities in breaking down barriers such as exclusion and inclusion criteria for services.
- Physiotherapy services aspire to maintaining a ‘holistic’ approach, continuing to plan and deliver services as a whole across health board locations, working closely with neighbours for cross border and geographical developments.
- Service planning and delivery for the whole physiotherapy service provides critical mass, opportunities for continuous professional development (CPD) and peer support development, cover for leave and ensures the best chance for
sustainable, safe services. Maintaining opportunities for clinicians to ‘grow’ with experience in acute and community settings and for students (the staff of tomorrow) to train is also essential.

- Services aspire to try out new models eg drop in clinics, mobile units.
- Self-referral for people to physiotherapy continues to be a model in development and the profession expects this to be available throughout Wales.
- Development of consultant Allied Health Profession (AHP) posts – possibly to take a lead over a wider geographical patch is an aspiration for the profession.
- Physiotherapists need to ‘make every contact count’ and play a much bigger public health role.
- Physiotherapists need to do more to assist the public and others to understand the role of physiotherapy and the value it brings to patients and organisations.
- Professionals must become better at utilising the "patient story" in order to then influence organisational structures and processes where they see changes could be made to improve patient experience. Services can still develop further and do more to empower patients.
- Physiotherapists must advertise the benefit of their leadership skills in relation to clinical leadership. Often leadership roles are taken on by medical or nursing colleagues yet physiotherapists and other AHPs have strong clinical leadership skills which are underused. Where appropriate, physiotherapists should also take on care coordination roles where it would bring maximum benefit to patients or clients working closely with physiotherapists.

Conclusion

This briefing paper has provided an opportunity to look at the contribution of physiotherapy to community service provision across all ages and following the patient/client journey. It has also provided an opportunity to undertake some forward thinking, considering where physiotherapy could make a difference in the future.

Appendix 1 contains a range of examples from across Wales illustrating the suggestions made in the text.

Appendix 2 contains some key examples from the CSP’s ‘Physiotherapy Works’ publications.
APPENDIX 1 - EXAMPLES FROM AROUND WALES

EARLY RECOGNITION OF PROBLEMS AND TIMELY INTERVENTION

Elderly Care Assessment Service (ECAS) – Cardiff and Vale University Health Board
This service provides comprehensive multi-disciplinary assessment for elderly patients who are failing at home. The main aim of the service is to prevent admission through the provision of timely and comprehensive support to patients in their own homes. Physiotherapy plays a key role in this service by maximising a patient’s ability to mobilise and providing early rehabilitation.

Early Intervention for Preterm or Low Birth Weight Babies – Aneurin Bevan Health Board
Within ABHB a dedicated specialist physiotherapist provides early intervention on the Neonatal Intensive Care Unit (NICU) for preterm and low birth weight babies. These babies are screened at regular intervals throughout their first 18 months of life and any abnormalities in development are highlighted to the relevant neonatologist to ensure the MDT are aware of the child and able to start appropriate intervention at the earliest possible date. This regularly occurs on discharge from NICU and provides a seamless service between secondary and community services.

Cancer Care Physiotherapy Timely Intervention Service - Velindre NHS Trust
The physiotherapy department at Velindre Cancer Centre (VCC) provide a service to the consultant, chemotherapy and radiotherapy clinics to offer timely intervention of treatment, equipment provision and advice where appropriate to ensure patients functional potential is being reached and maintained. The service also has an effect on admission avoidance. There is a small physiotherapy capacity for the patient to be followed up in the community.

The Gait Clinic: A new approach to the assessment service for children referred to paediatric physiotherapy services with minor gait abnormalities – Cardiff and Vale University Health Board
Children referred with minor gait abnormalities were previously placed on the service waiting list and usually seen within 14 weeks for assessment of their condition with the usual time allowed for this assessment being one hour. Clinical opinion within the service was that a full assessment appointment slot was not required and that patients could be assessed within a shorter space of time. Children were also seen by different therapists and it was felt grouping these children into one clinic would be a more effective use of time for the service. Following a stakeholder meeting to discuss the findings of the audit a gait clinic was set up at St David’s Children’s Centre, C&VUHB. This clinic offered families the opportunity to attend for assessment and advice, with appropriate advice leaflets also made available, but if further physical problems were identified then a follow up appointment would be arranged. Children referred with a mild alteration in gait are now seen in an identified clinic and shorter assessment times are proving cost effective with good feedback from parents that have attended the clinic.
Rapid Access MDT Frailty Clinics – Hywel Dda Health Board
These involve multidisciplinary/agency teams consisting of consultant medical practitioner/ physiotherapist/ pharmacist/community nurse/ mental health team practitioner and support worker. This service offers rapid access to clinical support e.g. radiological and haematological investigations. This service provides holistic management of frail patients and prevents unnecessary hospital admissions.

Community Knee Clinics – Cardiff and Vale University Health Board
Physiotherapy led community knee clinics provide expert assessment and early treatment for patients with musculoskeletal conditions affecting the knee such as osteoarthritis, patella-femoral pain or soft tissue injuries. Highly specialist physiotherapists can address patient needs by prescribing a rehabilitation programme and advising on self-management strategies. If required patients can be referred for investigations, diet and exercise interventions or for surgical opinion. Key findings highlighting the success of the service from patients seen in 2012/2013 are; frequent use of physiotherapy rehabilitation (34%), discharge back to primary care (35%) and 11% referral for surgical opinion.

Falls Prevention Program at Tenby Cottage Hospital - Hywel Dda Health Board
Physiotherapists are key professionals in the delivery of this multidisciplinary, community based service which provides rehabilitation, education, and early preventative intervention for elderly/frail patients who are at risk of falls. High risk patients are identified by GPs/district nurses and therapy community teams. They are booked into an initial assessment clinic so that the cause of their falls can be determined. A community visit is then arranged with the patient at their home to ensure environmental risk factors have been fully explored. They are then invited to attend a physiotherapy led, community based 6 week exercise/education program which is supported by the MDT. The approach is evidence based. To ensure good outcomes and the early prevention of digression, all patients receive telephone follow ups on a monthly basis following completion of the program. Reviews are then carried out at 6 monthly intervals in community health centres. Patients have open and direct access to the service in case their symptoms digress. Early contact is encouraged to prevent the risk of falls/fracture and admission to secondary care services.

Falls services in all community hospitals - Powys Teaching Health Board
Physiotherapy is part of a multi-disciplinary team linking with the Welsh Ambulance Service and the District Nursing service to prevent admission to District General Hospitals. It is part of the falls prevention programme and works closely with the third sector PURSH (Powys Urgent Response Service at Home) to keep patients in their home. The team provides referral into the falls programme to enable the service user to rehabilitate and recover their mobility and independence where possible.

Open Access for Multi Disciplinary Team Paediatric Assessments – Abertawe Bro Morgannwg University Health Board
This service provides fast access to the Paediatric teams based in the children’s centres across ABMU for parents, carers and all professionals.
@Home Service - Cwm Taf Health Board
A multidisciplinary team receives primary care referrals from local GP’s who are identifying vulnerable patients at risk of deterioration/admission. Patients undergo multidisciplinary assessment to identify and provide the support required for them to remain safely in the community.

Input to Residential and Nursing Homes – Hywel Dda Health Board
Community physiotherapists in HDHB provide intervention to residential home and nursing homes as well as convalescence beds to support rehabilitation and promote independent living. This approach assists to return patients home with less Social Service support. This is supported by providing intervention from competent support workers to carry out delegated therapeutic intervention.

Clinical Musculoskeletal Assessment and Treatment Service (CMATS) – Cwm Taf Health Board
Extended scope physiotherapy practitioners (ESP) work as part of a multi-disciplinary team alongside other health care professionals (including podiatry, chronic pain nurse specialist and recently appointed GPs). Clinics are provided in both the primary and secondary care setting. Using advanced assessment skills the ESP can ensure that each patient is placed on the most appropriate treatment pathway (which could include physiotherapy treatment, referral for further investigations or referral for surgical opinion). Where appropriate, patients can be diverted away from orthopaedic clinics, releasing capacity and reducing waiting times.

Clinical Musculoskeletal Assessment and Treatment Service (CMATS) - Powys Teaching Health Board
Advanced Orthopaedic Practitioners in Powys offer community access to orthopaedic assessment through CMATS based within GP surgeries and Community Hospitals. This service has simplified and modernised the MSK referral pathway, reduced duplication and prevented multiple referrals whilst ensuring appropriate and timely access to MSK services. It has resulted in the development of CMATS clinics where clinical specialists are now assessing orthopaedic referrals which would have gone directly to orthopaedic consultants. They have liaised with referring GPs encouraging them to refer to this clinic rather than send directly to the consultants so facilitating the most appropriate pathway/treatment for the patient. It ensures the patients are seen and treated in an environment most appropriate to their needs. It has resulted in a reduction in the number of referrals going to secondary care which can be managed in a community setting closer to their home and prevented patients from travelling up to 40 miles for an orthopaedic appointment.

Patient Self Referral/Direct Access to Physiotherapy Services- Abertawe Bro Morgannwg University Health Board
The Swansea locality outpatient physiotherapy departments based at Morriston and Singleton have developed several direct and accelerated access projects for patients over the past 5 years.

Initially a telephone assessment, advice and referral system was introduced (initially as a pilot in Gorseinon in 2004) across the Swansea locality. Patient access was further enhanced by the introduction of a paper self referral scheme to ensure access for those who were unable or uncomfortable with a telephone triage service.
The patient self referral service was then expanded with the introduction of a 'Walk in' clinic for the public at the Singleton physiotherapy outpatient department. This service is intended to cover the whole of Swansea, but due to the success of the project, there is an intention to expand the service to provide a 'Walk In' clinic at the Morriston location. This would provide easier access for those in the north of Swansea, including Clydach, Pontardawe, Gowerton, Loughor and Gorseinon as well as providing some support for A&E services.

**Self Referral to Physiotherapy - Powys Teaching Health Board**

Development and success of telephone triage giving early access to advice and self management for certain conditions has further been developed into physiotherapy self referral across Powys for all service users. Patients can now refer themselves using a paper based questionnaire available from many access points within the community and GP Surgeries. This is a new service and will be evaluated during the year for patient and staff experiences.

**Early Access to Physiotherapy for Patients Referred from Fracture Clinic - Abertawe Bro Morgannwg University Health Board**

A pro-active service for patients who have attended fracture clinic and been referred on for physiotherapy has been introduced at Morriston. The service ensures early contact for patients to re-assure, educate, promote self management and prevent complications. Initial findings are very encouraging from a patient satisfaction, service provision, patient outcome and efficiency perspective.

**Early Access to Physiotherapy for Staff - Abertawe Bro Morgannwg University Health Board**

The out-patient physiotherapy department has been extensively involved in the ‘Wellbeing through Work’ initiative. Although many calls are taken by the ‘Wellbeing through Work’ team, the bulk of MSK follow ups and treatments are done by the Singleton and Morriston Outpatient Physiotherapy Teams, as well as the direct staff referrals received through the Physiodirect, paper self referral and Walk in clinic initiatives.

Plans for the future include:
- more integrated working with A&E to support services
- computer access models for information and referral
- patient forum/service discussions.

**Fast Track Policy for Staff - Powys Teaching Health Board**

Powys physiotherapy service responded to the data from the Health and Well Being Team demonstrating MSK conditions and back pain were within the top 3 for sickness and absence loss of staff from work. Staff can fast track themselves into the service where they will receive an assessment, self help advice and management of their condition. Physiotherapy staff provide ergonomic advice particularly around driving postures and exercises. The teams also work closely with NERS and the community pain management team.
Case Finding in Falls Prevention in Swansea Locality Community Resource Team (CRT) - Abertawe Bro Morgannwg University Health Board

Swansea CRT are responding to the referral of older people presenting to Morriston Hospital’s A&E department where their ‘FROP – COM’ falls risk score indicates a medium to high risk of falls. Physiotherapists are able to apply their specialist knowledge and skills to a previously unidentified group of fallers by giving advice, exercise and referral to falls services within the Swansea area.

Providing equitable physiotherapy services for Children and Young People with additional learning needs 52 weeks of the year and not just during school term time – Cardiff and Vale University Health Board

Children and young people aged 5 – 19 years; with additional learning needs due to their complex health conditions, require regular physiotherapy assessment, monitoring and treatment in order to retain functional ability and to access their statutory right to education. A small team of specialist paediatric physiotherapists and healthcare support staff provide school based assessment, monitoring and treatment to pupils in 2 special schools and outreach services to pupils with complex needs included in all mainstream schools within Cardiff and the Vale local education authorities. Historically school based paediatric physiotherapy services had only been available for pupils during school hours (9.00 am - 3.30 pm), term time only and not during school holiday periods. This had resulted in restricted access to physiotherapy services for 38 weeks, and no access to services for 14 weeks of the year. Following relocation of one special school in Cardiff (Ty Gwyn) onto the Western Learning campus in Ely, the additional learning needs physiotherapy service was re-designed to place pupils at the centre of service delivery and provide children with additional learning needs with access to physiotherapy services for 52 weeks of the year.

Paediatric Neuromuscular Physiotherapy Post – Cardiff and Vale University Health Board

In April 2011 a 0.5 WTE paediatric physiotherapist was appointed to a paediatric neuromuscular physiotherapist post hosted within C&VUHB, providing specialist physiotherapy services to all health boards in the south east region including – CTHB, ABHB and C&VUHB. The current post holder works closely with a complementary 0.5 WTE paediatric neuromuscular physiotherapist post hosted within ABMUHB which provides services to the south west region including HDHB, PTHB and AMUHB. Improvements have been made in services for children, adolescents and young adults with neuromuscular disease (NMD) and in particular Duchene Muscular Dystrophy (DMD) within the South East region of Wales.

Palliative Care support – Cwm Taf Health Board

The physiotherapists in the palliative care team support the patient and their families throughout the whole of the journey at the end of a person’s life. They provide specialist interventions such as lymphoedema management as well as quality of life interventions such as leisure activities and exercise. They deliver much of the treatment in a person’s home providing much needed support to the families but also follow the patient into hospital if it’s required.
Paediatric Palliative Care/Transitional Physiotherapy Post – Cardiff and Vale University Health Board
In April 2011 a 1.00 WTE paediatric physiotherapist was appointed to a paediatric palliative care / transitional physiotherapist post hosted within C&VUHB and ABMUHB, providing specialist physiotherapy services to all local health boards in the south Wales region including – CTHB, ABHU, C&VUHB, HDHB, PTHB and ABMUHB. The aim of this post is to provide assessment, treatment, education and advice for young adults with life limiting conditions. Significant progress has been made in establishing, developing and promoting clinically effective and sustainable specialist physiotherapy provision to all adolescents and young adults with palliative care needs and may also require transitional care within south Wales.

ADMISSION PREVENTION AND FACILITATED DISCHARGE

Prevention of Admission of Children and Young People with Chronic Conditions – Cwm Taf Health Board
CTHB paediatric physiotherapy services offer emergency/SOS access to specific patient groups such as rheumatology, respiratory (e.g. cystic fibrosis) offering timely community intervention to prevent admission.

Early Supported Discharge for Stroke Survivors – Betsi Cadwaladr University Health Board
This service provides a home based rehabilitation service following discharge from the acute setting. The model results in reduced length of stay, improved reintegration into the community setting for patients. A multidisciplinary team, including physiotherapists and support works are key members of this team.

Integrated Therapy Services – Powys Teaching Health Board
A restructured therapy team in Knighton has changed skill mix and extended roles of staff to ensure continuity of service, timely responses and enhanced service provision. The small therapy team works across community beds, outpatients, community and integrated reablement services. The redesign of services has allowed therapists to see patients where their needs are best met and they can transition through the settings being managed by the same team negating the need for repeated referral and assessments. As an example, a person who has fallen and required an inpatient stay will have discharge facilitated with reablement and then go on to access a falls outpatient exercise group and be followed up in the community to improve confidence to access public transport. All this input delivered by one service at the right time and place with the right level of skills. Self referral is encouraged and facilitates the management of those with long term conditions to access the service when required. This allows the service to provide advice to prevent deterioration but timely rehabilitation if deterioration if it does.

Gwent Frailty Programme – Aneurin Bevan Health Board
The Gwent Frailty Programme has been in place for 2 years. It aims to support patients to remain as independent as possible, receiving the majority of their support and care close to their homes. This multi-disciplinary service, which includes physiotherapy, delivers community based care through six CRTs – one for each local authority area and two in Monmouthshire.
The teams provide care to frail and vulnerable people with a wide range of health needs, including assessment and treatment of acute conditions, active management of chronic conditions, falls services and reablement/rehabilitation. The teams also play a significant role in supporting the early discharge of patients from hospital settings where their care needs are better met in their homes.

**Multi Disciplinary Assessment Support Team Service (MAST) - Hywel Dda Health Board**
Physiotherapists are key professionals in this multidisciplinary team that includes health and social care professionals. The team ‘in-reaches’ its services from the community to provide a front of house service in A&E helping to prevent the admission of patients and facilitating transfer back to community.

**Musculoskeletal Clinical Assessment Service (MCAS) – Abertawe Bro Morgannwg University Health Board**
The MCAS is the main point of contact for all referrals from GPs and other health professionals across the Health Board which requires a specialist MSK assessment. The MCAS Team is made up of advanced physiotherapy practitioners and GPs with specialist interest in the assessment and management of MSK conditions. The team individually assess all referrals and make sure the needs of the patient are at the centre of their care pathway. Due to the team working across primary and secondary care, they have been able to ensure the correct professional is involved in the ongoing care of the patient. This reduces unnecessary referrals and enables patients to be seen more quickly.

**Development of Community Resource Teams Focussing on Admission Prevention – Cardiff and Vale University Health Board**
C&VUHB have recently developed 3 locality CRTs, 2 in Cardiff in partnership with Cardiff City Council and 1 in the Vale in partnership with Vale Council. All 3 CRTs are focussed on admission prevention through timely multi-disciplinary/multi-agency intervention and early facilitated discharge through the provision of full team (social service carers plus therapists) or therapy only support for patients who have informal carers.

**Development Community Resource Teams - Hywel Dda Health Board**
Physiotherapists are key members of community based teams that are able to rapidly respond to a broad spectrum of patients in the community with chronic conditions. The boundaries of this team overlap with secondary care advanced physiotherapy practitioners who are able to out-reach into the community to prevent hospital admissions. A recent example includes a patient with a chronic neuro-muscular condition who developed a chest infection at home. Physiotherapists working in the CRT, supported by secondary care advanced physiotherapy practitioners prevented the admission of this patient to hospital by prescribing, and setting up a ‘cough assist machine’ at the patients home. Without this, the patient is likely to have been admitted to a respiratory ward or high dependency unit.
Orthopaedic Physiotherapy Direct Pathway (OPDP) – Cardiff and Vale University Health Board
A direct physiotherapy referral pathway for orthopaedic post-op elective and trauma patients was developed to enhance patients’ timely transition from the inpatient to outpatient physiotherapy environment. Patient systems have been simplified and changes in administration processes now allow for these patients to access outpatient physiotherapy in a timely fashion following their surgical intervention.

Facilitated Discharge for Complex Conditions in Cancer Care - Velindre NHS Trust
Discharges from the in-patient setting at VCC can also be followed up in the community particularly for patients with metastatic spinal cord compression who need ongoing rehabilitation for sometimes a very short period of time due to reduced life expectancy.

Community In-reach Teams into A&E and Clinical Decision Units – Hywel Dda Health Board
These include physiotherapist/occupational therapist/social worker and community nurse practitioners based in community. These practitioners with required knowledge and experience of community services In-reach into hospital to prevent unnecessary admissions, facilitate discharge and to improve patient flow by ensuring timely follow up of support services within the community.

Outreach and Integration between Inpatient Medical/Respiratory Teams and Community Practitioners – Hywel Dda Health Board
The development ensures seamless transfers of care across all areas of the patient pathway in HDHB. This improves patient flow through services. Clinical leads undertaking training/education across specialities of physiotherapy and with wider MDT to up-skill practitioners e.g. stroke education/ specialist reviews with individual clients e.g. advanced respiratory practitioners from Inpatient setting assisting generic community practitioners with the management of complex respiratory conditions. This includes management of acute conditions to prevent unnecessary admissions.

Swansea CRT Focus on Early Discharge and Admission Prevention – Abertawe Bro Morgannwg University Health Board
Early discharge and admission prevention are supported by the CRT in Swansea through the timely provision of multidisciplinary intervention by nurse led health care support workers and therapists or therapist support alone for those who have informal carers.

Community Integrated Assessment Service (CIAS) and falls prevention – Cwm Taf Health Board
This recently formed service is designed to work as close to primary care as possible to identify and prevent admission of frail older people. Physiotherapists as part of a MDT provide advice, treatment and equipment to support the older person to remain at home. A significant number of service users are older people who have fallen and the service works closely with the existing domiciliary physiotherapy service who deliver the evidenced-based OTAGO falls prevention exercise programme.
Swansea CRT Support Local Authority Initiative - Abertawe Bro Morgannwg University Health Board
Swansea CRT therapists provide specialist intervention to 6 “Step up” and 5 “Step down” beds dedicated by City and County of Swansea in 3 residential care homes in Swansea. Physiotherapists provide tailored support and goal orientated intervention within the multi-disciplinary/multi agency team (including a social worker) allowing the service user to safely return home within weeks of placement. This avoids the need for hospital admission, reduces the length of hospital stay and avoids unnecessary long term placement.

Use of ward-based therapists to facilitate early discharge – Cwm Taf Health Board
Physiotherapists in community hospitals devise exercise programmes for in-patients which are handed over directly to the social service support workers without the need for an additional assessment by the reablement therapists. The home visit and initial supervision of the support worker is undertaken by the ward therapist facilitating discharge and ensuring a smooth transition home and releasing capacity for the reablement therapists.

Swansea CRT Reduces Length of Stay for Orthopaedic Patients - Abertawe Bro Morgannwg University Health Board
Physiotherapists working alongside the nurse assessors, health care support workers and other members of the CRT are implementing the drive to reduce bed occupancy times in both the acute and community hospitals in Swansea. Providing support to ease the transition from hospital to home and tailored rehabilitation enables an earlier discharge with progression to independence and restoration of mobility and function.

Therapy Assessment Team (TAT) – Cwm Taf Health Board
This team assesses people who present at A&E who are medically fit but require therapy or social care intervention to return home. They provide advice, equipment and have the facility to arrange social service care packages directly. Patients are followed up at home to ensure they are safe.

Hospital Therapy Support – Powys Teaching Health Board
Hospital staff have extended their roles to support and commence the reablement pathway of patients from hospital back into the community. Skilling of physiotherapy staff to manage the reablement assessment process integrated with social services has prevented duplication of the assessment process leading to a more rapid and effective discharge process and a reduced length of stay in hospital.

REHABILITATION

Stroke Outreach Service – Cardiff and Vale University Health Board
Provides follow up support to manage the transition between hospital and home and follow up rehabilitation for those who have complex needs post stroke and require follow up from therapists with specialist rehabilitation knowledge.
Rehabilitation in Cancer Care - Velindre NHS Trust
The physiotherapy department, in conjunction and collaboration with the wider MDT, offer cancer rehabilitation programmes covering the 8 domains of care:

- Physical, practical, nutritional, psychological, social, spiritual, financial and informational

Sessions are available as:
- One 2 hour session for basic advice
- 5 x 2 hour sessions weekly over 5 weeks
- Fatigue management programmes
- Breathlessness management programmes.

Baseline information can be delivered by any level 1 practitioner ie healthcare professional other than AHP’s (NICE Supportive and Palliative Care Guidelines 2004) including assistants. Complex cancer rehabilitation interventions will be delivered by specialist qualified practitioners.

Early Supported Discharge Focus on Rehabilitation – Cardiff and Vale University Health Board
As part of early supported discharge all physiotherapists within CRTs will provide ongoing person centred rehabilitation for patients to assist them in maximising their full potential.

Stroke Exercise Group (START) - Abertawe Bro Morgannwg University Health Board
Following a stroke, patients’ level of physical activity is often low. This reduced level of physical activity can increase the risk of recurrent strokes, cardiac disease and falls. SIGN guidelines 2012 recommended a long term strategy to encourage stroke survivors to engage in physical activity in the community. The START group was therefore created to address these issues. Stroke patients who have little or no impairments are invited to attend 8 weekly sessions which consist of circuit training, followed by an informative talk regarding stroke risk factors, pharmaceutical considerations, nutrition and OT information. Results from the programme so far have shown improved integration with physical activity at local leisure centres, quicker walking speeds and further distances.

Rehabilitation Day Hospital – Cardiff and Vale University Health Board
Physiotherapy is delivered within a multi-disciplinary rehabilitation service for adult patients with physical health needs. Patients can be referred for early discharge support, or from community based health professionals, particularly for chronic disease management and falls prevention. The team offer a number of specialist services as well as multi-factorial rehabilitation. These include cardiac failure management, Parkinson's days, and an OTAGO based falls programme, which is linked to community services via the falls technician.

Swansea Community Resource Team Reducing Length of Stay for Stroke Survivors - Abertawe Bro Morgannwg University Health Board
Physiotherapists working in the multidisciplinary Swansea CRT are facilitating early stroke discharge from acute hospitals. The service provides 6 weeks, goal orientated...
rehabilitation. Short term care support from the nurse led team of health care support workers is available to ensure focussed rehabilitation.

Rehabilitation in Mental Health – Cardiff and Vale University Health Board
There is a specialist physiotherapy service to neuropsychiatry providing assessment and treatment for concurrent or secondary physical problems following acquired brain damage affecting behaviour and physical function. This facilitates discharge into the community having gained the optimal level of independence. Physiotherapy is provided alongside psychology, speech and language therapy and occupational therapy working with carers, either family members or third sector providers.

Post Intensive Therapy Unit (ITU)/Discharge Follow-up Classes - Abertawe Bro Morgannwg University Health Board
With improvements in intensive care medicine, increasing numbers of patients are surviving catastrophic illness. Severe weakness is common in patients with prolonged critical illness and results in considerable morbidity, mortality, and increasing healthcare costs. The NICE 83 guidelines ‘Rehabilitation in Critical Care’ recommend follow up and rehabilitation in the community for post ITU patients. The programme in Morriston hospital allows any patient who has been discharged home following an ITU stay of 48 hours or more, to attend the physiotherapy gym for a six week supervised exercise programme. Patients work either individually or in small groups and complete an exercise programme specifically designed for their individual needs. Results of the programme demonstrate significant improvements in cardiopulmonary fitness, balance and anxiety and depression.

Domiciliary physiotherapy and reablement teams – Cwm Taf Health Board
Whilst these teams have been in place for some time they provide a core physiotherapy service in a person’s own home. They deliver rehabilitation exercises to maximise independence, this can be following an in-patient episode, from a primary care or social service referral and includes people who live in residential or nursing homes. The service is particularly valuable in providing practical advice, education and support for families and carers.

Day Units – Powys Teaching Health Board
Day units linked to community hospitals deliver chronic disease management e.g. pulmonary rehab, falls programme supported and led by physiotherapists. Where units are not available these services are delivered in the community hospitals.

PREVENTION, EDUCATION AND SELF–MANAGEMENT

Spinal Musculoskeletal Triage & Treatment Clinics (MTT) – Cardiff and Vale University Health Board
Advanced physiotherapy practitioners triage all routine spinal pain referrals from GP’s into the spinal orthopaedic service as part of the spinal pathway. Patients are assessed in a timely manner, and appropriately triaged to the most relevant service e.g. physiotherapy out-patients, NERS, education programme for patients or for further investigation e.g. radiological or haematological investigations including MRI and selective injection, or for review in secondary care services e.g. orthopaedic spinal surgeons, pain team. Many patients however can also be given evidence
based advice, and individual exercise prescription if individual physiotherapy treatment is not required and the majority are discharged after one appointment. This service has demonstrated to show a high level of patient satisfaction and significantly reduce the need for secondary care management.

**Best Use of Falls Technicians – Cardiff and Vale University Health Board**
C&VUHB have recently appointed falls technicians to each community resource team. They link with day hospital groups and follow-up patients who have attended falls groups in day hospital. They monitor them for 1 year following the evidence based OTAGO exercise programme, supporting individual fallers within their localities, providing them with OTAGO exercise programme if indicated.

**Partnership Working with NERS – Betsi Cadwaladr University Health Board**
This development is aimed at patients whom are unable through disability or lack of confidence to access exercise at County Council leisure centres. In Conwy and Anglesey, by linking with NERS people are offered physiotherapy support to facilitate rehabilitation in the gym setting. The physiotherapist works alongside the exercise professionals to aid delivery of the scheme, adapting and tailoring exercise programmes for those who have been directly referred to them and also reviewing existing clients on the scheme.

**Women's Health service – Cardiff and Vale University Health Board**
A continence education class is provided which aims to improve patient understanding of prolapse and urinary incontinence and provide strategies for self help where appropriate.

**Homecare Service for Adult Cystic Fibrosis – Cardiff and Vale University Health Board**
The All Wales Adult Cystic Fibrosis Centre provides a comprehensive out-patient and homecare physiotherapy service for patients at all stages of this chronic illness. The physiotherapy role in the community includes airway clearance management, exercise, the nebuliser service, oxygen assessment and provision, NIV as well as managing issues surrounding sinuses, stress incontinence, posture and musculoskeletal problems. The service aims to decrease admissions and facilitate early discharge while supporting those patients who wish for treatment or palliation at home. Physiotherapy has a presence at all cystic fibrosis clinics and provides a telephone clinic to optimise care and encourage self management. There is a dedicated gym based facility run by a physiotherapy technical instructor who provides support, guidance and education on exercise as well as creating another forum for further health promotion.

**Self-management Course for Patients with Ankylosing Spondylitis (AS) – Aneurin Bevan Health Board**
A twice yearly programme has been developed for patients with AS to provide education component regarding their condition and the importance of physical activity and exercise. During this course, the participants are able to try a varied range of activities led by physiotherapists and monitor the impact on their symptoms, tailoring exercises or intensity for each patient.
Pre-operative Physiotherapy Orthopaedic Team - Cardiff and Vale University Health Board
Physiotherapy is provided in MDT pre-operative patient education clinics for patients awaiting hip and knee replacement surgery. These sessions help to alleviate the anxiety of forthcoming surgery, help them to prepare for the initial post-operative period and to educate patients, giving them greater control over their situation. Due to the success of this, the service is exploring the benefits of working with other health professionals to create spinal pre-operative education clinics.

Orthopaedic Lifestyle Programme – Creating an Alternative to Surgery – Betsi Cadwaladr University Health Board
This programme has been developed in partnership with NERS and sees exercise professionals working alongside physiotherapists and dieticians across the Health Board locality. The programme is offered to all patients with a BMI of 35 or more possibly requiring hip or knee replacement. Patients must complete the programme before they can be considered for surgery.

Linking Cancer Care with NERS – Velindre NHS Trust
The 8 domains (as listed above) have a large educational and advice remit and promote self management. VCC is one of 3 pilot sites, funded by Macmillan Cancer Support to develop NERS for cancer patients, taking rehabilitation and exercise out of the hospital environment and into the community.

Back Care Project with Schools – Abertawe Bro Morgannwg University Health Board
This development involves a paediatric physiotherapist going in to local schools in the ABMUHB area to help them focus on back care.

Aims of this project are
• To ascertain the prevalence of back +/- or neck pain in school-children
• To identify the contributing risk factors
• To raise awareness of the importance of applying practical back care education in the school environment.

Partnership Working with NERS for Falls/Stroke/Pulmonary Rehab and Cardiac Rehabilitation – Hywel Dda Health Board
Physiotherapists work closely with NERS and leisure staff within the council to ensure balance and falls education and physical exercise programmes are carried on after rehabilitation programmes completed by qualified therapists. This assists with self-management and improved health promotion for patients with chronic conditions. This partnership has demonstrated positive healthcare outcomes including patient experiences.

Spinal Rehab - Abertawe Bro Morgannwg University Health Board
Providing exercise classes and education to patients who are recovering from an episode of back pain, or suffering with chronic pain. This aims to increase their ability to function, exercise, and enable self-management of their condition.
Prevention, Education and Self management in Mental Health Services – Cardiff and Vale University Health Board

Within the specialist physiotherapy team in adult mental health there are specially trained fitness instructors who provide supported access to leisure centres (Level 4 in mental health and fitness qualifications) for service users with moderate to severe mental health conditions in all local authority leisure centres in Cardiff and East Vale. This involves individual assessment, exercise planning and one to one support for up to 16 sessions, linking with leisure centre staff for onward attendance, signposting to other exercise approaches and healthy lifestyle promotion. They provide an invaluable link from an inpatient stay or crisis support in the community, helping service users to be motivated and look after their physical health alongside improving their mental well-being. Any physical problems can be addressed by referring back to the physiotherapy team. They also accept referrals for young onset dementia service users supporting them into exercise as part of the adult service.

Women’s Health Service - Abertawe Bro Morgannwg University Health Board

Using exercise classes to provide education, advice and rehabilitation for patients presenting with incontinence, may help to reduce the requirement for surgical intervention. Within a group environment there is the opportunity for patients to share similar experiences and receive peer support. By providing the education and exercises in a group session, this is cost-effective for the physiotherapist.

SUPPORT FOR CHRONIC CONDITIONS

Pulmonary Rehabilitation - Hywel Dda Health Board

Physiotherapists are key professionals in the MDTs delivering this program to patients with chronic respiratory conditions. Physiotherapists in this team provide differential diagnosis, advice on pharmacology (within the scope of supplementary prescribing) assess lung function, physical function and psycho social factors that influence condition management. The program educates patients on regarding the self management of their condition, improves their physical health (which includes their lung function) and teaches them how to manage/ minimise acute illness which could cause admission to secondary care services. The evidence base around this approach is strong and shows reductions in both frequency of admission and length of stay for this patient population. The leadership of this service has worked in partnership with university colleagues to undertake qualitative research into quality of life of patients following pulmonary rehabilitation. This has demonstrated positive outcomes on physical and mental health and demonstrated value for money from the patient’s perspective. This research has also led to changes to clinical practice.

Community Respiratory Resource Unit - Cardiff and Vale University Health Board

Physiotherapy has an integral role working within the multi disciplinary team to facilitate early and accelerated discharge for patients admitted with an exacerbation of chronic obstructive airways disease to the acute hospital sites. Patients are identified in the Admissions Unit, follow up is provided after discharge to monitor the management of the exacerbation, progressing to patient education, rehabilitation and self management, with the aim to reduce further readmissions. Once discharged patients may self refer for further advice on exacerbation management in order to prevent readmission. The team work closely with respiratory physicians in secondary care and GP’s, practice nurses, and clinical
case managers and palliative care services in the community to provide the best care for patients with COPD in their own homes.

**Early Supported Discharge for Chronic Respiratory Conditions - Cwm Taf Health Board**
This model demonstrates a supportive discharge from the acute wards into the community for patients with chronic obstructive airways disease with the aim of self management to prevent re-admission. Patients are identified while on the ward and early follow-up in the community by the physiotherapist is arranged.

**Community Based Pain Management Program - Hywel Dda Health Board**
This is a physiotherapy led multidisciplinary service for patients with chronic pain. Physiotherapists have been identified as key professionals in the delivery of these services, by the British Pain Society. Pain Management Programmes (PMP's) have been shown to be an effective, empowering and a sustainable way of helping this population for whom often a cure is not a realistic goal. They support patients to improve their functional capacity and reduce health seeking behaviour and provide an exit strategy from ongoing investigations and costly often ineffective secondary care interventions. This program is subject to ongoing quality audit and has demonstrated improvements in perceived functional capacity, health state and a significant reduction in anxiety and depression.

**Supported Self Management Programs for Vascular, Cardiac and Pulmonary Rehabilitation - Cwm Taf Health Board**
Education and exercise programs involving a multidisciplinary team from the NHS including physiotherapist's, occupational therapists, dieticians and nursing colleagues, which are based in the community involving patient attendances at local leisure centres for a set period of time with possible referral on to NERS for continuing support.

**Chronic Condition Management in Mental Health Services – Cardiff and Vale University Health Board**
A specialist physiotherapy service in adult community mental health teams provide sessions and home visits to facilitate assessment and treatment for concurrent or directly related to mental illness physical problems including anxiety, conversion and eating disorders. This utilises core neuro-musculoskeletal skills for physical rehabilitation, anxiety management approaches and mindfulness groups for both physical and emotional chronic pain. This provides essential access to physiotherapy skills and knowledge that integrates mind and body. This ensures that service users have equity of access to physiotherapy which they often find difficult to be referred to from primary care or to access due to their mental illness. This service is provided as part of a multidisciplinary approach with other community mental health team members to facilitate the acquisition and maintenance of optimal independence.

**Resilience of the Long Term Paediatric Caseload in the Community – Cwm Taf Health Board**
CTHB paediatric physiotherapy services have integrated the use of the ANGEL Taxonomy into managing patients in the community using it to describe resilience and target appropriate skill mix for the long term caseload dependent on complexity of the patient.
Neurological Outpatient Services – Hywel Dda Health Board
This is in partnership with integrated community services and assists with management of spasticity. This has improved waiting times and travel for services as patients are able to receive a service closer to home. This was established to ensure delivery of patient centred care.

Neuro Rehabilitation Clinics - Powys Teaching Health Board
Patients are seen in ‘One stop shop’ clinics offering a multi disciplinary approach to self referral and management of the neurological and long term condition. It provides ease of access and information for patients. It allows service users to have easy access to health professionals before they reach crisis. Part of a multi-disciplinary team, physiotherapy is key to helping these patients maximise their independence, through informing, signposting to treatment, other services and access to specialists and on-going consultant referral. The clinic utilises volunteers to host the service and greet patients often themselves users of the service. This has provided a valued and supportive environment within a health care community setting. A development of the service has been access to Motor Neurone Disease (MND) specialists via tele-health links where professionals can discuss a patient using technology improving overall care for the patient.

Spinal Assessment Clinic - Powys Teaching Health Board
Patients with long term and chronic spinal problems where travelling out of county for their assessment. This often resulted in long waits and continued visits to GP surgeries. The orthopaedic physiotherapy team linked up with the community pain management team to provide joint assessment clinics. This has proved beneficial to this group of patients and provides the GP with a pathway to refer the patients into. Joint assessments ensure the patient is having evidenced patient care at the point of contact addressing the biopsychosocial model of care for back pain. Patients have access to CBT, exercises, NERS, lifestyle management, physiotherapy empowering the patient to manage their condition. It has reduced the need for these patients to access secondary care.

‘MOVE’ Programme – Aneurin Bevan Health Board
Within ABHB the physiotherapy service works closely with the Torfaen education authority to promote an accredited physical development programme which seeks to enable even the most profoundly disabled children to move around the school using their motor skills. The physiotherapists working within this special school were instrumental in the school achieving ‘MOVE’ accreditation and this is the only school in Wales to hold a current accreditation by this international system.

Pulmonary Rehabilitation Services – Cardiff and Vale University Health Board
Physiotherapy is delivered as part of a multidisciplinary team for patients with chronic respiratory diseases. The 20 week course is centred on self-management of chronic respiratory conditions. The course aims to improve patient understanding and reduce primary and secondary care usage. It is a well-established treatment with a large body of evidence and it is included in most chronic respiratory disease guidelines (NICE, BTS, ATS, ERS, GOLD)
‘Self-re-referral’ Service for Patients with Diagnosed Neurological Conditions – Aneurin Bevan Health Board
This newly set up service provides a review and ‘self-re-referral’ service rehabilitation service for patients already diagnosed with a progressive neurological condition. This model enables patients to have direct service to the physiotherapy service for reassessment and treatment as part of the management of their neurological condition.

Renal Service – Abertawe Bro Morgannwg University Health Board
Provide cycling on dialysis, mobility and MSK self-referrals from day patients, advice on weight loss and exercise for out-patients, intensive in-patient rehabilitation within a MDT to facilitate complex discharges for people with chronic kidney disease (CKD). This service aims to maintain fitness and functional independence to the CKD population around south Wales working closely with other community services including CRT and NERS to achieve this.

Non Invasive Ventilation (NIV) Service – Cardiff and Vale University Health Board
The Physiotherapy service had short term funding to provide input into a regional nurse led NIV service Physiotherapy was identified as a key element in this team, providing vital chest monitoring and clearance advice, especially for neuromuscular patients. The physiotherapy input helps to keep patients out of hospital, improve their independence and optimise their disease management through timely intervention into respiratory complications.

Pulmonary Rehabilitation - Chronic Conditions- Abertawe Bro Morgannwg University Health Board
Providing exercise, education and advice to patients suffering with long term chronic respiratory conditions can improve lung function, enabling the patients to be able to improve their ability to do their normal activities. It teaches the patient how to manage their condition in order to avoid unnecessary admission to hospital.

Neurological Physiotherapy Self Referral – Cwm Taf Health Board
Following initial referral patients can self refer to the neurological physiotherapy service this enables patients to access the service as soon as they recognise a change in their symptoms. It encourages self management and helps avoid crisis admissions particularly in conditions such as MS.

Functional Electrical Stimulation (FES) – Cwm Taf Health Board
FES is a small electrical device that assists a neurologically impaired person to walk and can prevent falls, there may only be a small window of opportunity to gain benefit from this device and so timely intervention is vital. The neurological physiotherapist has been trained to assess and prescribe FES directly to the patient without having to refer the person to a tertiary centre which may result in a lengthy wait.

Pain Management Services - Abertawe Bro Morgannwg University Health Board
The ‘PACE’ programme aims, by advice, education and structured exercises, to deal with the disability associated with chronic pain. Working within a MDT environment,
patients can receive additional psychological and social support to help improve function, and improve daily life, and encourage long term self-management.

**Parkinson’s service – Cwm Taf Health Board**

This multidisciplinary service runs in partnership with the Parkinson’s Society who support the specialist nurse. The service is delivered from the Rehabilitation Day Unit and provides a programme of education, advice and treatment for people with Parkinson’s. The specialist physiotherapist undertakes individual assessments and rehabilitation along with the exercise class. The programme runs regular carers events and the physiotherapist offers individual advice to carers on mobility, transfers and manual handling.

**The Traumatic Brain Injury Service (TBIS) - Abertawe Bro Morgannwg University Health Board**

This service is one of 3 community brain injury teams within Wales. It is a specialist inter-disciplinary team consisting of clinical nurse specialist, occupational therapist, speech and language therapist and psychologist as well as physiotherapist. It provides physiotherapy across a wide range of settings: Physiotherapy departments, patients’ homes and local leisure facilities. The physiotherapist also signposts to existing therapy services and can support the client in engaging with these services, either as an outpatient, or during an in-patient stay. A combination of therapeutic and well-being activities are identified and the client is supported in adopting these as positive lifestyle choices.

**The Back Care Programme – Cwm Taf Health Board**

The back care programme is a community based programme (based in local leisure centres in Aberdare and Merthyr) and is run by the physiotherapy service. It is designed for groups of approximately 15 patients with chronic low back pain and is run over six sessions. The first and last sessions are ‘one to one’ which include assessment, goal setting and evaluation. The remaining four sessions are two hours long and give advice on back pain management, lifestyle modifications and exercise. The aim of the programme is to alter the patient’s role from that of passive recipient of treatment to a more active self-management. The programme provides education, graduated exercise, coping strategies and pain management. There is a problem solving approach for patients to talk about their views and address the social challenges caused by low back pain. The course is informal and relaxed with no pressure but plenty of motivation. Patients are encouraged to work within their limits, to ask questions, discuss concerns and find practical solutions to their problems together.

**LEADERSHIP OF MULTI-AGENCY/DISCIPLINARY TEAMS**

**Community Based Spasticity Management Service – Hywel Dda Health Board**

A pilot scheme (August 2012) has physiotherapists assessing, injecting and prescribing drugs as part of a community based spasticity management service. The aim of the service is to provide patients who have spasticity with care closer to home while improving outcomes and ensuring value for money. By using community-based physiotherapy assessors, injectors and supplementary prescribers, the capacity for clinics has been increased.
Partnership Working with Disability Sports Wales – Powys Teaching Health Board
N-able Sports Club and the 14+ physiotherapy team Powys have developed an inclusive sports club to incorporate rebound therapy into a local community setting and inclusive multi –sports club. Therapists are able to promote health and wellbeing in a socially inclusive setting. The partnership has developed health awareness sessions, adaptive bike taster sessions, badminton, curling; tennis; competitive Boccia competitions and importantly friendships and an exit route for physiotherapy intervention towards independence. It has raised the profile of disability within the local leisure centre and has been a mutually beneficial partnership.

Musculoskeletal Interface Service – Aneurin Bevan Health Board
A ‘well established’ team created to provide expert assessment and advice in the conservative management of MSK conditions. The team comprises physiotherapists, podiatrists and GP’s with special interest.

Swansea CRT and Welsh Ambulance Service Trust collaborate - Abertawe Bro Morgannwg University Health Board
Physiotherapists working in collaboration with other MDT members in the Swansea CRT have developed a rapid response to older people who have fallen who have been attended by the Welsh Ambulance Service Trust and have been able to remain at home. The team are able to respond within one working day to manage risk, implement strategies and home exercise programmes. The team is supported by a rapid access consultant hot clinic.

Continuing Health Care Clients Benefit from CRT Physiotherapy Assessment - ABMU Swansea Locality - Abertawe Bro Morgannwg University Health Board
Physiotherapists and other CRT members provide client centred goal orientated input to continuing health care clients, their carers and support workers, assessing and managing individuals with diverse and necessarily on-going complex care and support needs.

Rhondda-Cynon-Taf Reablement Service – Cwm Taf Health Board
This large reablement team consists of health and local authority staff and is lead by a physiotherapist. It involves reablement, intermediate and home care support workers and places a strong emphasis on training. The aim is that all care workers who interact with clients promote and restore independence at all times and this can reduce the need for expensive care packages.
APPENDIX 2 – EXAMPLES FROM ‘PHYSIOTHERAPY WORKS’

A randomised control trial in Wales (2000) found that there were 1/3 fewer admissions, halving hospital stay and fewer GP home visits where pulmonary rehabilitation is available. Access to such services cuts readmission rates from 33% to 7% and a study in 2010 showed a reduction in readmissions of 26%6.

Physiotherapy-led cardiac rehabilitation is clinically proven to reduce mortality, improve health and quality of life, and reduce hospital length of stay and readmissions. Programmes also support return to work and self-management of the condition7.

In a physiotherapy-led falls service in Glasgow, between 1998 and 2008, there was a reduction in admissions due to falls in the home of 32%, falls in residential institutions of 27% and falls in the street of nearly 40%. Over the same period, the number of admissions for hip fractures fell by 3%8.

In Wales (ABMUHB) the lymphoedema service showed:
- Reduced inappropriate referrals to vascular and plastic surgery
- Reduced cellulitis episodes from 58% to 9%
- Reduced GP and community nurse appointments for cellulitis, leaking legs, discomfort and decreasing mobility
- Reduced breast cancer related lymphoedema from 1 in 3 to 1 in 129.

Over a 6-month period, the introduction of a physiotherapy-led community multidisciplinary team in Newcastle resulted in reduced GP and consultant visits and reduced bed days in hospital for 38 people with MS10.

Early access to physiotherapy for two Government departments in Northern Ireland found 80% of people indicated that physiotherapy had prevented them going off sick and of those off sick 80% said physiotherapy shortened their absence.

Self-referral to physiotherapy in Scotland found cost for a physiotherapy episode of care was £95.48 whereas it was £113.24 for GP suggested and £126.17 for GP referral.

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In Cambridge, 75% of patients who self-referred did not require a prescription for medicines saving £12,000 per GP practice.

Telephone triage in NHS Lothian found over £300,000 was saved in salaries alone by reducing sickness absence and there was a 74% reduction in MSK disorders 9 months following introduction of the programme

York NHS Foundation Trust cut its long term sickness rates by more than 40% through early intervention with physiotherapy and psychotherapy saving the Trust £100,000 (it cost £100,000 but saved £200,000).

Northumbria Healthcare NHS Trust established early supported discharge (ESD) for stroke survivors, offering a service 7 days a week with up to 3 visits per day. This resulted in length of stay in hospital being reduced to half the national average and £800,000 was saved in bed days.

In Wales, a pilot ESD scheme in Swansea found a total of 164 bed days saved in a 6 month period.

An economic evaluation (2006) comparing physiotherapy to the drug Duloxetine for urinary incontinence showed physiotherapy to be cheaper and more clinically effective.