



Welsh Physiotherapy
Leaders Advisory Group

Physiotherapy

Essential to Community Service Provision

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Physiotherapy in Community Service Provision

Introduction

Physiotherapy is essential to the successful delivery of community services to meet population needs. Preventing injury or ill health, providing timely interventions and rehabilitation when injury or ill health occurs, helps people to regain and maximise independence and also reduces the costly impact of avoidable debilitation.

Promoting independence and supporting those who live with chronic conditions enables people to live full lives, including reducing or negating the need for social care and enabling people to return to or stay in work. Physiotherapists deliver health care across the whole patient journey, in every community setting and from the cradle to end of life. Physiotherapy services work with partner organisations, for example in social care and education, to achieve optimum outcomes for each individual.

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)¹, in essence, all services which are external to the secondary care hospital environment. Services which ‘in-reach’ to acute hospitals, musculoskeletal (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 for children and young people, services in partnership with local government e.g. reablement and services provided within or from community hospitals.

The Welsh Government guidelines define a community patient as one who’s contact may take place in the patient’s home, in a health centre, or other community setting, community hospital or in a department located in hospital premises, which may include day hospitals. Community patients will also encompass those seen in schools and GP surgeries.

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 musculoskeletal (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 lead and coordinate multidisciplinary community care for people with complex needs.

1 Welsh Government (2010) Guidelines for the collection of Therapy Services Data in Wales NHS Wales Data Dictionary Version 2.20 (unpublished)

2 CSP (2013) Physiotherapy Works for Social Care

<http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/social-care>

3 CSP What is Physiotherapy and what do Physiotherapists do? <http://www.csp.org.uk/your-health/what-physiotherapy>

4 CSP (2014) Physiotherapy Works – Falls and Frailty <http://www.csp.org.uk/professional-union/practice/evidence-base/physiotherapy-works/falls-and-frailty>

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.

- Reversal – restores someone to their pre-injury or illness level of independence i.e. reverse the impact of it
- Resilience- builds an individual's response to managing their condition through equipping them to self-manage through supported self-management programmes
- Response – tailors care to meet an individual's needs in the context of the whole person including work, family and leisure activity
- Results- delivers results that manage or resolve the issue that someone presents with such as pain, mobility, loss of independence
- Resources – provides cost effective solutions reducing GP visits, unnecessary hospital admissions and need for medication as well as the need for social care provision and often change of residence.²

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on a 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. Physiotherapy services meet individual need, developing and delivering 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.³

The Welsh Physiotherapy Leaders Advisory Group (WPhLAG) and the CSP Welsh Board consider physiotherapy services in the community specifically address:

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

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 (e.g. cardiac rehabilitation, pulmonary rehabilitation, falls prevention, back care) referring to the National Exercise Referral Scheme (NERS) as appropriate and in children and young people services working with health visitors and colleagues in the education sector.

Physiotherapists work in multidisciplinary/multi-agency frailty teams. For example falls management teams delivering evidence based falls and bone health programmes 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 falling⁴.

Early Recognition of Problems and Timely Intervention

Physiotherapists work with primary care in models which offer self-referral/ direct access for patients to physiotherapy and which impact on the management of neurological and orthopaedic waiting lists, the management of pain and a range of MSK conditions. Physiotherapy 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 and others, providing intervention and rehabilitation to prevent deterioration. Clinicians also signpost to other professions and third sector organisations as appropriate.

In children and young people services physiotherapy is essential for informing emerging diagnosis. Physiotherapy teams work closely with the education sector, providing physiotherapy input to schools, often within multidisciplinary/ multiagency teams.

Admission Prevention and Facilitated Discharge

Physiotherapists are integral to teams developed to prevent admission to hospital such as, therapy assessment teams in accident and emergency (A&E⁵), clinical decision units (front door turnaround), intermediate care teams and children's continuing care teams.

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 experience⁵.

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.⁷

Physiotherapists work as part of MCAS/ CMATS/MSK orthopaedic triage teams managing and reducing the orthopaedic waiting list and offering alternatives to surgery often leading to surgery avoidance. They may also work in primary care, in general practice, providing first contact practitioner assessment and intervention. This prevents unnecessary referrals into the general MSK service and secondary care and it also cuts re-attendance into primary care⁸.

Service provision to residential and nursing care beds can prevent or delay hospital admission, maintain mobility and functional ability as well as providing education and advice to care staff and families.

5 CSP (2017) Physiotherapy Works – A & E

<http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/accident-emergency>

6 CSP (2013) Physiotherapy Works – Stroke

<http://www.csp.org.uk/professional-union/practice/evidence-base/physiotherapy-works/physiotherapy-works-stroke>

7 Campaign to end loneliness <http://www.campaigntoendloneliness.org/threat-to-health/>

8 CSP (2017) Think Physio for Primary Care <http://www.csp.org.uk/professional-union/practice/primary-care>

9 Matt Wyatt (2012) ANGEL Taxonomy – a cognitive model of assessment, decision making and planning in complex care <http://www.complexcarewales.org/uploads/attachments/IcQaYxKUK.pdf>

Rehabilitation

Physiotherapists have an important role in de-escalation of complexity for patients as described by the ANGEL taxonomy⁹. Improving strength, mobility, 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.

People are being discharged from hospital earlier and, in many cases, may have greater (and more complex) rehabilitation needs in the community setting. Thus, rehabilitation may be provided in a range of different settings including hydrotherapy pools, leisure centres, physiotherapy gyms 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.

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

Physiotherapists working across a variety of settings are essential to 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. In addition to the core specialties of MSK, orthopaedics, respiratory, and neurology, physiotherapy services will be part of most specialties, 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.

Working with public health colleagues, physiotherapists can bring advice, particularly on exercise and injury prevention, to lifestyle management e.g. obesity pathway, smoking cessation.

Leading on Multidisciplinary/Multi-agency Teams

Physiotherapists are ideally placed to clinically lead a range of community teams across Wales. Developments in this area include leading on multi-agency teams in areas such as frailty, addressing issues including falls management and admission avoidance. Physiotherapists often have lead roles in the operational and professional management of multidisciplinary community integrated services.

Physiotherapists lead multidisciplinary teams to address those with complex needs in the community and outreach neurological clinic settings for children and young adults and adult services, including close links with community equipment stores.

Physiotherapists are leading spasticity management services being developed to provide advanced assessment skills and interventions, addressing chronic neurological issues and overseeing case management.

Future Considerations

The Welsh Physiotherapy Leaders Advisory group (WPhLAG) and CSP Welsh Board, considers the following areas will be important for development in the future:

- Delivering seamless services
- Developing the primary care role
- Strengthening public health role
- Improving accessibility of services
- Further developing scope of practice

Delivering Seamless Services

The profession aspires to children and young adult services working more closely with public health professionals across the education sector and linking in with adult services to provide a seamless approach to health promotion and self-management across all ages. 'Team around the Family' models support aspirations to make 'transition' seamless. From child to adult services, from primary to secondary care and back, specialist tertiary care to care closer to home, from adult to older peoples' services wherever the transfer. The profession sees opportunities to be drivers in adopting principles that challenge those existing structures and processes that restrict services being truly patient/person/child centred.

Developing the Primary Care Role

The role of the Advanced Practitioner within community services needs to further develop, providing timely accessibility to an advanced assessment and diagnosis. Being able to influence reduced admission to hospital and ensuring peoples' needs can be met within their own home continues to be a top priority for the profession in Wales.

The development of independent prescribing will enable intermediate care services to work more efficiently, addressing patient's needs within their own home and reducing the demand on our medical models of care. Independent prescribing will also see physiotherapists leading in areas such as spasticity management and respiratory management, and benefitting patients within falls and frailty teams. Building on our role within primary care, further developments with other AHP's on the 'fit for work/return to work'¹⁰ agenda will be enhanced with the ability to sign 'Fit Notes' which will also ease pressure on GPs.

Improving Accessibility of Services

7-day service¹¹ patterns need to be in place for certain services areas and will continue to develop e.g. physiotherapists are well placed to lead on respiratory service management, following the patient pathway from community and primary care through to secondary care services and back to community. Also, services aspire to try out new models of care e.g. drop in clinics and mobile units.

The profession sees opportunities in breaking down barriers such as exclusion and inclusion criteria for services. Self-referral for people to physiotherapy continues to be a model in development and the profession expects this to be available throughout Wales

Further development of the health care support worker roles will enable more prudent approaches to service delivery.

This should ensure the right person with the right skills treats the patient at the right time and onward referrals to other services carried out seamlessly with third sector partners. More can be done in relation to supporting formal and informal carers. This will bring opportunities to provide support in a more structured way with better recognition and supported delegation of tasks to carers in a variety of environments.

Strengthening the Public Health Role

Physiotherapists need to 'make every contact count' and play a much bigger public health role, creating further link and networks with public health professionals. This will enable the profession to be a stronger voice in health prevention and promotion, being confident to carry out healthy conversations and create a societal movement in positive lifestyle change and behaviours. The physiotherapy service needs to help the public to understand the role of physiotherapy and the value it brings to patients and organisations.

Further Developing Scope of Practice

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 practice based learning opportunities for clinicians to 'grow' with experience in acute and community settings and for students (the staff of tomorrow) to train is also essential.

It is recognised that professionals must become better at utilising the 'patient story' and service user involvement in order to drive service improvement and provide a robust feedback loop for patient and service user experience.

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. Development of consultant Allied Health Profession (AHP) posts, and the leadership these clinicians will bring, continues to be an important aim of the profession.

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 consider areas for development and future scope of practice.

The following appendix provides examples from physiotherapy services across Wales related to the areas of impact highlighted within the document. The examples and the overview provided demonstrate the breadth of physiotherapy and the importance of the interdisciplinary approach taken by the profession. Collaboration with wider networks and services continues to be essential for patient centred care.

10 CSP (2016) Physiotherapy Works – Fitness for Work

<http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/fitness-for-work>

11 CSP (2015) Physiotherapy Works – 7-day Services

<http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/seven-day-services>

APPENDIX 1 - EXAMPLES FROM AROUND WALES

EARLY RECOGNITION OF PROBLEMS AND TIMELY INTERVENTION

Early Intervention for Preterm or Low Birth Weight Babies – Aneurin Bevan University 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.

Multidisciplinary Neonatal Team Hywel Dda University Health Board

Includes a clinical lead physiotherapist as part of an integrated approach to getting it right from the start through person centred plans. Pathways have been developed in order to identify, screen and follow up at risk babies including Bayley's assessment and seamless transition from acute to community services.

Ponsetti Service – Aneurin Bevan University Health Board

A physiotherapy-lead Ponsetti service provides treatment for Babies born with CTEV across Gwent and South Powys. This includes antenatal advice to parents whose child has been diagnosed at scan, casting, and provision of boots and bar splinting. The review service follows up children until the age of 10 to identify any relapses and works in conjunction with the orthopaedic surgeon to ensure that these are managed.

Open Access for Multidisciplinary 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.

Paediatric hip dysplasia clinic. Abertawe Bro Morgannwg University Health Board.

This is a designated DDH clinic with consultant, specialist physiotherapy and radiology input. It is aimed at supporting attainment of the NIPE standards (2008) by facilitating early diagnosis and management of DDH in babies referred with abnormal GP hip assessments or abnormal scans.

Annual Review program for children with Cerebral Palsy – Aneurin Bevan University Health Board

The paediatric physiotherapy service has developed an Annual Review system for children with Cerebral Palsy. This allows all children who are known to the service the following;

- The opportunity with their carers to discuss any current concerns
- A review of the child's current activities
- Review of the child's mobility, ranges of movement, strength, posture etc. as required
- Formulation of a management plan in discussion with child and carers
- A prompt to check the date of the last hip X-ray, if indicated.

Paediatric Neuromuscular Physiotherapy Post – Cardiff and Vale University Health Board

In April 2011 a 0.5 whole time equivalent (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 ABMUHB. 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.

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, and more recently in Llandough Childrens 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.

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 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.

Disability Sport Wales Project – Betsi Cadwaladr University Health Board

The aims of this partnership are to: increase the numbers of physically active disabled people across the 6 authorities in the region; create a robust partnership between (disability) sport and health; contribute to the identification of talented disabled people who may be interested in/able to become involved with competitive or elite sport; decrease disabled people's requirement for intervention as a consequence of ill health linked to physical inactivity and identify a model for best practice with regard to establishing a conduit between health professionals and settings, and physical activity (including sport) professionals, which could be modified as appropriate and rolled-out throughout the other 6 Boards/Trust across Wales.

'Self-re-referral' Service for Patients with Diagnosed Neurological Conditions – Aneurin Bevan University Health Board

This 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.

Neurology outpatient self-referral - Abertawe Bro Morgannwg University Health Board

The Swansea based neurology specific physiotherapy outpatient service offers individuals the opportunity to self-refer into the service. This now accounts for over 30 % of overall referrals. The service has been evaluated and patient satisfaction remains at over 90 %.

Musculoskeletal Direct Access Clinics – Aneurin Bevan University Health Board

Open access clinics for patients with musculoskeletal problems have piloted within the Blaenau Gwent locality with an aim to roll out across the Health Board. These clinics run out of the physiotherapy department enable patients who have a MSK condition to access specialist band 6 physiotherapy triage assessment and provision of advice and basic, first line treatment rather than attending their GP. Although this does not lead to immediate access to ongoing physiotherapy treatment, this does free up GP time and enables the patient to have specialist MSK assessment and basic advice and treatment to enable them to self-manage or to follow while on the physiotherapy waiting list. The outcomes of the pilot are that 83 % are triaged for either urgent or routine physiotherapy treatment, 11 % are discharged with advice, 5 % are referred to the GP for further investigations and 1 % for referral to another service.

Self-referral to Physiotherapy - Powys Teaching Health Board

To support accessibility and early intervention and advice, patients can refer themselves using a paper based

questionnaire available from many access points within the community and GP surgeries. The form can be accessed from the PTHB website and further work needs to take place to ensure this process can be fully supported electronically.

Patient Self-referral / Direct Access to MSK Physiotherapy Services - Abertawe Bro Morgannwg University Health Board

The physiotherapy service provides four MSK assessment 'Walk in clinics', one at each major hospital site and accepts both paper and telephone self-referrals.

Patient Self-referral / Direct Access to Women's Health - Powys Teaching Health Board.

This enables a timelier access to physiotherapy interventions and the wider multi-disciplinary team such as midwives, health visitors and specialist nurses can facilitate access following early detection of symptoms.

Self-referral to Physiotherapy – Betsi Cadwaladr University Health Board

Patients can now refer themselves using a paper based questionnaire available from the physiotherapy departments as well as many access points within the community and GP surgeries. Outpatients service have undergone a transformation and are trialling 'walk in' clinics and revised pathways for clinically urgent cases

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.

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.

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 outpatient physiotherapy teams, as well as the direct staff referrals received through the physio direct, 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.

Physiotherapy Primary Care MSK Service - Cwm Taf UHB

This service has built on existing work and successful pilots and is funded by primary care. It will deliver direct access to MSK physiotherapists who will be first responders in triage and intervention. The service is available to the whole of the population in Cwm Taf and was developed in conjunction with all 4 GP clusters. Its launch is due in summer 2017.

Telephone assessment service - 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 across all departments. This supports reduced waiting times, elimination of unnecessary initial appointments and encourages patients to self-care through telephone contact.

@Home Service - Cwm Taf University 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 including physiotherapist to identify and provide the support required for them to remain safely in the community. Many of these patients are frail elderly who have fallen or have mobility problems as a result of complex co-morbidities. The Physiotherapist sees the majority of patients referred

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.

Low back Pain Triage – Aneurin Bevan University Health Board

In December 2015, a multidisciplinary triage team was introduced to review all referrals into ABUHB orthopaedic, rheumatology and pain services. This multidisciplinary team consists of a consultant surgeon and physiotherapist who meet on a weekly basis to review referrals with low back pain and determine the most appropriate pathway for the patient. Pathways include orthopaedic outpatient assessment, mainstream physiotherapy service, rheumatology, pain services and into the Health Boards Interface service for further assessment including clinical imaging. Initial information indicates that this service reduces unnecessary duplicate referrals into a range of services and reduces the demand into orthopaedic surgical services.

Integrated Continence Care Pathway - Powys Teaching Health Board

The specialist women's health physiotherapists work closely with the continence specialist nurses providing timely intervention, offering a pelvic floor exercise programme before the provision of incontinence pads. This prudent approach supports an improved quality of life and unnecessary provision of incontinence pads.

MSK Physiotherapist in A&E – Cwm Taf University Health Board

Completion of a 1-year pilot of a MSK Physiotherapist in Royal Glamorgan's A&E department demonstrates positive outcomes for patients both clinically and in shortening the pathway. As well as significant resource savings for medical colleagues. The physiotherapist triages people with musculoskeletal problems in A&E, provides immediate advice and orthotics, undertakes short-term intervention and sign-posts to other services as appropriate. Early indications suggest a reduction of 150 patients a month (30 % reduction) requiring orthopaedic clinic appointment and a saving of 5 hours a month Consultant time directly in A&E. 60% of patients do not require any further intervention.

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.

Rapid Access MDT Frailty Clinics – Hywel Dda University 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.

Primary Care MSK Practitioners (physiotherapists) working within a GP cluster - Abertawe Bro Morgannwg University Health Board

One whole time equivalent physiotherapist providing MSK assessments within the Neath GP cluster.

Advanced Practitioner Physiotherapists (APP) in Primary Care – Betsi Cadwaladr University Health Board

This service aims to simplify the musculoskeletal (MSK) referral pathway by making Advanced Practitioner Physiotherapists the 1st point of Contact for MSK conditions in Primary Care. This will reduce duplication, prevent multiple referrals/re-referrals, relieve pressure on the General Practitioners and create a safe, sustainable solution whilst ensuring appropriate and timely access to MSK services. Research demonstrates that up to 20 % of a GP caseload is musculoskeletal indicating that APPs could become the 'gate keepers' for MSK services in primary care. The purpose of this initiative is to allow patients presenting with MSK complaints to be seen in their local GP surgery by an APP, thereby reducing the demand on the GP, relieve pressure on primary care services and release vital GP capacity allowing them to deal with more complex medical cases, to "do what only they can do".

The aim is to target primary care by the following approaches:

- Requests from GP clusters / individual GP practices wishing to invest in this type of innovative service
- Requests from the Primary Care Support unit (PCSU), identifying practices with recruitment difficulties. A scoping exercise is being carried out to determine which areas are most at risk and need the need for these practices to consider this change model.
- Pro- actively targeting practices with high MSK referral rates into secondary care.
- Practice with the required space and mentorship.

To enable this to happen the workforce must have the full set of extended scope skills in their tool box. Up skilling the workforce in the fields of independent prescribing, injection therapy and the ability to request and interpret imaging and blood results. Up skilling of the workforce is essential to ensure the APP can manage the clinical caseload in its entirety.

Overall Goals – First point of contact for 70 % of MSK patients in primary care: achieve patient acceptance, understanding and satisfaction with this new model of care.

Further targets include

- Up skill the Advanced Practitioner workforce with the correct skill set for primary care
- Demonstrate a reduction of referrals into MSK secondary care services
- Demonstrate an increase in appropriateness of MSK referrals in secondary care services (e.g. improved Orthopaedic Conversion rate).

Clinical Musculoskeletal Assessment and Treatment Service (CMATS) – Cwm Taf University Health Board

Highly specialist physiotherapy clinicians 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 sites. Using advanced assessment skills physiotherapists 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.

Clinical Musculoskeletal Assessment and Treatment Service (CMATS) – Betsi Cadwaladr University Health Board

Advanced Practitioners (AP) work as part of a multi-disciplinary team alongside other health care professionals. Using advanced assessment skills the AP 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.

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.

Falls Prevention Program at Tenby Cottage Hospital - Hywel Dda University 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 – throughout Betsi Cadwaladr University Health Board

Multi factorial risk assessments and multi-disciplinary working to provide evidence based long term falls programmes to rehabilitate and restore confidence and independence. This service links closely with other services for example Ear, Nose and Throat (ENT) and Cardiology to provide holistic patient centred care.

Falls services in all community hospitals - Powys Teaching Health Board

Physiotherapy is part of a multi-disciplinary team linking with the Welsh Ambulance Service, District Nursing service and Third Sector to prevent admission to District General Hospitals. These links will continue to be maintained as part of the falls prevention programme and working closely with the third sector PURSH (Powys Urgent Response Service at Home) to keep patients in their home. The physiotherapy service and wider disciplinary team have revised the programme in line with NICE guidance and are piloting a new approach, offering more regular access to a stability and strengthening programme and multi-disciplinary education sessions specifically targeting those at risk of falling. This new approach will enable the service user to rehabilitate and recover their mobility, independence and confidence as quickly as possible.

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.

Falls Prevention Education- Abertawe Bro Morgannwg University Health Board

CRT physiotherapy team provides falls prevention training to community and residential /nursing home support workers in Bridgend County Borough Council area. Improving knowledge of intrinsic and extrinsic causes of falls and encouraging good practise to increase awareness of falls prevention. This has been rolled out to other areas of ABMU with “train the trainers sessions” to ensure continuity across the health board.

CRT physiotherapy team organise and participate in multi-disciplinary Health Care Professional training in falls prevention for ABMU health staff and BCBC social services staff. CRT physiotherapy team have trained and support a technician to carry out walking aid clinics in residential homes in BCBC, to ensure all walking aids used in these areas are safe and fit for use.

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.

Input to Residential and Nursing Homes – Hywel Dda University 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.

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.

Palliative Care support – Cwm Taf University 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 breathlessness and 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.

ADMISSION PREVENTION AND FACILITATED DISCHARGE

Prevention of Admission of Children and Young People with Chronic Conditions – Cwm Taf University 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 Response Team – Abertawe Bro Morgannwg University Health Board

This is a multi-disciplinary team, which is an advanced nurse practitioner led service, with access to consultants for review. It accepts referrals from a variety of referral sources within the community for patients who are in crisis due to an acute illness, to prevent avoidable admission to hospital. The team also accept patients from the Emergency Department (ED) to promote a fast turnaround in discharge within 48 hours.

The team are able to respond within 4 hours of referral. Timely provision of physiotherapy to support mobility, pain management, falls assessment, thus providing an integral part of the service.

Front Door Assessment - Betsi Cadwaladr University Health Board

Physiotherapists are working collaborative with their Occupational Therapy, Nursing and Social Care colleagues to assess and provide early management of elderly and frail patients who present at EDs aiming to prevent admissions and ensure patient have appropriate health and social care support to remain safely at 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.

Emergency Therapy Teams (JETT) and Stay Well @home Teams (SWAHT) – Cwm Taf University Health Board
These admission avoidance teams are based in the medical assessment units and intervene on behalf of primarily frail elderly people who present to A&E who do not require medical intervention. These group of patients however, do require assessment and support from therapy or social care 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.

Community In-reach Teams into A&E and Clinical Decision Units – Hywel Dda University 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.

Early Supported Discharge in Trauma and Orthopaedics - Betsi Cadwaladr University Health Board

This service facilitates the early discharge of patients who require ongoing support in the community and who historically would have remained in hospital in a rehabilitation ward. The patients are provided with social care, occupational therapy and physiotherapy rehabilitation programmes provided by generic technical instructors.

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.

Use of ward-based therapists to facilitate early discharge – Cwm Taf University 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.

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.

Early Stroke Discharge- Abertawe Bro Morgannwg University Health Board

A pilot project from the Morriston site facilitating early stroke discharge from ward F with immediate follow up and provision of supported home treatment programmes. Early results are showing a significant reduction in LOS, improved functional outcomes, improved patient /family experience and greater patient / family satisfaction.

Early Supported Discharge Team for Stroke – Cwm Taf University Health Board

This team facilitates discharge to the person's own home from the acute stroke centre in Prince Charles Hospital. They take around 40 % of all stroke patients and deliver specialist stroke rehab in the person's home.

TOCALs (Transfer of care and liaison service)- Hywel Dda University Health Board. Front of house team in reaching from community and linking with acute setting as part of admission prevention and facilitating discharge in particular for frail older adults. Expert teams including skilled support staff support linking closely with Primary care in Carmarthenshire as part of MDT working identifying patients at risk. This facilitates early identification of need, preventing admission.

Residential Reablement – Abertawe Bro Morgannwg University Health Board A therapy led service with 6 step up/

step down beds based in a social services residential home, reducing the length of hospital stay, or avoiding unnecessary admission. Provides continued rehabilitation with a physiotherapist and occupational therapist providing a multi-disciplinary, goal orientated programme, which allows the service user to return to their own home within weeks.

Integrated Therapy Services – Powys Teaching Health Board

Restructured therapy teams incorporating assistant practitioners and blended band 4 roles across therapies has

changed skill mix and extended roles of staff to ensure continuity of service, timely responses and enhanced service provision. The small therapy teams work 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.

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, reduced length of stay in hospital and therapy led focused goal planning in the community. Physiotherapists are an integral part of the virtual ward teams which highlight patients at risk of being admitted to hospital and collaborate to provide the support required in order to avoid admission.

Community Reablement Team - Abertawe Bro Morgannwg University Health Board **The CRT is a therapy led service**

to support early discharge from hospital and to prevent admission to hospital with a short term (up to 6 weeks) rehabilitation programme to maximize independence and re-integration into the community. The team will accept patients with a variety of physical condition and operates as a joint health and social services team with an integral care aspect. Therapists provide a tailored support and goal orientated intervention working on independence with ADLs, exercise programmes and mobility. Physiotherapists also provide a one off visit for an occupational therapy led enabling service to review and progress mobility to allow increased independence.

Development of Community Resource Teams - Hywel Dda University Health Board

Physiotherapists are key members of community-based teams that are able to respond rapidly 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 patient's home. Without this, the patient is likely to have been admitted to a respiratory ward or high dependency unit.

Community Resource Teams - Betsi Cadwaladr University Health Board

Multidisciplinary Health Teams based in the community are working in an integrated way with Social Service colleagues. There are good practice examples where these are sites in community setting for example Leisure centres and are co-locates with Social Care Colleague and Single Point of Access teams which is streamlining patient care and providing additional capacity.

@home services supporting Primary Care– Cwm Taf University Health Board

This expanding service is designed to work as close to primary care as possible to identify and support frail older people to remain in their homes and prevent admission. The Physiotherapist 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.

Community Integrated Assessment Service (CIAS) and Falls Prevention – Cwm Taf University Health Board

This 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 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.

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.

Bridgend Domiciliary Service- Abertawe Bro Morgannwg University Health Board

Domiciliary physiotherapy service provides an assessment and advice for adults who are unable to attend the outpatient physiotherapy department, or where the effort of the journey into the department would be detrimental to the benefits of the treatment or if an environmental assessment would be beneficial. Advice and exercises are given where applicable to help maintain/regain function and where appropriate clients will be referred on to other services.

Development of Community Resource Teams Focussing on Admission Prevention – Cardiff and Vale University Health Board

C&VUHB has developed three 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.

Outreach and Integration between Inpatient Medical/Respiratory Teams and Community Practitioners – Hywel Dda University 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.

Community Respiratory Service – Aneurin Bevan University Health Board

This service provides specialist respiratory input to patients in the community setting with neuromuscular weakness. The focus for the physiotherapists within this service is to monitor signs and symptoms of respiratory insufficiency and manage secretions. Conventional physiotherapy techniques are unlikely to be effective in this patient population and specialist respiratory physiotherapy assessment and treatment must be considered. Specialist respiratory physiotherapy intervention may include cough augmentation strategies, breath stacking technique, respiratory muscle training where appropriate and provision of training for patients and carers.

All interventions are tailored to the patients' individual needs, taking into account their communication ability, cognitive status and mental capacity. Where appropriate the families and carers will be involved in decision making especially when equipment is being issued. The physiotherapist works very closely with the extended multidisciplinary team to provide co-ordinated care and ensure effective communication, allowing appropriate and timely assessment and management. Where appropriate the specialist respiratory physiotherapist can offer support to the acute care physiotherapy team to ensure timely and appropriate discharge planning and equipment provision. It also the aim of the service to provide respiratory support in the community setting to prevent readmission especially where the patients have specified their end-of-life plan.

Physiotherapy support to Orthopaedic ERAS – Aneurin Bevan University Health Board

To comply with the All-Wales bundles of care for Enhanced Recovery after Surgery, all joint arthroplasty patients must undergo the same process in the pre-operative phase, have the relevant information for surgery and have access to a physiotherapist for assessment and discharge planning. The physiotherapy service provides support to the orthopaedic fitness for surgery process and will assess all patients prior to major joint surgery in the same clinic as the Clinical Nurse Specialists. The main aims of the service are to establish a baseline of information about the patient and their functional abilities (Chartered Society of Physiotherapy minimal data set). This includes

- Checking range of movement, muscle strength, gait, falls and general abilities.
- Issue of relevant equipment such as walking aids and knee braces to
- maintain safety prior to surgery.
- Discuss relevant recovery, surgeon protocols, patient perceptions, expectations and involvement.
- Issue a personal “build-up” programme prior to surgery.
- Discharge planning to ensure adequate help and support is available post-op.

PORT (Pulmonary Out Reach Team) - Betsi Cadwaladr University Health Board

This is a multidisciplinary team of which physiotherapy is a key player. The team facilitates the early supported discharge of patients with CPOD and the supported discharge of patients admitted to a high dependency unit (HDU). The team ‘in-reach’ to offer in-patient support. Techniques include breathing control, chest clearance, energy conservation as well as onward referral to Exercise on Prescription and Pulmonary rehabilitation.

Gwent Frailty Programme – Aneurin Bevan University Health Board

Gwent Frailty 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.

Community Based Exercise Programs – Abertawe Bro Morgannwg University Health Board The Physiotherapists

within CRS run several exercise groups within Swansea. The groups are all based within various community settings, including local authority run gyms and warden controlled complexes with the aim at promoting wellbeing and exercise. The groups are split into 2 levels; Senior Stability, based around strength and balance and Fit for All which has a more emphasis on cardiovascular training.

Community based Frailty Clinics - Abertawe Bro Morgannwg University Health Board

Physiotherapists have developed a monthly Frailty Clinic based in a GP practice within Swansea. The aim of this is to identify individuals at risk of falling before they fall. Individuals are assessed and then offered either a home exercise program or a space within one of the existing exercise groups. This is currently being piloted within 1 area in Swansea but if successful it will be rolled out to other interested GP practices. We are also piloting this within a residential setting too.

Community based Postural Management – Abertawe Bro Morgannwg University Health Board

The CRS physiotherapists within Swansea have developed and delivered a bespoke training package to care staff within a large nursing home. The training is aimed at increasing awareness within the care setting and identifying “at risk” clients early to avoid long term complications.

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.

Virtual Clinic for Degenerative Neuromuscular Conditions - Hywel Dda University Health Board.

Establishing guidelines and pathways for assessment and identification of respiratory management in terms of cough assist support has supported admission prevention for this vulnerable patient group.

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.

REHABILITATION

Plagiocephaly Service - Cardiff and Vale University Health Board.

Plagiocephaly referrals to be seen in a new way following recent audit, upon referral information and advice to be sent to the family, followed up with telephone triage at 1/12 to then ascertain if an appointment to see a therapist for assessment is required or if progress has been made following received advice and the child can then be discharged. This service is being trialled this term.

Intermediate Care, Reablement and Enhanced Care – Betsi Cadwaladr University Health Board

Initiatives with different thresholds and acceptance criteria but which all involve multidisciplinary working including in-reaching into the emergency department (ED), links with social services and care agencies. Ultimately aiming to reduce hospital admission, reduce hospital stays and act in an effective way at times of patient crisis.

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 disease days, and an OTAGO based falls programme, which is linked to community services via the falls technician.

Domiciliary Physiotherapy and Reablement Teams – Cwm Taf University 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.

Neuro Rehabilitation Teams - Hywel Dda University Health Board.

As part of supporting the neurological delivery plan physiotherapists will lead on and influence the approach to and a service delivery model for neurologically impaired patients. The initial focus will include newly acquired brain injury patients in order to ensure seamless transition from acute to community settings including agreed evidence based rehabilitation closer to home.

This includes a co-produced emphasis within modalities such as hydrotherapy as part of establishing expectations and outcomes in terms of rehabilitation.

Community Neuro Rehabilitation Service (CNRS) – Aneurin Bevan University Health Board

As part of the programme of stroke redesign, a new community neurological rehabilitation service has been developed which provides an early supported discharge pathway option for people with stroke within the Health Board and those requiring repatriation to the Health Board. The service provides a person centred multidisciplinary intervention and promotes the principles of independence and self-management.

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 occupational therapy information. Results from the programme so far have shown improved integration with physical activity at local leisure centres, quicker walking speeds and further distances.

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.

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.

Functional Electrical Stimulation (FES) - Powys Teaching Health Board

A service and pathway has been developed for the assessment and provision of Functional Electrical Stimulation (FES) for people suffering with dropped foot. Historically, any patient that would be appropriate for an assessment for using FES to aid dropped foot was sent out of county to neighbouring health boards for an assessment and provision of FES as appropriate.

Providing services closer to home reduces travelling times for patients and results in improved satisfaction rates for patients. Specialist clinicians have been trained within the health board to assess suitability for FES and pathways have been developed for provision of equipment and sustainability of an equitable service. There are plans for physiotherapy and podiatry to work closely in the continued development and provision of this service.

Specialist Upper Limb Rehabilitation - Powys Teaching Health Board

There has also been investment in post stroke upper limb rehabilitation equipment such as Neuromuscular Electrical Stimulation (NMES), E-LINK, Saebo gloves and a Saebo Mobile Arm Support (MAS). Clinicians across the health board have received training in the use of NMES and a pathway and service has been developed. Both stroke units in Powys have a stock of Saebo gloves and access to the MAS as well as the use of supportive technologies such as the E-LINK.

Rehabilitation in Cancer Care - Velindre NHS Trust

The physiotherapy department, in conjunction and collaboration with the wider MDT, offer cancer rehabilitation programmes covering the eight 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 i.e. healthcare professional other than AHP's (National Institute for Clinical Excellence (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.

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.

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.

Rehabilitation in Long Term Conditions – Powys Teaching Health Board

Physiotherapists work closely with the interdisciplinary team to deliver chronic disease management e.g. pulmonary rehabilitation, cardiac rehabilitation and falls programmes, incorporating physical activity and education. Close links with the Long term conditions service and the third sector support best outcomes.

Blended Assistant Practitioners - Powys Teaching Health Board

The development of these Band 4 blended assistant practitioner role across therapies enables a more prudent delivery of rehabilitation across the inpatient and community settings. This helps support facilitated discharge from our community hospitals and rehabilitation is followed up in the community addressing patient led goals and increasing independence.

Hydrotherapy - Cardiff and Vale University Health Board

Hydrotherapy is provided to Community patients within the Childrens Hospital for Wales, Dolphin Outpatients, Orthopaedic/MSK for children to age 13 years are also seen in this setting since the service opened in 2015.

PREVENTION, EDUCATION AND SELF-MANAGEMENT

Motor Coordination development pathway - Abertawe Bro Morgannwg University Health Board

This prudent approach to the management of children presenting with coordination difficulties focuses on prevention, early intervention education and self-management. It includes a regular and well established universal coordination training programme for school staff who then implement the activities with all pupils. Teaching staff can apply a staged programme of activities for children requiring a higher level of intervention. Only children who present with ongoing activities after this intervention would access physiotherapy and OT services. Pre and post pathway assessments are in place showing functional improvements. The programme has significantly decreased therapy waiting lists and re-referral rates for this client group.

Women's Health Service - Powys Teaching Health Board

Patients may be seen in groups or on an individual basis at any time during the antenatal and postnatal period for a back care programme. This offers women one to one intervention where appropriate or peer support in the form of group work to address core stability, strengthening exercises and postural advice. At each stage of the pregnancy the objectives of this programme are to provide support, education and advice whilst ensuring patients optimise their health.

Antenatal and Postnatal Pelvic Floor Pathway - Powys Teaching Health Board

Working collaboratively with the midwives helps identify antenatal and postnatal women with "High risk" pelvic floor indicators. These patients are then referred directly to physiotherapy for a pelvic floor exercise programme.

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 +/- 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.

Women's Health Prevention Management – Powys Teaching Health Board

Women who acquire 3rd or 4th degree tears during delivery are automatically referred to the service for Pelvic floor exercises and advice. These patients are reviewed regularly so they do not suffer any long term problems.

Lymphoedema Risk Reduction Services - Hywel Dda University Health Board

The service focuses on education and awareness training through established Agored Cymru units. This has included breast cancer patients primarily to date. This service also includes an increasing referral of head and neck cancer patients as part of reducing the risk of lymphoedema post-surgery.

Further education and awareness of lymphoedema in children and young people has evidenced an increase in the recognition and referral to this service within paediatric lymphoedema services.

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.

OAK Patient Activation Programme – Aneurin Bevan University Health Board

This education programme on osteoarthritis (OA) of the knee is delivered by physiotherapists and runs in each locality of ABUHB on a monthly basis. It has been developed in conjunction with primary care. It is designed to provide patients and their carers/partners with up-to-date information on all of the treatment opportunities available to them for the management of OA of the knee. The group nature of the sessions also enables group support and discussion. The approach is specifically designed to 'activate' patients by providing appropriate information and support them to 'choose wisely'. Patient feedback from the sessions indicates a significant improvement in patient understanding of their condition and the options available to manage it. Patients are able to self-refer to physiotherapy services from this education group. This format of patient education is also being used as a blueprint for other long term conditions such as low back pain.

Pelvic Girdle Pain – Aneurin Bevan University Health Board

Pregnant women with pelvic pain during their pregnancy are referred by primary care or midwifery service to the physiotherapy outpatient departments. The service is designed to target patients who have started to develop pain and aims to provide education, advice and guidance on how to manage as their pregnancy progresses. Physiotherapists who take these groups are able to identify patients who would benefit from further one-to-one treatment.

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.

Self-management Course for Patients with Ankylosing Spondylitis (AS) – Aneurin Bevan University 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.

Spinal Musculoskeletal Triage and 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.

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.

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.

Partnership Working with NERS for Falls/Stroke/Pulmonary Rehab and Cardiac Rehabilitation – Hywel Dda University 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.

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.

Linking Cancer Care with NERS – Velindre NHS Trust

Physiotherapists provide a large educational and advice remit and promote self-management. VCC is one of three 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.

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.

Bridges Self-management - Powys Teaching Health Board

Delivery of the Bridges self-management training aims to promote self-management and co-production of rehabilitation both on the ward and in supporting people to live with the effects of a stroke once they go home. As a

result, the team in Newtown and Brecon have secured funding for a pilot “Moving on After Stroke” programme. It is a time limited programme for people on discharge home, which involves structured discussion and peer support, taster sessions for people to try something new, an education session and an exercise group.

SUPPORT FOR CHRONIC CONDITIONS

Resilience of the Long Term Paediatric Caseload in the Community – Cwm Taf University 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.

COPD Early Discharge Service, Princess of Wales Hospital - Abertawe Bro Morgannwg University Health Board

A service provided by nursing staff and a physiotherapist to facilitate early discharge for patients admitted with an exacerbation of chronic obstructive airways disease to secondary care. Patients are identified in the acute admissions wards (ED and AMU), respiratory and medical outlier wards. The service runs Monday to Friday and follow up is provided after discharge (usually the next day) to support the management of the exacerbation. Patient education regarding exacerbation recognition and management is central to the service as well as self-management strategies including airway clearance, medicines support, breathlessness and activity advice.

This is complimented with close links to a respiratory consultant, occupational therapist, dietician and pulmonary rehabilitation, ensuring all suitable patients are offered the chance to complete the programme as per national guidelines. The aim of the service is to reduce readmissions and improve self-management. Once discharged patients can self-refer at any point in the future for advice or if they are exacerbating and a domiciliary visit can be conducted with a view to provide excellent care for patients with COPD in their own homes.

Admission Avoidance for COPD Patients - Abertawe Bro Morgannwg University Health Board

Working alongside the early discharge COPD team in Bridgend there has been the development of an admission avoidance scheme for COPD patients who have had an exacerbation of their condition in the North Network area of the locality. The specialist physiotherapist is a key member of this team providing essential links between secondary and primary care and allowing the patient access to specialist physiotherapist intervention.

Pulmonary Rehabilitation (PR) - Abertawe Bro Morgannwg University Health Board

Due to investment into the PR service, the service is able to provide a greater number of PR courses linked in with GP clusters enabling the course to be more accessible, of a timely nature and truly multi-professional. Physiotherapists have been an integral part of this development with a Physiotherapist as clinical lead for the service. From September 2016 PR is provided in every GP cluster network ABM wide (11 clusters). Waiting lists have reduced to between 4-5months with the aim to reach British Thoracic Society Quality Standard guidelines of 3 months from referral to

treatment. The PR service runs in partnership with the National Exercise Referral Scheme (NERS) promoting long term adherence to exercise and behaviour change assisting in the self-management of the patients' chronic respiratory disease. The team are also starting to deliver respiratory clinics from some GP practices.

Pulmonary Rehabilitation - Hywel Dda University 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. Proposals for a hub and spoke model of delivery has been undertaken with a view to provide further programmes from a distance using video conferencing technology. This will support the ability to target assessed patients within a community setting as part of prudent working and providing care closer to home in a rural setting.

Pulmonary Rehabilitation - Betsi Cadwaladr University Health Board

The pulmonary rehabilitation Hub and Spoke model is established in North Wales to provide additional capacity and ensure easy and equitable access for patients. Hubs are based at the 3 DGH site and spoke venue within the community. GPs can refer directly to the programme. The program assesses physical function as well as psycho social factors that influence condition management, it provides education for patients on self-management of their condition, advice on pharmacology and promotes activity through individualised plans to improve their physical health and lung function. We are seeing improved outcomes and prevention of admissions for patient with this Long Term Condition.

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).

Community Respiratory Resource Unit - Cardiff and Vale University Health Board

Physiotherapy has an integral role working within the multidisciplinary 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.

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.

Supported Self-Management Programs for Vascular, Cardiac and Pulmonary Rehabilitation - Cwm Taf University Health Board

Separate programmes run for each of the specialist areas. They include Education and exercise programs lead by physiotherapists in multidisciplinary teams. The evidenced-programmes are delivered both on Health premises and in local leisure centres and include signposting for self-management with possible referral on to NERS for continuing support.

Residential Programme- Powys Teaching Health Board

The residential programme is an intensive two-week programme during which participants stay at the Centre for Long Term Condition Management, Bronllys Hospital from Monday to Friday and go home at weekends. During this time they take part in a variety of activities which help them to improve their quality of life despite having chronic pain or fatigue. It is not a cure for either condition.

Pulmonary Rehabilitation and Cardiac rehabilitation - Powys Teaching Health Board

As part of multidisciplinary teams, physiotherapists provide exercise, education and advice to patients suffering with long term chronic respiratory conditions to help 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. Close links with NERS enables long term self-management.

Cardiac Rehabilitation - Abertawe Bro Morgannwg University Health Board

Cardiac Rehabilitation programmes are run at various venues throughout Bridgend and Neath Port Talbot for patients who have had a Myocardial Infarct, Stent, Coronary artery bypass or Valve surgery. These programmes provide multidisciplinary education and exercise sessions for patients recovering from a Cardiac event. The aim is to educate the patients on all aspects of their condition and to motivate them to make healthy lifestyle changes to reduce their risk of further cardiac events.

Cardiac Rehabilitation – Betsi Cadwaladr University Health Board

Physiotherapy is a key part of the multidisciplinary team providing cardiac rehabilitation across North Wales in a variety of locations which are accessible to the people of North Wales.

Cardiac Rehabilitation/Community Resource Team (CRT) Physiotherapy Collaboration Projects – Abertawe Bro Morgannwg University Health Board

(1) Low – Mod Risk Stratified Cardiac Patients are being moved into already existing Physio led Community Exercise classes as part of their standard Cardiac Rehab package. Education / Nursing / Psychological support continues to be provided as previously in a group format ensuring patient co support is not diluted.

Early indications show patients are being seen sooner, in a timely way as set out by the BACPR Standards with positive patient satisfaction and with the aim of waiting list reduction.

(2) Cardiac patients deemed ‘not in the high priority group’ for Cardiac Rehabilitation and not fitting into Cardiac

Rehabilitation acceptance criteria but sourcing and being denied exercise due to their complex physiological background are being screened and assessed by the Specialist Cardiac Rehab Physiotherapist and Physiotherapy CRT. These patients if appropriate are filtered into the already existing exercise classes and as appropriate referred to other sources. These patients would previously have no access to Physiotherapy treatment.

Lymphoedema services - Hywel Dda University Health Board

The service provide joint interventions for complex leg led by physiotherapists (Lymphoedema specialists) and district nurses working closely with tissue viability nurses.

Community Based Pain Management Program - Hywel Dda University 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.

Haemophilia – Betsi Cadwaladr University Health Board

A physiotherapy haemophilia service has been started in North West Wales to offer advice and treatment to manage this complex condition. A major component of this role is condition management and prevention of joint damage. The physiotherapist is a member of a specialist MDT.

Macmillan Health and Wellbeing Clinics – Betsi Cadwaladr University Health Board

A physiotherapist is seconded to Macmillan to support the Health Board in seeking to test, inform and accelerate local change by piloting the delivery of Macmillan Health and Wellbeing clinics with a view to establishing such clinics as an integral part of the cancer pathway across North Wales. Health and Wellbeing Clinics are one off multi-disciplinary clinics to support patients to get back to everyday life.

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.

Community Pain and Fatigue Management Sessions - Powys Teaching Health Board

These are a pair of sessions which provide an overview of pain and fatigue management strategies. The sessions are run throughout Powys and it is recommended that people attending these sessions also attend the Invest in Your Health Programme. Each session is 2½ hours and they are usually 7 weeks apart.

Invest in Your Health - Powys Teaching Health Board

The Invest in Your Health Programme is run in local venues throughout Powys. It is a 6-week programme (2½ hours per week) led by a member of staff from the Health Board working with a trained volunteer facilitator. The programme looks at helping you develop a series of evidence based self-management skills to help participants maximize their health and wellbeing. The course is also available through Skype for Business platform for people who find it difficult to attend the community run courses.

Pain Management Plan Workbook - Powys Teaching Health Board

Those who request it are provided a copy of the "Pain Management Plan" workbook. This contains information and advice on managing pain as well as activities to work through to help people learn to manage their pain. Telephone or skype based coaching is available to support people through the process.

The Back Care Programme – Cwm Taf University Health Board

The back care programme is a community-based programme based in local leisure centres and was recently commended by the Minister for Health, Social care and Sport. It is run by the physiotherapy service and designed for groups of 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.

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.

ACTivate Your Life - Powys Teaching Health Board

ACTivate your Life is a 4 session course designed by Prof Neil Frude which uses Acceptance and Commitment Therapy to help people improve their health and wellbeing. It is delivered in lecture format and therefore can be attended by large groups.

Neuro Rehabilitation Clinics - Powys Teaching Health Board

Patients are seen in a Community Neurological Clinic, offering a multi-disciplinary and 3rd sector 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. 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.

Neurological Outpatient Services – Hywel Dda University 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.

Neurological Physiotherapy Self-referral – Cwm Taf University 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 University 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.

Huntington's Disease Service – Aneurin Bevan University Health Board

Physiotherapy is an integral part of this specialist community based multidisciplinary team to support patients with Huntington's Disease within ABUHB.

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.

'MOVE' Programme – Aneurin Bevan University 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.

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.

Community Independence and Wellbeing Team (CIWT): Complex Care Service for People with Long Term Conditions – Abertawe Bro Morgannwg University Health Board

CIWT is a multi-disciplinary team and supports people with complex and long term life limiting illnesses, chronic progressive or improving health conditions, and sudden onset impairment as a consequence of trauma, physical or sensory needs. The team is jointly run and managed with Bridgend County Borough Council, providing therapy and social care services for adults within the Bridgend local authority. The team has a range of skill mix ranging from specialist therapists, clinical nurse, social workers in adult disability, and sensory service for visual and hearing impairment. CIWT utilizes this skill mix in order to provide holistic rehabilitation and care. Support and services are delivered at home or social environment/community in which the person lives. The team also work people who have family or carers who require advice or assistance to support them in their caring role.

Mental Health Community Physiotherapy - Abertawe Bro Morgannwg University Health Board

Based at the Princess of Wales Hospital, the mental health physiotherapy team provide a domiciliary service for clients who are unable to access mainstream services. We see clients in their own homes or in care homes and are able to provide advice, tailored exercise programmes, falls management and postural management assessments. We work closely with the mental health teams to ensure that our input is timely, effective and sustainable.

Management of Ankylosing Spondylitis Patients - Abertawe Bro Morgannwg University Health Board

A highly specialist physiotherapist provides information and education on a one to one basis re A.S and offers self-management advice, exercises and information re NASS and local groups. Patients are also registered on the "Talking A.S" website so they can regularly record their BASDAI, BASFI and BAS-G scores in order to self-monitor their chronic condition. Specific problems can also be addressed and an appointment with their rheumatologist fast tracked, as required.

LEADERSHIP OF MULTI-AGENCY/DISCIPLINARY TEAMS

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.

Complex needs clinics - Hywel Dda University Health Board

Multidisciplinary clinics both in Children and Young Peoples services and Adult Neurological services led by physiotherapy. These clinics include agreed referral and assessment criteria and recorded person centred plans in order to support a model of co-production and evidenced outcomes.

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.

Musculoskeletal Interface Service – Aneurin Bevan University Health Board

A well-established team created to provide expert assessment and advice in the conservative management of MSK conditions. The team comprises physiotherapists and podiatrists who assess patient with complex MSK conditions, providing a triage service to determine appropriate pathways into hospital based secondary care services such as orthopaedics, rheumatology or providing expert advice for ongoing conservative management through mainstream therapy services, primary care and patient self-management. The team also provide advanced treatment interventions. This reduces unnecessary referrals and contributes to the management of RTT.